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The Moral Reasoning of Nurse Practitioners

Diane C. Viens DNSc, MS, FNP, RNC
University of San Diego

THE MORAL REASONING OF NURSE PRACTITIONERS

by

Diane C. Viens, M.S., R.N.C., F.N.P.

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Dissertation Committee
Patricia A. Roth, Ed.D., R.N., Chairperson
Rosemary T. Goodyear, Ed.D., R.N.
Anna K. Omery, D.N.Sc., R.N.

ABSTRACT

THE MORAL REASONING OF NURSE PRACTITIONERS

The purpose of this phenomenological study was to identify the moral dilemmas experienced by nurse practitioners in their clinical practice and to describe the essential features of moral reasoning utilized by the nurse practitioners to resolve the moral dilemma.

The participants in the study were ten female volunteers who were currently employed as NPs in a variety of settings. Unstructured interviews were conducted with the participants and the qualitative data was analyzed using a nine step process.

Five essential features of moral reasoning emerged through the process of data analysis: values, elements in the contextual framework for moral reasoning, influencing factors, recognizing the dilemma, and outcomes. The first essential feature, values were those ideals which motivated the participants in making decisions amid competing choices in any given situation. The next essential feature, elements in the contextual framework for moral reasoning described the environment in which the NP practiced, including other persons within that setting. Elements in the contextual framework for moral reasoning also described the nurse practitioner role and referred not only to the activities the NP performed, but also to the nurse-patient relationship. Influencing factors were those elements that changed the everyday, clinical practice of the NP into one

which became a moral dilemma. Influencing factors impacted the setting, the participants within the setting, and were the factors taken under consideration in the decision making process. One or more of these influencing factors were catalytic in motivating the practitioner into making a decision about the dilemma. The catalysts emerged because of certain values which were held in high esteem by the participants.

Two patterns of moral reasoning were identified: independent and lateral reasoning. The nurse practitioners who utilized the independent pattern of reasoning based their decision making on self-chosen values regardless of other influences present in the situation. Lateral reasoning was a mode of reasoning where the individual chose to defer the decision to others in the environment.

The implications for nursing practice, education and research based on the findings in this study are discussed. Recommendations are proposed which include further research into the essential features of moral reasoning to determine whether the findings in this study can be generalized to other nurses. It is hoped that research studies such as this will advance the knowledge of nursing and other disciplines concerning moral reasoning and ethics.

DEDICATION

TO

The memory of

my parents, Arthur and Louisia Viens
I would have loved to have you here
with me to see your daughter graduate.
I thank you for having given me
the love of knowledge and
the perseverance to go after what I want

AND TO

The nurse practitioners in this study
who exemplify the profession of nursing
at its finest
and
who gave me an unexpected gift:
a renewed love and pride in my profession

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And last, but by far not the less, to Bosha, my best friend and partner in life, the sacrifices you've made during these years will not be forgotten. THIS ONE'S FOR YOU!

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CHAPTER 1

Currently, there is an increased awareness of ethical issues in all aspects of everyday life. National leaders who have been implicated in unethical behaviors have focused attention on questions of ethical conduct. Further, the AIDS epidemic, the abortion issue and increased use of modern technology in health care have heightened public awareness of ethical issues.

The nursing profession has also experienced a resurgence of interest in ethical issues. Rapid technological advances in health care and the inherent moral dilemmas created by these changes have sparked interest in the ethical dimension of nursing practice. The nurse is often caught "in the middle" (Aroskar, 1988, p. 123) between the potentially diverse wishes of the client, the family and the physician. Aroskar (1988, p.127) suggested that a new triad of "the nurse-patient-machine" may further compromise the nurse's ability to care for clients by establishing a barrier in which the nurse relates to the machine rather than the patient.

As health care technology has mushroomed, health care resources have dwindled. Nurses are faced with caring for individuals whose needs cannot be adequately met by the prevailing health care system. Nurse may find themselves

again caught "in the middle" between the under-served client and the institution and/or governmental mandate which may prohibit providing the nursing care the client requires. The resurgence of interest in ethics reflects a long tradition of concern for ethics in nursing.

The history of nursing indicates that as early as 1897 there was movement to formulate a code of ethics for nurses. A code of ethics for nurses has been in place since 1950 and has been revised several times (Viens, 1989). The code of ethics serves as an "implicit contract through which the profession informs society of the standards and values by which it functions" (Viens, 1989, p. 45). The code also serves as a guideline of the standards of ethical conduct for the professional nurse. The code of ethics for nurses, however, has only been one means of addressing ethics in professional nursing practice.

The efforts over the last two decades of the nursing profession's efforts to delineate its epistemology has also had its impact on nursing ethics. As nursing has sought to establish its own separate body of knowledge through philosophical inquiry and empirical research; so too has the profession begun to question the ethical foundation of nursing practice as separate from that of medicine. This has led to inquiry on the foundation for a nursing ethic.

Concurrently, quantitative research has been conducted which has attempted to document ethical dilemmas and to

describe the process of moral reasoning and moral decision making in nursing (Gortner, 1985, Ketefian & Ormond, 1988). In addition, nurses have increased their individual knowledge by attendance at continuing education seminars about ethics (Fry, 1989a, Omery, 1989). Books and publications on nursing ethics have flourished. In the 1980s, there were approximately 60 books and articles per year on nursing ethics as compared to five articles per year in the 1960s (Pence, 1986). All of these factors have contributed to increased interest and inquiry about the topic of ethics within the profession of nursing.

Statement of the Problem

Professional nurses encounter moral dilemmas in their practice daily. Health care has become increasingly complex, which has necessitated advanced knowledge of sophisticated technology. The professional nurse provides nursing care within this complex health care system to individuals who are often faced with difficult issues, some of which are dramatic life and death decisions. The nurse is often called upon to assist the client to reach a decision when perplexing problems rise. The very nature of the practice of nursing then, implies that the activities the nurse performs in carrying out her responsibilities are potentially charged with issues of a moral nature. The professional nurse must therefore be prepared to act as a moral agent.

The nursing profession has long had an interest in the moral issues which its practitioners encounter. To prepare nurses for making moral decisions in practice, nursing education has placed emphasis on the use of bioethical principles and models of ethical decision making. Nursing research has focused primarily on the measurement of and the variables which influence moral development and moral reasoning among professional nurses.

Research has established that nurses are able to identify moral dilemmas in their practice setting, however, much less is known about the essential features of these experiences for the nurse and how these moral dilemmas are resolved. A few research studies have begun to focus on the description of the thoughts and feelings of selected groups of nurses who have been involved in a moral dilemma (Holly, 1986, Cooper, 1990a, Omery, 1985, Wilkinson, 1987/88, Zablow, 1984).

While this is a sound beginning to elucidate the moral dilemmas experienced by nurses and the moral reasoning utilized to resolve them, nurses working in acute care settings have been the predominant participants in these studies. Only two nurse researchers (Aroskar, 1989, Murphy, 1976) have conducted research in moral decision making outside the hospital environment. Yet, the trend in health care is for fewer clients to receive nursing care in institutions and for more clients to be cared for outside

the acute setting. Little is known about the moral issues the professional nurse experiences in the community, in primary care and in work or school settings. Aroskar (1977) proposed that a setting other than the acute care setting changes the nurse's relationship with the client in that there is increased autonomy for both the client and the nurse. Little is known about whether moral dilemmas and their resolution are influenced by these differences in setting and the amount of perceived nurse/client autonomy. Nurse practitioners are nurses who practice in a variety of primary care settings.

Nurse practitioners (NPs) are registered nurses with advanced preparation who provide health care to clients of all ages. They may work alone or with other health care providers. Nurse practitioners provide comprehensive services which can include physical examinations and complete health assessments, treatment of common acute episodic and chronic stable illnesses. Many nurse practitioner programs emphasize health education, health care information, counseling and guidance as a strong part of the NP's role (Brown & Waybrant, 1988). The NP's educational preparation can vary widely, anywhere from a one year's certificate program to programs of two years or more which usually culminate in a masters degree in nursing.

The recent trend has been for nurse practitioner preparation to be at the graduate level. This has received

support from the major nursing and specialty organizations and has been reflected in the job market by the increasing demand for NPs with a masters degree as a requirement for a variety of positions. A study of the job market over a ten year period suggested that the importance of advanced preparation at the doctoral or masters level increased significantly (Shanks-Meile, Shipley, Collins, Tacker, 1989). Requirements in most states to function as a nurse practitioner includes RN licensure and certification by national nursing organization.

Nurse practitioners may work in ambulatory clinics, health maintenance organizations, jails, senior centers, nursing homes, occupational health, schools, physicians' practices, and shelters for the homeless and by virtue of their unique role often function quite autonomously. This may include seeing a case load of clients for which the NP is responsible for the assessment, diagnosis and care, including treatment by protocol, of acute and chronic illnesses. A physician may or may not be available on site for consultation. The nurse practitioner must therefore provide what has been traditionally viewed as medical care as well as nursing care. Little is known about the moral dilemmas the nurse practitioner encounters and how this duality of roles influences these dilemmas or the moral reasoning used by the NP to resolve the moral dilemmas.

Purpose

The purpose of this research study was to describe the essential features or characteristics of the moral reasoning experienced by a selected group of nurse practitioners in the practice setting. Two research questions were generated from this problem statement:

First, what is the moral reasoning used to resolve these moral dilemmas?

This question was further divided into two parts:

a) what are the essential features or characteristics of this moral reasoning and

b) what are the interrelationships between these essential features of moral reasoning?

Second, what are the moral dilemmas experienced by nurse practitioners in their clinical practice?

Definition of Terms

For the purposes of this study the following terms were defined:

Moral Dilemma: a perplexing situation related to right or wrong, where there are two or more courses of action, none of which are clearly satisfactory or unsatisfactory.

Morality: an individual's sense of right and wrong based on one's values and beliefs.

Moral Reasoning: a psychological process by which an individual deliberates about a situation which involves issues of right and wrong conduct.

Moral Judgement: the decision or outcome made by the individual in a situation involving issues of right and wrong conduct.

Essential Features: those necessary characteristics which make up the phenomenon under study (Omery, 1985, Spiegelberg, 1982). Without these essential features, the phenomenon would cease to be what it is or change drastically (Psathas, 1973).

Assumptions

An assumption is a statement which is accepted as true and does not need verification (Polit & Hungler, 1989). Assumptions were stated before data collection was begun. It is important in qualitative research for the researcher to critically examine assumptions and biases in order for these to be set aside during the research study (Schatzman & Strauss, 1973). This was particularly important when the research method was eidetic phenomenology. In eidetic phenomenology, all assumptions must be identified and bracketed or set aside in order for the researcher to view the phenomenon under observation without preconceived notions (DaSilva, 1988, Swanson-Kauffman & Schonwald, 1988). For this research study, the assumptions were as follows:

1. Nurse practitioners encounter moral dilemmas in their practice setting.
2. Nurse practitioners will be able to describe the moral dilemmas which they experience in their practice setting and

the resolution of these moral dilemmas.

3. While recognizing that nurses as a group are representative of the pluralistic society in which we live, with diverse values, behaviors, and beliefs, the descriptions given in this study will be reflective of the nurse practitioner's experience with moral dilemmas.

4. Both moral orientations, justice and care, have been noted to be utilized by both men and women in resolving moral dilemmas and neither orientation is exclusively used by either sex.

5. The nurse practitioner often practices autonomously in settings in which she may physically be the only health care provider present. Further, clients in primary care settings come to the NP for an encounter which is often very brief. The client may or may not choose to comply with the instructions the NP has given, giving the client in a primary setting considerable autonomy. This autonomy on both the part of the nurse practitioner and the client will influence the type of dilemmas and the moral reasoning the nurse practitioner experiences.

8. The relationship between the client and the nurse practitioner is unique and this uniqueness will influence the kinds of dilemmas and the moral reasoning the nurse practitioner experiences.

9. The nurse practitioner performs some functions, such as prescribing medications by protocol, which have been viewed

as belonging to the role of the physician. This expansion of the role of the nurse will influence the moral dilemmas and the moral reasoning the nurse experiences.

Significance of the Study

The nursing profession is currently engaged in scholarly dialogue in an attempt to define its own ethic. Whatever the outcome of that endeavor, a research study which described the process of moral reasoning of practicing nurses can only add knowledge to that inquiry. The descriptions of moral dilemmas as recounted in this study may provide cues and insights as to where the moral foundation of nursing lies. If nursing wishes to begin to distinguish an ethic for the nursing profession, it seemed essential to attempt to begin to describe the issues and the reasoning process utilized by nurses in their practice. Approaching the nursing ethic question from a practice standpoint as well as a theoretical/philosophical standpoint seemed to be the most advantageous approach.

The profession's movement towards a nursing ethic will help to differentiate for nursing itself and for society the uniqueness of the discipline of nursing (Omery, 1989). This can only help to strengthen the profession from within and strengthen the image of nursing as a profession with other disciplines and for society.

This qualitative study describes the moral dilemmas faced by nurse practitioners in their practice and adds to a

beginning description of moral dilemmas in the nurses' own words and gives voice to a group of professional nurses who thus far have been unheard.

Additionally, unresolved moral dilemmas in practice have been implicated as a contributing factor to increased stress in professional nurses (Wilkinson, 1987/88). Wilkinson (1987/88) suggested, based on a phenomenological study conducted with acute care nurses, that the frustration and stress of being unable to successfully resolve moral dilemmas contributed directly not only to the quality of patient care but to nurses leaving the profession. A better understanding of the moral dilemmas experienced and their resolution can shed light on these issues and has the potential to ultimately impact the quality of care as well as the retention of nurses within nursing.

Information from this study may help to provide direction for the future education of nurse practitioners on ethical issues in practice in order to shape nurse practitioner education which more closely resembles the practice setting and thus better prepares the nurse for practice. Further, the nurse practitioner community can gain much insight from a description of moral dilemmas encountered by their peers.

Research conducted on moral issues and decision making is of interest to many disciplines inside and outside of health care. This study adds to the understanding of that

phenomenon and is of benefit to other disciplines. Moreover, since nursing is predominantly a women's profession, knowledge of the process of moral decision is of particular interest to other disciplines who have interest in adding to the understanding of the differences and similarities between sexes in regards to moral decision making.

Each profession has an obligation to clarify the ethical practice of its practitioners for society at large. This descriptive study helps to clarify nursing's position within the health care system. With the current interest in ethical issues, there seems to be a societal mandate for professions to examine their moral actions. This research study was an attempt to examine nursing ethics and ethical issues.

CHAPTER 2

REVIEW OF THE LITERATURE

A review of the literature suggests that there have been several factors which have influenced ethics in nursing. Nursing has long had an interest in ethics as is evidenced by the Code of Ethics for Nurses' history, dating back to the turn of the century. Further, ethical content was always included in the curriculum of the early schools of nursing. Content on ethics from other disciplines has also shaped ethics in nursing. Nursing has often borrowed and integrated content from other disciplines, particularly that of medicine. As a result, nursing ethics has been strongly influenced by biomedical ethics, particularly in nursing education. The moral development model of Lawrence Kohlberg and more recently that of Carol Gilligan have also impacted the nursing profession. Much of the research in nursing ethics has predominantly centered around the measurement of the moral development and moral reasoning of its practitioners, utilizing Kohlberg's model of moral development as a theoretical framework. Most recently, discussion has focused on the distinct and unique moral foundation of nursing, which may ultimately lead to a separate nursing ethic. All of these factors have shaped

ethics in nursing. The review of the literature for this study addressed these influences which play a part in a discussion of today's nursing ethics.

Historical Overview

In the early history of American nursing education, content on ethics was viewed as an important part of the nursing curriculum. Nurses obtained information about ethics primarily from content given in lectures at their training schools and from texts on ethics. However, there seemed to be much confusion among nurses about what ethics really was. Although texts purported to discuss nursing ethics, often the content was devoted to matters of etiquette and the virtues that the "good" nurse ought to possess.

In the 1950s and early 60s, ethical content and separate ethics courses in particular, seemed to all but disappear from nursing curricula. An exception were those nursing programs with a religious affiliation. Fry (1989b) stated that no one is quite sure why this occurred in nursing education. However, the 70s and 80s witnessed unprecedented interest in nursing in the area of ethics as evidenced by the tremendous increase in publications on the subject (Pence, 1986). Over the years, the concept of ethics changed as the profession of nursing evolved. The changes in the ANA Code of Ethics for Nurses is reflective of these changes in the profession (Viens, 1989).

The Code of Ethics for Nurses

The American Nurses Association's Code of Ethics for Nurses has been in existence since 1950 when it was ratified by the membership at its national convention (Viens, 1989). A professional code serves two main functions. It is a contract with society, outlining for the public the ideal conduct of the profession's practitioners. It also serves as a guide to the nurse as the standard of conduct or ideal ethical behavior that the nurse is expected to emulate (Cox, 1985, Omery, 1989). Inherent within the code are moral principles such as autonomy, beneficence, justice, and fidelity which are deemed to be essential for ethical practice (Cassells & Redman, 1989). Fry (1989c) suggested that the inclusion of the code may help the nursing student to focus on the moral values prized by the profession. The professional nurse ought to be familiar with and utilize the code in clinical practice as a guide to ideal ethical behavior.

Some have misinterpreted the purpose of the code and have suggested that it be used to resolve ethical dilemmas. Gaul (1989), in a discussion of the study of baccalaureate students by Cassells & Redman (1989), stated that the majority of respondents did *not* utilize the Code for Nurses as a *basis* for resolving ethical dilemmas in practice. A research study (Cox, 1985) which examined ethical decision making by a random group of staff nurses reported that few

nurses used the Code as a basis for ethical decision making. The use of the Code of Ethics alone as a framework for making ethical decisions is not the intent of a code of ethics. The code is meant only as a guide to ideal behavior. There is no provision within the Code as to how a nurse decides on the parameters of that ideal behavior. The nursing profession is now only beginning to address the parameters of what "ought" to be done in a given clinical situation. The recent statement by the American Nurses Association's Committee on Ethical Practice (1988) on withdrawing and withholding food and fluids from individuals which outlines specific guidelines of what the nurse "ought" to do when dealing with this dilemma is a good example of the use of normative ethics in nursing.

A nurse educator who misconstrues the intent of a code of ethics may pass this misinformation on to students. As a result, the graduate nurse may be misled in believing that the use of the Code will solve moral dilemmas in clinical practice. Stenberg (1982) went so far as to state that the study of the nursing code ought to be included in nursing ethics content expressly to make the point that codes are limited tools for ethical decision making. Nurse researchers who attempt to measure the use of the Code of Ethics by nurses in direct relationship to ethical decision making may misinterpret the results of the data and suggest that nurses are not resolving moral dilemmas in their

practice; when in fact what they may be measuring are the nurses' familiarity with and purpose of the Code in the practice setting.

In summary, it is essential that nurses become familiar with their professional code of ethics. Content in ethics in nursing has often included presentation of the Code of Ethics for Nurses, however, it is essential that there also be clarification of the intended uses of a professional code so that nurses may utilize their code appropriately in their practice.

Several theoretical frameworks for presenting content in nursing ethics have also been utilized. These will be reviewed in the next section.

Theoretical Frameworks for Approaching Nursing Ethics

Biomedical Ethics Approach

Currently, there is animated debate about whether there is a separate nursing ethic and what such an ethic might look like. Some ethicists (Veatch, 1981) continue to maintain that nursing ethics is a sub-category of biomedical ethics. This point of view is understandable when placed in the historical context of medicine's dominant position in the health care arena. As a result, the use of the biomedical ethics approach has been and continues to be the most frequently utilized framework to teach ethics in nursing and has led to application of biomedical ethics to moral dilemmas in nursing practice (Fry, 1989c).

The deontologic and utilitarian approaches are used as the basis for evaluation of moral dilemmas within this paradigm (Bandman & Bandman, 1985, Beauchamp & Childress, 1983, Gaul, 1989, Thompson & Thompson, 1985). Emphasizing a posture of detachment and objectivity, moral principles and rules are applied to the situation in order to reach a decision. Reliance upon rules and principles guides and justifies ethical choice.

It is understandable why this approach has been attractive to nursing. It was introduced into nursing's curriculum before much of the discussion about a separate nursing ethic was formulated. Further, the content can be borrowed from biomedical ethics fairly intact into nursing; and probably was first introduced by nurses who pursued information about ethics from departments of philosophy or from bioethical institutes. In addition, the bioethical approach came into favor during a time when the scientific method was very popular in the community of nurse researchers and educators. Many aspects of the bioethics approach to nursing ethics resemble the scientific or quantitative method. It is a very logical, objective and deductive means to solve an ethical dilemma. Blum (1988) labeled this the "*impartialist* view of morality" (p. 472). Information about the bioethics approach provides a sense of certainty and consistency, giving the individual the feeling that use of bioethics will readily resolve moral dilemmas in

clinical practice.

On the other hand, there are drawbacks to the use of this paradigm. Churchill & Siman (1986) have cautioned against the misuse of principles in moral discourse. The use of principles needs to be less as instruments of certainty and more "...like compasses giving us direction, but rarely dictating a single path or destination..." (p. 464); and "...more as tools for guiding actions, like probes to find our way in a dimly lit room" (p. 464). This viewpoint echoes that of Toulmin (1981) who advised that reliance solely on principles can become its own form of tyranny.

For nursing, the use of the biomedical model has caused additional concern. Fry (1989c) has suggested that when the framework for ethics in nursing is biomedical "the result is a trend in nursing ethics that does not take into consideration the role of nurses in health care, the social significance of nursing in contemporary society, or the value standards for nursing practice" (p.12). It indeed places nursing ethics as a subcategory under biomedical ethics. Further, the issues that a nurse may have as a health care provider may be substantially different from others on the health care team. However, these may not necessarily be identified under this framework. Nurses may face moral problems of a unique nature and may indeed not solely rely upon traditional concepts for ethical deliberations (Cooper, 1990a). This results in a ethical

framework for moral dilemmas which may not be adequate for the complexities of the moral health care dilemmas. The moral dilemma experience in nursing can easily be lost utilizing the biomedical approach (Yeo, 1989).

Despite these criticisms, the traditional approaches to ethical issues can offer much to nursing in terms of ethical theories and principles and their application to situations common to all of health care. It is not necessarily an inappropriate framework for nursing. An understanding of the predominant theories, rule and principle decision making provides a framework for dealing with some of the ethical issues which are facing those involved in health care. In addition, use of a mutual paradigm for ethics fosters dialogue between health care professional when situations of a moral nature arise.

Additional Approaches in Nursing Ethics

Articles and texts on ethics in nursing have reflected the dominant philosophical framework of rule and principle ethics (Aroskar, 1977, Benjamin & Curtis, 1981, Bunting & Webb, 1988, Jameton, 1984, Thompson & Thompson, 1985). "Most nursing articles and texts on nursing ethics assume that the moral foundations supporting the nursing ethic have the same distinct characteristics of a physician or biomedical ethic, rather than a specific nursing ethic" (Cooper, 1990a, p. 14).

While the rule and principle approach has been

prevalent in the nursing literature, some exceptions have been noted (Cooper, 1990a). Zuzich (1978) presented both structuralist and situation ethics as alternative ways of viewing nursing ethics. Situation ethics was described as a one norm ethics and viewed love and justice as one and the same, therefore the only norm for making any decision is love. Structuralist ethicists have claimed that there is an inherent"...moral code of which the individual is unaware and which he cannot express. This deep structure is innate and common to all men" (Zuzich, 1978, p. 6). This innate code provides for the creative solution of moral dilemmas within and outside of traditional means of moral decision making.

Other authors, while using the traditional ethical approaches, have placed emphasis on other aspects of nursing ethics. For example, although Benjamin & Curtis (1981) discussed ethical rules and principles, they also focused on issues of nurse-patient, nurse-physician, nurse-institution relationship and issues of paternalism and confidentiality.

Jameton (1984) positioned nursing as "the morally central health care profession" (p.xvi). Nursing not medicine ought to determine the future of health care. This was in sharp contrast with Veatch's (1981) view of nursing as subordinate to the medical profession. Furthermore, Jameton broadened the definition of an moral dilemma for nursing to go beyond the conventional one given in many

biomedical ethics textbooks which state that an ethical dilemma exists only when two moral principles are in opposition (Beauchamp & Childress, 1983). Jameton has sorted moral problems into three types: when the nurse is unsure which moral principles apply to a situation or may even be unsure that a ethical problem exists, the nurse is said to have *moral uncertainty*. *Moral dilemmas* arise when the nurse knows that two or more moral principles are in opposition, but no choice is clearly the best choice. When the nurse is clear about the course of action, but institutional constraints prevent the nurse from pursuing the right course of action; *moral distress* is said to exist. This expanded definition allows for a fuller expression and representation of the experience of the practicing nurse in dealing with moral dilemmas.

Curtin and Flaherty's (1982) text placed emphasis on the humanistic aspect of nursing and the specific responsibilities that were involved. It characterized ethics as involved in all client interactions, not just the dramatic life and death situations. Normative approaches of teleology and deontology were included as well as non-normative approaches to nursing ethics. Non-normative ethics included ethical emotivism, ethical skepticism and ethical relativism. Emotivists claim that ethical action is based on emotional feelings and skeptics believe that human beings do not really know the difference between right and

wrong. Ethical relativism is closely related to situation ethics. The determination of right and wrong is contextually, culturally or relative to the individual.

In addition to these various ways of viewing ethics in nursing, many authors have developed models to facilitate the ethical decision making process.

Decision-making models

Decision making models have appeared in several of the publications on ethics in nursing (Aroskar, 1977, Bunting & Webb, 1988, Curtin & Flaherty, 1982, Thompson & Thompson, 1985). White (1983) has referred to this phenomenon as "formula ethics" (p. 42-43). These models often appear as elaborate diagrams, circles or a series of steps, which if followed, promise to lead to resolution of the moral dilemma (Omery, 1989). This reduces nursing ethics to a precise mechanical technique in which to resolve ethical problems. The moral dilemma must be compressed to fit the steps in the model.

The ethical decision making models are based on the problem solving process. One is led to believe that use of the models will allow the individual involved in the dilemma to make a choice of an alternative and reach a resolution. Inherent in this process must be the examination of one's values in order to arrive at that choice (Omery, 1989). If values clarification content is not included in the process, then the individual may be at a loss when use is made of the

ethical decision making model. It has been proposed by White (1983) that the links between values clarification, ethics and decision making have not been carefully developed and are all distinct activities that do not necessarily blend well together. All of these activities take time to learn and elements of each are not usually included in a ethics course. Additionally, application of ethical principles and theories to an ethical dilemma do not immediately produce a resolution. The impression is often given that use of "formula ethics" will do just that (White, 1983).

Limited exposure to a decision making model for nursing ethics (Bunting & Webb, 1988), as often appears in nursing journals and ethics texts, without some in depth understanding of the complex philosophical issues involved may also lead the nurse to assume that the model can be utilized as is presented in the clinical setting. However, ethical dilemmas which occur in practice do not necessarily happen in the order prescribed by the ethical decision making model (Fry, 1989b). It is often a haphazard process, information is gathered in bits and pieces. The dilemma may occur in a crisis situation where there is little time to initiate the decision making model and the steps then are of little use. The models can, however, be a beginning or reference point in beginning to think about moral dilemmas in nursing practice and can be helpful in providing the

nurse with a method of approaching a moral dilemma and systematically gathering information about the issue.

Along with the use of the biomedical approaches to nursing ethics and the generation of a number of decision making models, an area that has received considerable interest in nursing ethics has been in the area of moral development and moral reasoning. For nursing, by far, Kohlberg's model of moral development has been the leading theoretical framework used in nursing education as a means of understanding and fostering moral development and has also found extensive use in nursing research to describe the moral development of nurses. In addition, Kohlberg's model of moral development has been purported as a basis for beginning theory development in moral behavior for the nursing profession (Ketefian, 1987). Kohlberg's model has also been advocated as a framework for teaching ethics (Munhall, 1982, Stenberg, 1982) and has been reported to have been added to some nursing assessments (Miller, 1984).

Kohlberg's Model of Moral Development

Building on the works of Dewey and Piaget, Lawrence Kohlberg (1984, 1987) formulated a model of moral development with three levels, each level having two stages. Each stage is sequential and is viewed as a structured whole; that is to say that individuals function consistently within these stages in all situations of their lives. Moving from stages one through six depicts movement from

simple to more complex moral reasoning. As the individual moves from one stage to the next, s/he integrates all the information learned from the previous stage. The model can then be described as a cognitive developmental model, hierarchical in nature and based on the principle of justice (Kohlberg, 1984).

According to Kohlberg, there are certain factors which favor moral development. Advancement in moral development is dependent upon continued development of cognitive thinking. The individual must develop essential critical thinking abilities necessary to reason morally. In addition, an environment which stimulates discussion; fosters accountability and responsibility for moral decisions and an awareness of the consequences of those decisions appears to facilitate moral development. Furthermore, the educational setting which deliberately fosters cognitive conflict and dissonance stimulates the individual to look for ways to resolve conflict. Participation in this disequilibrium forces the individual to examine old ways of thinking and results in movement to a higher level of moral reasoning (Ketefian, 1981a, Kohlberg, 1984). The educational setting clearly plays an essential role in moral development.

Kohlberg's stages of moral development

Kohlberg's model is organized into three levels each with two stages (Kohlberg, 1984, Thompson & Thompson, 1985).

At the first level, the Preconventional level, moral reasoning is viewed as self-centered. In the first stage (Level I), authority and avoidance of punishment are the motivators for doing the right thing. At the next stage, fairness becomes paramount in making moral reasoning. The individual deduces that being fair to others will in the long run allow personal needs to be met.

Level II, the Conventional level, has two stages which finds the individual moving from the self-centered view of Level I to a societal perspective. At Stage 3, Mutual Morality, doing right is doing what peers expect or what is dictated by one's role in society. With the next stage, the individual moves to doing right in order to maintain social order.

The highest level, Level III, is called Principled Morality and contains two stages. Moral reasoning in Stage 5 moves to right as doing good for the greatest number. Stage 6 is the Universal Ethical Principled Morality where right is following one's own chosen ethical principles. As the individual moves through the stages s/he moves from an egocentric perspective to a universal perspective.

Critique of Kohlberg's Model of Moral Development

This cognitive developmental theory has been well accepted in nursing for several reasons. Kohlberg's model fits the prevailing framework of bioethics well because Kohlberg emphasizes the principle of justice as the essence

of morality. An additional added attraction is that Kohlberg's model can be borrowed in its entirety and applied to nursing. Some tools to measure moral development have already been developed and tested for reliability and validity. In addition, this model allows for the placement of individuals into one of six stages of moral development, thus making comparing and contrasting nurses with other population groups possible. Moreover, it is important to note that Kohlberg's model gained in its popularity within nursing during an era when quantitative research was most valued. Thus a model which facilitated the measurement of moral judgement as an outcome was valued within nursing's research community. Omery (1983b) posited that the model was also attractive because the highest levels of moral development were made to seem attainable if the nurse was exposed to appropriate role models and was placed in situations of "cognitive dissonance" (p.14).

Initially, nursing appeared to accept Kohlberg's model of moral development without assessment of its limitations as well as its assets. The model had been widely used in part because of Kohlberg's claim of reliability and validity across age span, culture and socio-economic conditions throughout 20 years of longitudinal and cross-cultural studies (Gilligan, 1982, Ketefian, 1987, Kohlberg, 1984, Omery, 1983b). In recent years, however, there has been evidence in the literature, both in and out of nursing, to

suggest that Kohlberg's model needed to be evaluated carefully before its use was adopted without question. Omery (1983b, 1985) and Parker (1990) reviewed the literature which has critiqued Kohlberg's model. These reviews have elucidated challenges to several of the assumptions upon which Kohlberg's model was based.

The claims of reliability and validity of Kohlberg's model of moral development have been disputed by many who have suggested that there has not been a consistent pattern of findings among research studies in moral development utilizing this theoretical framework. Parker (1990) has proposed that this may demonstrate that the instruments utilized do not adequately measure moral development or that the theory on which the instrumentation was based is invalid. These two criticisms go hand in hand, as it is difficult to establish a valid instrument for a concept such as moral development if that concept is not situated on well-grounded theory (Parker, 1990).

There has also been evidence of recurrent regression in the stages of moral development thus bringing into question Kohlberg's assertions that an individual moves through the levels and stages of moral development in a sequential and irreversible manner (Omery, 1983b, Parker, 1990).

In addition, the claims of universality of the model have been further disputed because the model has not been found to have application across cultures. Snarey (1985)

did a comprehensive review of all available cross-cultural studies of moral reasoning using Kohlberg's model and method. His findings indicated that the lower stages were virtually universal, but that the presence of Stages 4 or 5 were extremely rare across cultures. "One possible interpretation is that the present definitions of the higher stages are completely culture bound and ethnocentric" (Snarey, 1985, p. 226). Others have refuted the order of the stages Kohlberg has proposed, however, Snarey (1985) found the order of the stages to hold up cross-culturally.

An additional difficulty arises with the use of Rest's (1975) Defining Issues Test (DIT) as a measure of stage identification in Kohlberg's theory, as had been done in several research studies in nursing. Although reliability of the DIT is well established, both Kohlberg (1984) and Rest (1974, as cited in Parker, 1990) have acknowledged that the DIT does not measure the theoretical concepts of Kohlberg's cognitive developmental theory. The DIT has continued to be the chosen instrument for measurement of moral reasoning of nurses (Parker, 1990).

The use of the hypothetical dilemma as the technique by which to identify the stages of moral reasoning has also been criticized. Kohlberg had always used a set of hypothetical dilemmas followed by open ended statements. The Heinz dilemma is the best known of these (Kohlberg, 1984). Walker, de Vries, & Trevethan (1987) conducted a

study which administered the standard Kohlberg hypothetical dilemmas along with asking the participants to relate a real life dilemma of their own. The researchers concluded that the hypothetical dilemmas elicited a somewhat higher moral reasoning score than the real life dilemmas, thus supporting the premise that the hypothetical dilemmas elicited the highest moral reasoning ability of the individual. The choices made in a hypothetical dilemma then, do not necessarily give any indication of how the person might actually respond in a given situation. Measurement of moral reasoning does not necessarily measure moral behavior.

Another assertion made by Kohlberg was that his model of moral development was said to be unaffected by situational factors revolving around a dilemma, that is that to say that circumstances surrounding the situation would not affect the decision made. A study by Bussey & Maughan (1982) in which the sex of the characters in the hypothetical dilemma was shown to influence levels of moral reasoning.

A most serious criticism of Kohlberg's model has centered around the issue of gender bias (Gilligan, 1982, Huggins & Scalzi, 1988, Munhall, 1982, Omery, 1983b, Parker, 1990). "Kohlberg's theory had evolved from interviews only with males and from their responses to hypothetical cases of an ethical nature" (Munhall, 1982, p. 44). In order to evaluate this particular critique, a meta-analysis was

conducted by Walker (1984) on all of the studies using Kohlberg's instrument in which sex differences in development of moral reasoning were examined. He concluded that when occupational and educational differences were taken into account, no sex differences could be found. Baumrind (1986) challenged Walker's findings and insisted that his methodology was flawed and that there is evidence of gender bias in Kohlberg's model of moral development. Baumrind went further by insisting that the principle of justice, which Kohlberg has chosen to base his model on, likely is not the basis for everyone's moral reasoning. A strong case was made for this by Haan (1982) who suggested that there was no objective principle of justice which exist universally in the world. This further compounds the issue of validity since an instrument tailored to measure only justice would not measure other concepts which might predominate in moral reasoning, such as caring. These critiques are of special import to nursing since nursing is predominantly a profession of women and caring is such an important concept in nursing.

To summarize, Kohlberg model, despite its wide acceptance and utilization, still needs further investigation. To date, this model continues to be the predominant framework utilized by nurse educators and researchers to explore nursing ethics and has potential use for nursing. As the limitations outlined here and their

implications continue to be addressed by the profession; the utilization of Kohlberg's model of moral development will become further clarified.

Carol Gilligan's Model of Moral Development

Gilligan (1982) worked with Kohlberg's model of moral development for several years and became aware of what she called " a different voice". "In the research from which Kohlberg derives his theory, females simply do not exist. "..Prominent among those who thus appear to be deficient in moral development are women..." (Gilligan, 1982, p. 18). Similarly, Freud, Piaget, and Levinson had also based their findings and subsequent developmental theories on groups of males. This has led to a world view in which males have become the accepted norm by which development is measured and the female is often seen as deficient because her behavior does not fit this norm.

Gilligan set out to study moral development by conducting interviews with women. Women were asked to describe moral conflicts in their lives; what constituted a moral dilemma, and how decisions were made about those dilemmas. Women who were faced with an abortion decision were interviewed and then re-interviewed one year later. Based on this and other research, Gilligan described a model of moral development she has come to call the "care perspective" (Gilligan, 1987). Gilligan cited the works of authors Chodrow and Miller among others as background for

this model of moral development. These authors brought attention to the nurturing and caring characteristics of women's lives. Viewed as traditional female roles, nurturing and caring have been devalued by society. Both authors have urged a reevaluation and positive reaffirmation of these attributes (Meyers & Kittay, 1987).

This care and sensitivity to others is what made women appear morally deficient when measured by Kohlberg's stages of moral development. For women, moral problems originate from conflicting responsibilities rather than rights which are in opposition. While men tend to take a moral issue out of context and make moral decisions that are formal and abstract, women's thinking about a moral issue is contextual, that is bound to the particulars of time, place and persons involved. "This conception of morality as concerned with the activity of care centers moral development around the understanding of responsibility and relationships, just as the conception of morality as fairness ties moral development to the understanding of rights and rules" (Gilligan, 1982, p.19).

The ethic of care then is different than the ethic of justice in that the care ethic is centered on a network of connection, of relationships, and is preserved by the process of communication. The question then becomes not "What is right? but "How do I respond in this situation?"

Gilligan's Stages of Moral Development

Gilligan identified three levels with two stages each in her model of moral development. This sequencing is similar to Kohlberg's, although Gilligan saw the stages somewhat differently. Gilligan viewed the progression through the stages as linear, much like Kohlberg did, however, Gilligan's stages of moral development allows for more fluidity with movement between the stages, rather than a hierarchical process.

In Level I, the individual survives by submission to the authority of others. The transitional stage in Level I sees the individual move from selfishness to seeing responsibility for others as more important. At the second level, goodness is seen as not hurting others without thought of harm to one's self. The transition shifts the emphasis to include responsibility for one's self as well as the welfare of others. The highest level is characterized by Gilligan as the morality of nonviolence (Meyers & Kittay, 1987). Caring becomes a universal obligation and maturity implies an understanding of the interdependence of the self and others. Attending to relationships even when it is inefficient or uncomfortable is of paramount importance (Gilligan, 1982, Miller, 1984, Meyers & Kittay, 1987, Omery, 1983b, 1985).

Research integrating Gilligan's work has appeared in a variety of scholarly journals representative of several

disciplines. Bussey and Maughan (1982) investigated sex differences and moral behavior. Using Kohlberg's standard dilemmas to test stages of moral reasoning, the sex of the main characters in the hypothetical dilemmas were reversed. No information was provided on the previous use of sex reversal in the Kohlberg dilemmas nor the validity of this method. Males scored at a higher stage (Stage 4) than female (Stage 3) for all sex classifications when measured by Kohlberg's method. In the reversed role dilemma scores for females remained the same, but the males scored at the lower stage (Stage 3). The conclusion was that Kohlberg's model was not immune to sex bias, and lent credibility to Gilligan's findings suggesting that moral reasoning is gender related.

A study by Lyons (1983) was designed to test Gilligan's hypotheses. Open-ended interviews were conducted with 36 individuals. Using data previously gathered by Gilligan, Lyons developed two coding scales which identified affinity of the justice and care perspectives. Findings suggested that women predominately utilized the connected and care response perspective and men used the objective and justice perspective. Lyons (1983) concluded that "...that a morality of care exist in some individuals" (p.141).

Langdale (cited in Gilligan, 1986) investigated the moral decisions of 144 women and men. Findings suggested that the use of the orientation was correlated at a

significant level with gender, with women predominantly using the care focus and men the justice focus. Langdale also found that females who voiced care in their moral orientation (females 86%, males 14%), scored lower on Kohlberg's moral development stages than individuals, predominantly males (males 69%, females 31%), with a moral orientation of justice. Validity and reliability of the coding scheme was not reported. Gilligan (1987) conducted research on 80 middle class North American adolescents and adults and found that 69% raised both issues of care and justice. When asked to focus, 54% focused on one perspective or the other. Men focused predominantly on issues of justice, with the focusing of women divided between justice and care. These findings suggested that the factor of gender may be related to moral orientation.

A comprehensive review of the literature concerning gender differences in moral reasoning was conducted by Bebeau and Brabeck (1987). The conclusion suggested that there was little evidence from the literature that gender affected moral reasoning. Proposing a different perspective, the authors then conducted their own study and investigated whether there were gender differences in "ethical sensitivity" or the ability to define the situation as moral in nature. Results suggested that there was some indication that women showed greater moral sensitivity than males. Twenty-five percent of students did not recognize

either justice or care issues. The investigators felt this indicated that there is a great need for education in the area of ethical issues.

Critique of Gilligan's Model of Moral Development

Numerous critiques and reviews of Gilligan's model of moral development have emerged since the publication of Gilligan's work. Critiques have centered around several issues. The first concerned the samples used by Gilligan. The abortion study interviewed only women and critics (Addelson, 1987, Auerbach, Blum, Smith, & Williams, 1985, Kerber, 1986, Luria, 1986) have argued that by virtue of the subjects and the issue, the conclusion of a "voice" different from males is implicit in the question. Second, Auerbach et al (1985) and Addelson (1987) pointed out that Gilligan relied solely on women's verbal accounts of the moral dilemmas and ignored the effects of the process of socialization on moral development. Since no demographic data was reported by Gilligan, the effect of other variables was difficult to assess.

Others have pointed out that Gilligan's assertion that women have a "different voice" may be interpreted as a "better voice" and foster feelings of self-righteousness in women and slow the process of equalization between the sexes (Kerber, 1986, Luria, 1986). On the other hand, this "different voice" may be seen as a "second voice" (Auerbach et al, 1985, Nails, O'Loughlin, & Walker, 1983) or "...is

Gilligan's ideal of feminine virtue tied to female social subordination?" (Auerbach et al, 1985, p.154). Kerber (1986) and Greeno & Maccoby (1986) contended that Gilligan's model made the assertion that women are superior to men on the basis of biology and/or culture. Women for centuries have been trapped by their own and men's stereotypical characterizations based upon sex. Although women have had the reputation for being more caring, this has yet to be proven. More quantitative as well as qualitative research is essential to validate Gilligan's assumptions (Greeno & Maccoby, 1986).

The methodology used by Gilligan has been criticized (Auerbach et al, 1985, Luria, 1986). Methodological issues addressed have been that the sample size was small and/or gender biased and that no demographic data was given about the subjects. Luria (1986) further contended that no rationale was given in Gilligan's work for the composition of the sample and that there was no information provided about the reliability of the measurement system used. This criticism can be made for all the work that Gilligan has reported. Finally, Auerbach et al (1985) felt that Gilligan did not adequately look at the process of moral development, the factors involved and what causes women to attain moral maturity.

Kohlberg (1984, 1987) responded to Gilligan's work by stating that there was no evidence of gender bias in his

studies. Higher education levels produced the discrepancies and when this was controlled for, gender bias disappeared. Countering Gilligan's claim to an ethic of care, Kohlberg stated that care springs from an intuitive source and focuses on the responsibilities of parents, friends and loved one and cannot be equated with dilemmas of justice which require a decision between two principles. Kohlberg's response to the care perspective is of interest. He placed caring on an intuitive level, not on a level with principled behavior. The inference being that caring is at a level beneath principles. Since intuition and caring are both associated with women, does this place women beneath those who have principled behavior?

A meta-analysis by Walker (1984) of a large number of studies using Kohlberg's theory of moral development found no significant differences in stages of participants that could be attributed to gender. Greeno & Maccoby (1986) and Luria (1986) supported the view that there was no evidence of gender bias in Kohlberg's work.

Other scholars (Benhabib, 1987, Meyers & Kittay, 1987, Meyers, 1987, Stack, 1987, Stocker, 1987) have seen Gilligan's work as challenging the accepted notions about moral development and moral orientation. The ethic of care has been viewed as giving credibility to the experience of women and female moral characteristics (Auerbach, 1985, Held, 1987, Meyers & Kittay, 1987). Further, others have

suggested that Gilligan's model gives credibility to caring as a value (Held, 1987). "...Gilligan's work implies the need to take women's experience seriously....to integrate the insights of women into a comprehensive theory, or to establish an independent theory that makes women's ethical concerns its core" (Meyers & Kittay, 1987, p.13).

Gilligan has also received attention in the nursing literature; however, no evidence was found of any nursing research which utilized Gilligan's model. Munhall (1983) cited Gilligan's work as evidence of gender bias in a study she had completed earlier using Kohlberg's model. Gilligan's model has been applied to aspects of patient care (Miller, 1984, Taylor, 1985). Omery (1983b) described Gilligan's model along with other models of moral development, although it was not fully evaluated for its usefulness in nursing because of its newness and lack of research concerning its applicability to nursing. Huggins and Scalzi (1988) in response to an attempt to suggest Kohlberg's model as a basis for a foundation for nursing ethics (Ketefian, 1987); suggested that Gilligan's ethic of care appears to fit nursing well. Use of Gilligan's model could be utilized by the discipline as a means of valuing nurses' work (Vance et al, 1985). Cooper (1989, 1990a, 1990b) suggested that Gilligan's model of moral development is compatible with nursing's historical and philosophical legacy of caring. However, before it can be adopted as a

model of moral development for ethical nursing practice, further research needs to be done, particularly within the discipline of nursing. There is no question that Gilligan's work has given "voice" to the experience of caring, which has traditionally been valued within the nursing profession.

Discussion

Gilligan's model of an ethic of care is in its formative stages and by no means has the history and data of the Kohlbergian model. However, it can be said that the suggestion of a different moral orientation, predominantly in women, has stirred discussion concerning moral development and moral reasoning.

Research results are inconclusive concerning the validity of Gilligan's model. There are issues concerning the methodology used by Gilligan in her research which need to be addressed in order to establish validity of her method. The question has also been raised as to whether Gilligan's initial work was also gender biased since her sample included only women.

Gilligan and her colleagues continue to teach an interpretive method of data collection using her framework designed to explicate the themes of caring and justice (Cooper, M.C., March 1, 1989, personal communication, Gilligan & Associates, February 17, 1989, personal communication). It is a qualitative method, which poses specified questions to the participants. The researcher

then looks for the care and justice perspective, using guidelines and parameters provided in a manual by Gilligan. While this method may appear attractive to utilize in nursing research, there are issues about the research method taught by Gilligan and her associates that are problematic. The method is confined to identification and description of themes of care and justice in the interviews conducted with the participants. If the researcher is true to this method of data analysis, it is conceivable that other themes which might have emerged would be lost; themes which might have provided important data about how the nurse views and resolves a moral dilemma. Nursing is at an embryonic stage of defining its ethic. It seems especially important to approach research in nursing ethics as holistically as possible to describe the phenomenon fully.

The qualitative approach to research is one which is grounded in a philosophical framework which is reflected within the research methodology (Munhall & Oiler, 1986). Gilligan clearly explicated the philosophical basis for her initial research in "In a Different Voice" (1982). However, she has not provided enough details of the research methods utilized in any of her research studies to evaluate the methodology further.

It is clear that Gilligan's work has ignited an interest in caring as a value and has sparked an interest in as well as given credibility to women's experiences. It is

time now for the disciplines vested in caring to further develop this body of knowledge.

Several nursing scholars have advanced caring as a theoretical framework for the profession (Benner & Wrubel, 1989, Leininger, 1984, Watson, 1988a, 1988b), while others proposed that caring is the moral foundation for nursing (Fry, 1988, Gadow, 1985, Watson, 1988a).

The Development of a Moral Foundation for Nursing

A driving force behind the inquiry into a separate nursing ethic has been the emergence of nursing as a unique and separate discipline and a subsequent critical re-examination of the role of the nurse. Scholarly inquiry has derived substantive nursing knowledge. Dissemination of this knowledge has caused nurses to begin to explore the moral responsibilities of the nurse. With this approach, there has been increased awareness of the differences between nursing and medical ethics.

The nurse's position is a unique one within the health care system. While the nurse's primary responsibility is to the client, the nurse, because s/he is usually employed in an institutional setting, has accountability to the employer. In addition, the nurse has a working relationship with other health team members. S/he is legally bound to carry out the physician's orders. This triad of responsibility to the client, institution and the physician has often been referred to as "the nurse-in-the-middle"

dilemma (Aroskar, 1977, 1988).

In an article on the moral foundation of nursing, Yarling and McElmurry (1986) have taken the position that because of this very position within the health care system "*nurses are often not free to be moral*" [italics added] (p.63). The authors have suggested that there are many obligations faced by the nurse: to the patient, to the employer, to the physician, to the profession and to the nurse herself as a moral being. As a result of these numerous obligations, nurses lack the autonomy necessary to carry out their primary obligation which is to the patient and as a result, nurses experience uncertainty, moral dilemmas and moral distress. At stake is a compromise of the nurse-patient relationship which is basic to nursing and "*the necessary foundation for a nursing ethic*" (p.65). A nursing ethic which will strive to change the structure and policies of the social institution in which nursing practices was advocated by the authors. Labeled "a social ethic....It must be one that seeks to free nursing practice from its `hospitalonian captivity'"(p.69). Autonomy in nursing is viewed as the central issue. Political and societal action is necessary if nursing is to become autonomous.

Taking a different approach, Bishop and Scudder (1987) proposed that the "in-between" position is a beneficial place for the nurse to be. Since the aim of nursing is

first and foremost the welfare and well-being of the patient, then "the first responsibility of any nurse is excellent practice" (p.36). What comprises excellent practice is the moral sense of nursing. Any inquiry into a nursing ethic must begin with what occurs in actual every day practice, rather than ethical theory. Refuting Yarling and McElmurry's (1986) claim that the nurse needs to advocate for more autonomy; they suggested that the every day actions of the nurse are indeed moral. Bishop and Scudder (1987) contended that the nurse has authority and power over day-to-day nursing care. What is recommended is that the nurse expand this legitimate power and authority for better patient care. The in-between status places the nurse in a position to foster co-operative decisions on behalf of the patient.

In a subsequent article, both positions are refuted (Cooper, 1988). Both Yarling and McElmurry's (1986) social ethic and Bishop and Scudder's (1987) moral sense of nursing are rejected as a basis for a moral foundation for nursing. Cooper (1988) argued that the covenantal relationship between the nurse and the patient provides a more substantive foundation for such an ethic. Models of the covenantal relationships, based on the principle of fidelity, and characterized by truth telling and promise keeping in patient care, are described by Cooper (1988). Covenantal relationships are advantageous to the nurse as

well for it places the nurse in a position to receive from the patient as well as to give care. This can provide unlimited potential for human enrichment.

Packard and Ferrara (1988) suggested that the moral foundation for nursing might be clarified by a clearly developed idea of what nursing is. While the author did not attempt to postulate what they themselves saw as the moral foundation for nursing; they discussed nursing and its components in the hopes that careful clarification of what nursing is will help lead the way to what the moral foundation for a nursing ethic ought to be.

While it is essential to explore the moral foundation for the profession, attempts to elucidate the central values in nursing must be approached with caution. What has traditionally been an appropriate foundation for medicine is not necessarily appropriate as a basis for a for nursing. For example, the concepts of autonomy and covenantal relationships have a long tradition in biomedical ethics and have influenced discourse in bioethics (Fry, 1989c). Fry (1989c) suggested that biomedical ethics, as currently conceptualized do not represent an adequate basis for a nursing ethic. "The context of nursing practice requires a moral view of persons rather than a theory of moral action or behavior or a system of moral justification" (p. 20). A nursing ethic requires a moral view of persons and must include care at its core.

Caring as a Moral Foundation for Nursing

Caring has been posited as the essence of the profession of nursing (Gadow, 1985). Caring as a moral ideal entails a commitment to a particular end. For the profession of nursing, that end is the safe guarding and enhancement of human dignity.

Caring requires that the nurse protect the patient from objectification as this is a threat to the person's dignity and removes the person from the centrality of their own experience. Caring, in other words, demands that the patient remain as the focus and not become overshadowed by medical technology and machinery. The patient can be further objectified when only the body is seen as important and subjective feelings of the patient are negated. Clearly, the focus of science is on the objective with negation of the subjective. The person's experience can easily be ignored. Two ways have been suggested in which to symbolize caring: touching and truth telling. Truth telling not only requires presenting the objective information necessary for the patient to make an informed, autonomous decision concerning his/her health; but "truth as the most comprehensive and most personally meaningful interpretation of the situation possible, encompassing subjective as well as objective realities, idiosyncratic as well as statistical tendencies, emotional as well as intellectual responses" (Gadow, 1985, p.38).

When a caring relationship exists, the nurse touches the patient's body as the lived reality of the patient. "Its purpose is not palpation or manipulation but expression-an expression of the nurse's participation in the patient's experience" (p.41). Gadow's approach encompasses caring based on the reality of the nurse-patient relationship in health care.

Nursing Research in Ethics

The nursing research in moral reasoning and ethical practice was reviewed by Ketefian & Ormond (1988). A majority of these studies utilized Kohlberg's model of moral development as a theoretical framework to investigate moral development and levels of moral reasoning in nursing. The purpose of many of these studies was to demonstrate a relationship between moral reasoning and the variables which have potential impact on moral reasoning. An overview of the major nursing studies in moral reasoning in nursing is presented here.

Murphy (1977) was the first nurse to utilize Kohlberg's model in nursing research. Nurses in different work environments were studied to determine if different work settings influenced moral development. Hospital head nurses staff nurses, public health nurse supervisors and public health nurses were included in the sample (N=120). Results indicated that there were no significant differences among the nurses in the two types of work setting. Further, most

nurses were found to be at either Stage 3 or Stage 4 of moral development. Among the recommendations made was that a study be carried out to determine if there are any differences in levels of moral reasoning related to gender.

Crisham (1981) is to be credited with developing the first instrument, patterned after the DIT (Rest, 1975), which presented ethical dilemmas in nursing to participants in research studies. While this approach more closely approximated the real-life dilemmas nurses faced in their daily practices; for some, however, the dilemmas in the Nursing Dilemma Test (NDT) (Crisham, 1981) may still have been unfamiliar to the participants and may have affected their responses and thus the level of moral development obtained from these responses (Parker, 1990).

Nursing research on moral development has demonstrated that there may be a positive correlation between levels of education and higher levels of moral development (Crisham, 1981, Felton & Parsons, 1987, Ketafian, 1981a, 1985, Mayberry, 1986, Munhall, 1980). Findings corroborated that educational level "...showed persistent and powerful relationship to moral development and principled decision making" (Mayberry 1986, p. 78). There was also some indication that previous experience with dilemmas also positively influenced the nurse's level of moral development (Crisham, 1981). However, several studies have indicated that nurses with more years of clinical experience tended to

score at a lower level than nurses with clinical experience of one year or less (Crisham, 1981, Ketafian, 1981b, 1985, Mayberry, 1986) suggesting that factors in the work setting may negatively impact on the nurse's moral behavior.

Subsequent studies by Ketefian (1981a, 1981b, 1985) found that there was a relationship between critical thinking, level of educational preparation and moral judgement in nurses. Results appeared to support the assumption that persons with greater critical thinking ability also have a higher level of moral reasoning.

Research studies have also been conducted with hospital nurses and focused on the types of ethical dilemmas encountered and the nurses participation in ethical decision (Holly, 1986, Zablow, 1984). Nurses were found to be unable to define or give an example of an ethical dilemma. Part of the difficulty may have been the operational definition of an ethical dilemma, which may have been too narrow. "The percentage of the nurses found able to define an ethical dilemma might have been increased...had the definition of an ethical dilemma been broadened to include a focus on caring and responsibility rather than rights and values" (Holly, 1986, p. 129).

Qualitative studies were conducted with staff nurses working in intensive care settings (Cooper, 1990a, Omery, 1985). The purpose of the studies was to describe a moral dilemma the nurses had encountered in their clinical

practice and how that moral dilemma was resolved. Omery (1985) identified three major components of moral reasoning: principles, mediating factors and mode of reasoning. Principles were the justifications that the participant gave as the reason for the chosen action. Mediating factors were those factors which tempered the participant's response to the ethical problem whether it be legal, physician-nurse relationship and so forth. Two modes of reasoning also emerged from the data: Sovereign reasoners who based their judgments on personally valued principles regardless of other pressures around them. Accommodating reasoners conformed their judgments about ethical problems to the perceived norm of their identified group.

A similar study was conducted by Cooper (1990a) who interviewed nurses about their experiences with moral dilemmas in the clinical setting. Results suggested an interrelationship between the themes of justice and care. Nurses relied on justice based concepts initially as a basis for their relationships with clients and justice was predominant in ongoing nurse-patient relationships where the client could not participate such as a comatose or brain dead patient. However, when the nurse-patient relationship developed and took on meaning, care became the central value framing the nurse's moral responses.

Another study which did not specifically look at moral dilemmas, but was designed to explore the meaning for nurses

of caring relationship was conducted by Kahn & Steeves (1988). Interestingly, the authors found that participants shared many incidences that clearly had ethical implications. These were shared not as ethical dilemmas but as problems related to the inability of the nurse to care for the client. Kahn & Steeves (1988) suggested that nurses did not recognize caring as a value and therefore did not link this inability to care to an ethical problem. Further qualitative research will continue to elucidate this link between caring and the nursing ethic.

Critique of Research Findings

Research conducted on moral development supported some of the assumptions of Kohlberg's model. Level of education did appear to positively affect the level of moral development (Crisham, 1981, Felton & Parsons, 1987, Ketefian, 1981a, 1981b, 1985, Mayberry, 1986, Munhall, 1980) and increased critical thinking abilities paralleled increased moral development (Ketefian, 1981a).

A particularly troublesome finding in these studies has been that nurses scored below the highest or Principled Level in Kohlberg's model of moral development (Murphy, 1977). Comparison of the results of the means of moral reasoning scores in a number of nursing studies indicated that nurses and nursing students often scored within the expected means for senior high school graduates (Nokes, 1989). This might lead one to deduce that nurses do not

recognize moral dilemmas or are unable to make moral decisions. Perhaps it is the utilization of Kohlberg's model that did not accurately reflect the moral decisions which are made by nurses. Indeed, if nurses use a different orientation to moral dilemmas or use language which does not fit the justice perspective, they may very well be viewed as unable to recognize and/or resolve moral dilemmas.

Of interest, were the findings of the relationship between nursing practice and moral reasoning. Nurses who have more years of practice scored lower on the moral development scales than nurses with less experience (Crisham, 1981, Ketefian, 1981b, Mayberry, 1986), and in some studies, lower than nursing students. Is this because the educational setting does not adequately prepare the graduate for the "real world" of nursing or does it suggest that the work environment fails to support the professional behaviors the nurse attains in the educational setting? Murphy (1978) has suggested that since institutions are organizationally structured such that nurses are placed in a subordinate role to the hospital and to the physician and obedience to authority is stressed instead of personal responsibility; the nurse may consciously or unconsciously view ethical decision making as the responsibility of the institution or the physician. This may be a factor in accounting for the findings associated with length of clinical experience and lower moral development scores.

Many of the instruments developed by nurse researchers have been modeled after the DIT and have been used to measure stages of moral development. All of the instruments used hypothetical case studies which have been derived from real life nursing dilemmas. In addition, subjects were given options from which to make a choice. This appeared to be problematic in two areas. First, it did not establish whether the nurse would act in a real life situation as she would given a pencil and paper test. For example, when an individual is asked if s/he thinks that speeding is illegal the answer would most likely be "yes". But this does not indicate that the individual does not ever drive above the speed limit. Second, it did not allow the nurse to suggest an alternative solution to the situation that may not have been thought of by the researcher. Most importantly, this method, since it provided the dilemma for the nurse, did not answer the question of whether the nurse would recognize a moral dilemma in the real world and what constitutes a moral dilemma for the nurse.

Frequently, the nurse researchers utilizing Kohlberg's model have been remiss in citing these limitations. Instruments have been designed without notation of the drawbacks of Kohlberg's and Rest's tools. Further, even though it is unlikely that the existing instruments are able to measure moral behavior, one nurse researcher (Ketefian, 1981b) has continued to utilize a tool which purports to

measure this phenomenon. One needs also to seriously question whether the Kohlbergian model ought to be used as a framework for nursing given that nursing is predominantly a female profession. Any instrument constructed based on Kohlberg's assumptions is suspect because of gender bias.

There is evidence that moral dilemmas and the moral reasoning process to resolve these dilemmas are of greater complexity than had been previously thought (Cooper, 1990a, Omery, 1985). Recent research studies have suggested that rule and principle ethics along with Kohlberg's model of moral development may not adequately account for the moral experience of the nurse.

It is timely to continue to use a qualitative approach to further the description of ethical dilemmas in clinical practice and to begin to explore the process by which these dilemmas are resolved by a group of practicing nurses (Cassidy, 1991).

Summary and Conclusion

This review of the literature has examined the current status of ethics in nursing. The literature suggests that the biomedical model has limited application for nursing for a variety of reasons, primarily because it subsumes nursing under medicine and because this limited view of ethical dilemmas in health care may not necessarily encompass the values espoused by nursing or address the ethical issues faced by the profession. In essence, biomedical ethics may

not allow for an adequate and accurate picture of what nursing ethics is.

Further, the ethical decision making frameworks proved to be cumbersome, have not been easily adaptable to the practice setting, and are not necessarily helpful in helping the professional nurse arrive at a moral decision. Cassells and Redman (1989) reported that only 23% of the nurses surveyed felt that they could readily use a framework for resolution of ethical dilemmas.

Nursing research conducted in nursing of the description of moral dilemmas and moral reasoning have predominately utilized Kohlberg's model of moral development and quantitative methods of analysis. Nursing has not always been favorably represented by using these deductive methods of inquiry. Nurses have either been cited as unable to recognize ethical dilemmas (Murphy, 1977, Zablow, 1984) or have not moved beyond Stage 3, Mutual Morality or Stage 4, Social Support Morality (Murphy, 1977).

Gilligan's seminal work has led to a reevaluation of Kohlberg's model of moral development and has generated inquiry into women's epistemology. It can be said that Gilligan's work has legitimated the concept of caring. The emergence of caring as a value can only enhance the nursing profession whose historical underpinnings are based on caring. However, the issues surrounding Gilligan's research methodology are problematic. Additionally, if themes of

caring are prominent when women make moral choices, as Gilligan suggests, then qualitative methodology will surface this theme along with others, rather than focusing only on care and justice as Gilligan's method requires. Qualitative research in moral reasoning can validate the existence of an ethic of care in the profession of nursing.

CHAPTER 3

METHODOLOGY

Qualitative methods of inquiry refer to methods that produce descriptive data based on the written or verbal account and/or direct observations of the participants (Taylor & Bogdan, 1984). The emphasis is placed on the everyday experience of living in the "real" world as the focus of inquiry (Munhall & Oiler, 1986).

This inductive approach to research was best suited to this study because description of the phenomenon was desired and the essential features of moral reasoning had yet to be adequately identified. Further, previous methods of inquiry had been demonstrated to contain perceived biases and it seemed best to return to the natural state to reexamine the phenomenon naively (Chenitz & Swanson, 1986, Marshall & Rossman, 1989, Munhall, 1989, Sandelowski, Davis, & Harris, 1989).

Phenomenology

Phenomenology is one of many qualitative research approaches. Phenomenology has been described as "philosophy, method and approach" (Psathas, 1973). Its roots can be traced to the works of Edmund Husserl, the philosopher and mathematician. Husserl's development of phenomenology grew out of a dissatisfaction with the

scientific method. He felt that the positivistic view prevented researchers from "seeing" phenomena. Husserl advocated for a philosophy which allowed the phenomenon to be seen and experienced as it is lived (Cohen, 1987, Knaack, 1984, Omery, 1983a). The phenomenological method stems from the belief that people and the world can only be understood by describing and analyzing experience at it is lived (Munhall & Oiler, 1986).

Spiegelberg (1982) described the essential elements of the phenomenological method. First, the researcher investigates a particular phenomenon. Intuiting is essential during this phase. Next, an eidetic analysis or reduction occurs to describe the general essences or structures of the phenomenon. Third, the interrelationship between the essential features or the essences are grasped. Intuiting is a difficult concept to convey to another person. Intuiting has been described as seeing with the eyes open, and really looking and listening (Spiegelberg, 1982, Cohen, 1987). It is the full and real experience of a phenomenon, not just its objective characteristics, but with all its meaning (Ray, 1985). Natanson (1973) captures the essence of intuiting as: "seeing unencumbered by knowing" (p. 92).

Eidetic reduction or analysis evolved from the word "eidos", which Husserl used to discuss essences (Natanson, 1973). This involves looking at the parts of an experience

which are representative of the essential features or essences and demonstrating common patterns shared by the phenomena (Spiegelberg, 1982). It is the "whatness" of the experience or as Psathas (1973) stated: "eidetic analysis involves seeing through the particulars of the experience to the underlying features or essences without which the phenomena would not be what it is" (p. 9).

Making associations or identifying interrelationships is the last essential element in the phenomenological approach (Spiegelberg. 1982). This includes not only making connections of relationships between the essential features but also identifying the connections within the essential features. Though these three steps are discussed in a seemingly linear process, it is far from that. The phenomenologic method is indirect and circuitous in nature.

An essential part of the phenomenological method was that of clarification of assumptions or presuppositions and the bracketing of those assumptions (DaSilva, 1988, Knaack, 1984, Natanson, 1973, Rose, 1990, Swanson-Kauffman & Schonwald, 1988). This process required the researcher to examine all assumptions and pre-conceptions, both personal and theoretical, about the phenomenon under study and to clearly set these in writing before the beginning of the collection of data. Bracketing or setting aside of assumptions is essential in an attempt to accurately portray the lived experience of the participants. As Spiegelberg

(1982) explained this process is not synonymous with denial of the existence of the phenomena, but is detachment of all we know about the phenomena in our world. With this technique, the researcher sets aside her "reality" before and during the data gathering.

Ethical Considerations

This research study proposal was submitted for review and accepted by the Committee on the Protection of Human Subjects at the University of San Diego before the study began (See Appendix E) and was conducted under the guidelines established by this committee.

Consent

Potential participants received an information letter (see Appendix B) and a sample consent form (see Appendix C) at the nurse practitioner meeting which they could study and ask questions about. Information about the study was repeated before the actual interview took place and any questions were then addressed, before the consent form (Appendix C) was signed and questions continued to be addressed as they arose during the study.

Anonymity and Confidentiality

The confidentiality and anonymity of the participants was protected by coding all data so that no names or identifying description remained in the data. The list of names, along with the corresponding codes were known only to the researcher.

Participants were made aware, through the information letter that all interviews were to be audiotaped and the tapes were to be transcribed by a paid transcriptionist. However, no one else, besides the researcher and the transcriptionist had access to the tapes. Future publications will not report responses in such a way that individual participants can be identified. All materials, tapes, notes and discs were stored in a locked cabinet accessible only to the researcher. All names, phone numbers of participants and the audiotapes will be destroyed at the end of the research study.

Risks

Since this study asked participants to explore phenomenon from their own life experience by discussing moral dilemmas and decisions in their clinical practice, it was anticipated that there would be minimal risk. There is always the slight risk that discussion of moral dilemmas can reveal very personal and emotional feelings and may cause some distress. This did not occur. However if this had occurred and the participant became unduly upset, the interview would have been stopped and time would have been spent helping the NP explore these feelings and helping her to reach some resolution. Had this approach not sufficed, arrangements had been made with a nurse counselor to be available to aid the NP. In addition, at the beginning of the interview, the participant had been advised that the

interview would be terminated at any time the participant requested it or if the researcher felt it was in the best interest of the participant to stop the interview. Again, this situation did not occur.

Research Strategies

Sample

The participants for this study consisted of female nurse practitioners (NPs) currently employed as nurse practitioners in a variety of settings in a large city in the western United States. Only women were solicited as participants because nursing remains by and large a woman's occupation, with only 1.9% of nurses in the United States being male (Rowland, 1984), and it was felt that an all female sample of nurse practitioners would be most representative of the gender composition of the profession of nursing.

The participants were solicited through the nurse practitioner interest group. The researcher contacted one of the officers of the local nurse practitioner organization and explained the research study. Permission was granted to the researcher to attend a meeting of the organization. An introductory letter was given to all NPs attending the meeting which explained the purpose of the study and how the study was to be conducted. At this meeting, the nurse researcher discussed the purpose of the research study. Interested NPs were asked to sign their names and give their

phone numbers on a sheet of paper which was circulated among the group members. Also, the name and phone numbers of the nurse researcher was provided on the introductory letter so any NP who did not volunteer at the meeting could initiate contact on a volunteer basis. A consent form was included with the introductory so that the participant could familiarize herself with this form before the actual interview was to take place.

Interviews were also conducted with NPs who were referred by word of mouth from participants in the study. These two avenues of soliciting volunteers were sufficient to obtain the necessary number of participants for this research study.

Volunteers were accepted into the study who meet Colaizzi's (1978) criteria of having lived the experience of having had a moral dilemma in their clinical practice as nurse practitioners and who were able and willing to discuss it. Participants were accepted until ten nurse practitioners had been interviewed. This number was based on the suggestion by Bogdan & Taylor (1975) that the beginning researcher ought to begin with a small group "with not more than eight to twenty-five subjects" (p. 74). Similar studies have had eight and ten participants respectively (Cooper, 1990a, Omery, 1985).

Data Collection

The NPs who expressed an interest in participation in

the study were contacted by the researcher. At that contact, the researcher reiterated the purpose of the study. An appointment was scheduled for the interview at a time and place mutually convenient to the researcher and the participant. A variety of settings were utilized for the interviews, the participant's office, the researcher's office, the participant's home and on two occasions, a public restaurant. The aim was to choose a setting with a minimum of interruptions, which was quiet, private, without distraction and was mutually agreeable to the researcher and participant. Surprisingly, although the researcher did not intend to use a public setting such as a restaurant, this setting was often freer of interruptions than were other settings.

Demographic Characteristics

Demographic characteristics were obtained in order to develop a composite picture of the NPs who participated in this research study. Demographic data was elicited in two ways in order to remain in agreement with the phenomenological approach used for the study. Before the interview actually began and after the information letter had been reviewed, the consent form signed and questions answered, the participants were asked to respond to a series of questions, such as name, address, home and work phone number and educational preparation which was gathered on a separate sheet of paper. A sample of these questions is

included in Appendix D. Other questions about a particular participant were interspersed throughout the interview in order to learn more about the nurse practitioner. As the researcher became more versed in conducting the interviews, questions of a demographic nature were often used when the interview seemed to be stalled or the participant seemed particularly anxious about the topic being discussed. This diversion from the topic of the interview often allowed for the return to the interview in a few minutes with the participant more relaxed. The demographic information interspersed within the interview was later extrapolated and summarized by the researcher at the end of the interview on the audiotape in a memo format. This memo was then transcribed along with the interview. Table I summarizes the demographic characteristics of the nurse practitioners who participated in this study.

Table 1

Demographic Characteristics of NP Participants (N=10)

Sex	N
Female	10
Male	0

Age (Years)	N	Range
	3	27-35
	5	36-40
	2	41-43

Basic Nursing Preparation	N	Degree
	2	AD or AA
	7	BSN
	1	Diploma

Years of Practice as RN before Becoming NP

N	Years
3	1-5
5	6-10
1	11-15
1	20-25

Mean years of Practice 8

Nurse Practitioner Preparation	N
Certificate	1
Masters Degree	9

Years of Practice as Nurse Practitioner

N	Years
3	<1
3	3
1	7
1	11
1	14
1	16

Mean Years of Practice as NP 6

Work Setting	N
	3 Pediatrics
	1 Family practice
	2 Women's health
	3 AIDS Research
	1 Orthopedics

Interview Process

At the beginning of the interview, the information letter and consent forms were reviewed. The consent form was then signed by both the participant and the researcher. Any questions which arose to this point were addressed. The procedure for the data collection was discussed. It was explained to the participant that this was a taped interview, that only the researcher and the transcriptionist would actually listen to the taped interview. The nurse practitioner was assured that confidentiality would be maintained by removing any identifiable reference to person or place which appeared in the first reading of taped interview and replacing it, if necessary to maintain the flow of the interview, with a fictional name, title, or reference to place. It was felt that this reassurance helped eliminate any concerns the participant might have about confidentiality and allowed the NP to speak freely without having to consciously eliminate personal names and places.

After one or two interviews, it became obvious that a short discussion of the type of interview this was, and how the interview would proceed, was necessary. Participants were told that the interview would begin at the same point for all involved, with an open ended question. The participant was then allowed to freely discuss the moral dilemma with the researcher asking questions or using

clarifying words to elicit the essential features of the process of moral reasoning. The nurse practitioner was informed that the questions asked by the interviewer might seem repetitious, but were necessary in order to conduct an in-depth interview on the research questions. Participants were asked once more whether there were any questions and told that the interview could be stopped at any time the NP wished. The tape was then turned on and the interview was begun with the following question: "Tell me about a time or an incident when you had to make a moral decision in your clinical practice. Talk about it as completely as you can. Give as much information about it as you can, what you remember, how you acted, what you thought and how you felt." The researcher then delved further with the participant for further details and clarifications. Areas of consideration for discussion and questions which were used as guidelines for the interview are located in Appendix A.

A total of fourteen interviews were conducted with thirteen nurse practitioners, each lasting from one to two hours. Of these fourteen interviews, eleven were used in the data analysis. The first two interviews were done in order for the researcher to familiarize herself with the technique of doing the phenomenological interview. The first interview transcript was reviewed and the interview technique was critiqued by a dissertation committee member. Based on this critique, it was felt that the interview was

not in-depth enough to address the research questions. The second interview conducted was also discarded by the researcher because the interview technique did not focus on the research questions in depth. These interviews therefore, became the practice ground for the remaining interviews that were done. A third participant's interview was not included in the data because the moral dilemma shared had occurred before the nurse had become an NP and therefore did not meet the criteria of selection for this study.

Participants had been told that there was the possibility the researcher and/or the participant might wish to have a second interview. A second interview was an option the researcher wished to leave open for the following reasons: the researcher might wish to clarify a point from the first interview with a participant, or may have felt that rapport was not fully established during the first interview or the participant might have felt uncomfortable with the researcher and the audio-taped interview. This discomfort could have posed a potential threat to incomplete description of the moral dilemma and the NP's response to this problem. Further, after the first interview the participant might have reflected on the information discussed and might wish to bring to light additional aspects of the experience that had not been realized during the first interview (Omery, 1985). None of the participants

in this study contacted the researcher for a second interview. There was only one participant with which the researcher scheduled a second interview. This was done because, after doing the initial reading of the transcript of this particular interview, the researcher felt that several areas were in need of further exploration. Interestingly, the second interview with this NP yielded very little new data and seemed to echo closely the material from the first interview. This also satisfied this researcher's curiosity about whether a second interview with the participants might elicit more data on the essential features of the process of moral reasoning. It did not, and no further second interviews were scheduled. This second interview brought the total interviews to fourteen.

Immediately following the interview, before the audiotape was given to the transcriptionist, the participant was assigned a code number. Once the participant's name has been coded, the sheet with the name and other information were placed in a locked cabinet accessible only to the researcher.

Within 24-48 hours after the interview was completed the taped interview was delivered to the paid transcriptionist. The interview was transcribed from the tape to a computer disc with one hard copy and returned to the researcher within 5-6 days. The researcher transcribed the first interview and one other interview which was

determined to be too quiet for the transcriptionist to hear.

Coding of the Data and Field Notes

The data was coded to protect the participants anonymity and to facilitate the handling of the data for data analysis. Field notes were kept during the research study. The field notes consisted of: 1) the verbatim transcription of the interview with the participant, 2) any impressions, ideas, additional information which added richness to the data. The third part of the field notes were my own reflections on the interviews, observations about myself, and the methodology. These memos were also the place where notes were kept on what I was thinking as I proceeded through the data collection and analysis. These memos were also invaluable in keeping track of methodological information, intuiting about the data, critiques of the interview techniques, mistakes, confusion, questions and data analysis as the study progressed. These notes were added to the audiotape after each interview, or anytime there was the need to record information about the study. These were transcribed by myself or the paid transcriptionist and added to the field notes in a consecutive manner. Memos were also made after the first reading of the transcript was done. These were added directly to the end of the notes that had been made on audiotape and transcribed at the end of each interview. These first post-reading notes usually critiqued the

interview in terms of interviewing style to continue to have the interviews reflect the research questions. This critique helped in continuing to develop the skills necessary to conduct the phenomenological interview.

Field notes were typed single spaced with a two-inch left hand margin to allow space to enter comments beside the notes. Each page was set up as follows: at the head of each field note at the left side, the code for the participant and the date of the interview appeared. The participant's name was coded as follows: the first letter of the first name was used ("P" for Paula, for example), a double digit code signified the sequence of the participant's interview in the study (03 indicated the third interview in the study) and 1 or 2 represented the first or second interview. Therefore the code P0301-May 3, 1990 represented participant Paula's first interview, which was the third one collected and the date the interview took place.

This coding was used in the field notes to refer to the participant and the participant's audiotape and any other materials pertinent to the specific participant was coded in the identical manner. The participant's code was also used to signify when the participant was speaking in the transcription and INT. identified the interviewer. The field notes were consecutively numbered in the upper right hand corner, along with the participant's code. The participant's code was added here to facilitate quickly

finding an entry which was associated with a specific participant. This was helpful particularly when the field notes became quite numerous.

All tapes were transcribed by the same paid transcriptionist, except for the tape of the first interview and one other interview which was transcribed by me. This was done in order to evaluate the first interview and reflect on the technique of data collection and the content of the interview. The typed transcription copy of the first interview was also reviewed by a committee member to ensure that the interview was focusing on answering the proposed research questions. As stated earlier, the data from this first interview and the second were not used because these interviews served as a pilot to familiarize the researcher with the techniques of phenomenological interviewing. One other interview, as stated previously, was also transcribed by the researcher, because background noise made it difficult to hear.

Data Analysis

The method of data analysis for this study was based on the methods of Colaizzi's (1978) and Giorgi (1985). The steps which were used in data analysis are as follows:

1. Immediately after the tape and hard copy was returned from the paid transcriptionist, the tape were listened to and compared to the typed hard copy. This was done in order to check for accuracy of the transcription in comparison

with the taped interview. Listening to the tape also brought to mind the actual interview and helped to gain a sense of the whole experience. Notes were made at this time of pertinent thoughts concerning the particular interview. The audiotape and hard copy were then stored in a locked file, according to the established coding system. After all the interviews were done and had been listened to for accuracy of the transcription, step 2 of data analysis was undertaken.

2. Each transcript was carefully read again to gain a sense of the whole.

3. The interview was read again, this time marking sentences of significance in the interview that relate to the phenomenon. Colaizzi (1978) calls this phase "extracting significant statements" (p. 59). These were highlighted in the text.

4. With this step, a new file was created with WordPerfect bearing the designated code for this particular interview and all significant statements in the interview that had been highlighted in step 3 were copied into this newly created file.

5. The significant statements were reduced, that is any recurrent thoughts and statements were condensed and grouped together. A new file was created for this step and the reduced significant statements were copied into this file. The file created in step 4 remained intact in order to be

able to validate the accuracy of the reduction of the statements should the need arise.

6. The next step involved organizing the significant statements into "clusters of themes" (Colaizzi, 1978, p. 59) or categories. Another file was created on WordPerfect bearing the interview's code and identifying it as the theme or category file for that interview. All significant statements which related to that category were copied into this category file for that particular interview.

7. Once the categories were identified, the interview was re-read once again to assess that the categories identified were reflective of the interview and that no significant data had been left behind in that interview.

8. A short summary narrative was then written which described this interview, highlighted the categories and their interrelationships.

9. A short memo was then written summarizing salient points and ideas which might be helpful later on in the data analysis.

These steps were repeated with each of the ten interviews. Each participant's interview was arranged in separate files on the computer and in hard copy.

10. At this point, each interview was reviewed once again for redundancies in categories within each interview and these were condensed.

11. A hard copy of the categories and the significant

statements under the categories from each of the ten interviews was then taken and each category from each interview was arranged on 5x8 index cards.

12. The 5x8 cards generated from all ten interviews were taken and categories that had commonalities, similarities, and expressed the same ideas were sorted together.

12. Once all the cards were sorted into groups of categories reflective of all of the interviews, these groups were worked with, re-arranged and sorted. When this sorting, collapsing and re-arranging process had been exhausted what remained were five categories which are the essential features of moral reasoning.

13. The essential features were then examined for the interrelationship within the features themselves and between the five major essential features.

14. Finally, the five essential features and their interrelationships were arranged schematically into the process of moral reasoning.

Methodological Rigor

Methodological rigor is an essential part of qualitative research. It is an assurance to everyone, including the researcher, that the findings of the research study can be accepted with confidence. Lincoln & Guba (1985) argued that reliability and validity, terms which are used to refer to quantitative instrumentation, do not fit well when discussing rigor in qualitative research. Kirk

and Miller (1986) suggested that reliability and validity can pertain to qualitative research because when defined loosely reliability can be defined as a measurement procedure which will give the same answer whenever it is used and validity is the extent to which the instrument gives the correct answer. Several methods were utilized to assure methodological rigor in this qualitative research study.

First, assumptions and presuppositions were carefully laid out before the study began. This assured that the researcher's biases concerning the questions under study were obviously stated and bracketed before any interviews were conducted to insure that the participants' experiences were being recorded and not those of the researcher. In addition, each interview was stored away after the first reading of the transcription in order that this researcher not be biased by a previous interview while interviewing another participant. Storing all the interviews until the end of all the interviews made the data appear fresh and new when the data analysis began, thus providing new insight into what the interviews contained.

Credibility and dependability was also enhanced by ongoing discussions with committee members who offered critiques at all stages of the research study. As stated before, the first interview was read and critiqued by one committee member, versed in the phenomenological method, to

aid the researcher in enhancing those interview techniques which would best elicit responses to the research questions. Further, after each interview had been read for the first time, the researcher did her own critique of the interview technique with an eye towards assuring that the researcher's assumptions were not being imposed in some way. As the interviews progressed, the researcher became more adept at phenomenological interviewing, thus assuring the credibility of the study by consistently working towards the goal that the participants' views concerning the research questions were accurately represented.

In addition to these ongoing discussions, two committee members reviewed actual transcripts and compared these to the categories that had been elicited from those particular interviews, seeking consistency between the data in the interview and the categories that had been identified. Additionally, after the essential features and their interrelationships had been decided upon by the researcher, there were several meetings with these two committee members who reviewed the essential features, the themes related to them, and the interrelationship between them. At these discussions, much negotiation took place when a committee member did not feel that a particular theme was reflective of the data and/or the research questions. Resolution of any discrepancies took place and agreement was usually reached by consensus between the researcher and committee

members.

Peer debriefing as described by Lincoln & Guba (1985) was utilized to strengthen the trustworthiness of the study. This was described as discussion with a disinterested peer who can validate or refute the interpretations made by the researcher thus providing an added check on the validity of the study. This was done at two points during this research study. The first peer debriefing took place after all the interview data bits had been placed onto index cards and the index cards had been sorted into common categories. At this point, there were still ten major categories with the interrelationships of these ten categories tentatively established. A peer was selected who was doctorally prepared and experienced in qualitative methodology, but neutral in terms of the population and topic under study. The researcher met with this peer judge on several consecutive occasions. The peer judge reviewed all the cards to validate that the significant statements placed on 5x8 cards and sorted into a particular category was reflective of that category. When there was disagreement by the peer judge of what the data bits signified, the researcher would take the peer judge's comments and suggestions and re-work these particular major and minor themes into categories and examined their interrelationship. The researcher than returned to the peer judge with the reworked data until the two agreed that the themes were

reflective of the data from the interviews. This not only added to the validity and confirmability of the data analysis, but provided fresh insight from a peer who saw the data in a different light.

The second peer debriefing took place after Chapter 4 had been written. This colleague is a nurse practitioner and doctoral candidate familiar with qualitative methods of research. Two interviews were given to this peer judge, along with all the files pertaining to those interviews. The peer judge then read Chapter 4, the report of the findings, to ascertain whether the chapter reflected the data extracted from the two sample interviews. Any disagreements were resolved by consensus between the peer judge and the researcher.

Finally it was the intent of this researcher to provide enough information about the design of this research study and a rich description of the findings in order to allow the reader to evaluate the methodology utilized and the results obtained. This can also serve to facilitate the replication of a similar study in the future.

CHAPTER 4

REPORT OF THE FINDINGS

The analysis of the interviews with the ten participants yielded five major essential features of moral reasoning used to resolve the moral dilemmas: values, elements in the contextual framework for moral reasoning, recognizing the dilemma, influencing factors, and outcomes. The report of the findings includes an overview of the moral reasoning of the participants, followed by an in depth description of each of the major essential features in order to delineate their characteristics. Following this discussion, the interrelationship of the essential features of moral reasoning is addressed. Finally, a discussion of the moral dilemmas experienced by the participants is presented.

Overview of Moral Reasoning

There were five essential features which characterized the moral reasoning of the participants in the study. All the participants mentioned these essential features when describing the moral reasoning utilized to resolve the dilemma. The five essential features were further categorized into major themes which expanded the understanding of each essential feature. In addition, some of the major themes under these essential features had minor

themes which further clarified the attributes of a particular essential feature.

Values emerged as an essential feature of moral reasoning. Values were those ideals which motivated and directed the participants in making decisions amid competing choices in a given situation. Values were basic to how the participants reacted and prompted the choices the individual made in a given situation, even though the person might often be unaware that values were influencing her decisions. When the situation was that of a moral dilemma, one or more values often became pivotal in swaying the nurse practitioners in choosing between competing choices. Values were sorted and weighed by the participants contingent upon the specific circumstances which influenced that particular situation. Values are summarized in Table 2.

Table 2

Essential Features of Moral Reasoning

Values	
Major themes	**Minor themes**
Responsibility	
Caring	
Respect for persons	
	Being non-judgmental
	Reciprocity
	Autonomy
	Respecting
	Confidentiality
	Advocacy
Justice	
	Right/Access to health care
Trust	
Honesty	
Helping	
Sanctity of life	
Religious beliefs	
Empathy	
Beneficence	
Intuitive values	

Elements in the contextual framework for moral reasoning were an essential feature not only because the elements in the contextual framework were necessary in order for the

dilemma to take place and for moral reasoning to occur, but also because these factors framed the context of the situation in which the dilemma occurred. The environment depicted the surroundings in which the nurse practitioners practiced. The environment was viewed as the backdrop or the climate of the clinical practice surroundings in which the NPs worked. The environment included the type of practice and the perceived role expectations of the participants within that setting. The participants described goals of the clinical practice as well as outside influences such as ways in which the practice was funded as important characteristics of the clinical environment. For this major theme, the participants also described others who also were present in the practice. These others were other nurse practitioners, physicians, staff, and a team of health professionals. Colleagues were described in terms of activities involving the NP and others in the environment as well as the sharing and/or not sharing of common goals and values.

A second major theme under the essential feature of elements in the contextual framework for moral reasoning was the participants' perception of the nurse practitioner role. This theme depicted the NPs' perception of the role of the nurse practitioner in the environment, and also activities that were carried out as part of that role. Activities the NPs performed were described as multifaceted and encompassed

health maintenance issues, crisis intervention as well as treatment of illnesses by protocol. A significant minor theme which was integrated into the description of the nurse practitioner role was that of the nurse-patient relationship. This minor theme along with others is discussed in detail later in the report of the findings. This essential feature, elements in the contextual framework for moral reasoning, along with its major and minor themes, is summarized in Table 3.

Table 3

Essential Features of Moral Reasoning

Elements in the contextual framework for moral reasoning	
Major themes	Minor themes
The environment	
	The clinical practice
	Colleagues
The nurse practitioner role	
	Perception of the role
	Nurse-patient relationship

To recapitulate, the essential features of elements of the contextual framework for moral reasoning and values formed the basis for the ordinary, everyday practice of the nurse practitioner. These two essential features were operational in all the situations the NP encountered on a

daily basis.

When certain external influencing factors were superimposed on the ordinary, everyday clinical practice, however, the ordinary clinical encounter become one of a moral dilemma, thus moral reasoning was operationalized.

Influencing factors were those elements that occurred and impacted the situation the participant was in in such a way as to alter the ordinary everyday clinical encounter into one that was unusual and constituted a moral dilemma. These factors were identified as pivotal by the nurse practitioners not only in changing the everyday encounter into a dilemma, but were influential in the choices the NPs made as well. Typically, one or two influencing factors were more influential than others. Four major themes emerged as essential types of influencing factors. The first major theme, influencing factors in the setting; an example of this was the health care delivery system in America. Another theme which emerged was identified as factors which influenced participants in the situation. A third theme involved factors which were considered in the decision making process. This major theme usually involved considerations of options available, and factors which were catalysts to the decision. The catalysts were usually directly related to the nurse-patient relationship. These will be discussed later in greater detail. The third essential feature, influencing factors is outlined in Table

4.

Table 4

Essential Features of Moral Reasoning

Influencing factors	
Major themes	**Minor themes**
The work setting	
	The health care system
	Other considerations
	The population in the setting
	Other providers
The participants	
	Clients
	Colleagues
Considerations in the decision making process	
	Legality
	Risks to NP, clients and others
	Past experiences
	Consulting others
Catalysts to the decision	

Recognizing the dilemma was another major essential feature of moral reasoning. For the purposes of this study, a moral dilemma was defined as a perplexing situation related to right or wrong, where two or more courses of action could be taken, none of which was clearly satisfactory or unsatisfactory. Many of the participants voiced concerns about patient safety and advocacy issues. These concerns were reflected in outcomes, the next major

essential feature of moral reasoning.

Outcomes were the responses of those involved in the situation evoked by the moral dilemma. Within the major theme of deciding to act were actions considered by the nurse practitioner and others as a result of the dilemma and occurred both on a personal and professional level. Some actions took place while the situation was occurring, however, some participants discussed actions taken after the dilemma was over. Cognitive responses were those outcomes which reflected the thinking of the participants about the dilemma. Feelings that the NPs had about the moral dilemma emerged as affective responses. Evaluative responses were those in which the participants examined, reviewed and weighed the situation and discussed what they had learned, what choices might be different in another similar situation, and what the benefits for those involved were. Table 5 summarizes this last essential feature with its major and minor themes.

Table 5

Essential Features of Moral Reasoning

Outcomes	
Major Themes	**Minor themes**
Deciding to act	Professional actions Personal actions Actions by others Actions after the situation
Affective responses	
Cognitive responses	
Evaluative responses	

Essential Features of Moral Reasoning

Values

Values were personal ideals that motivated the individual in making decisions and in choosing the courses of actions surrounding the moral dilemma. All ten participants described several values which provided the basis for the decision making in moral reasoning. Seventeen separate values were recounted, each will be discussed separately in detail and listed in order of the frequency of their occurrence during the interviews. Although values are captured here as an essential feature to facilitate discussion of moral reasoning, it its important to bear in

mind that values were operational in the background throughout the entire process, and were always present in whatever the nurse practitioners were doing.

Responsibility

Responsibility was seen as a one's duty or obligation of self and others. It was described in a variety of dimensions. Professional and global responsibilities of the nurse practitioner were articulated. Responsibilities of the client were also described.

Professional responsibility of nurse practitioner role.

There were the professional responsibilities that accompanied the nurse practitioner role.

> In that position I have a lot of responsibility, you have a lot of autonomy.
>
> [as an NP] I'm taking more responsibility.

Accepting this responsibility was mentioned as follows:

> Being an NP, I am responsible for things that I do, I am responsible for my actions.

and occasionally the responsibility of the role weighed heavily and sharing made it easier:

> Responsibility is heavy, you get paid for going home and worrying about people.
>
> I find that in some situations, the responsibility weighs heavily and if you share that with somebody that you feel is knowledgeable, it just makes it lighter.

Responsibility also implied an obligation to be prepared in caring for patients.

> Responsibility means being prepared both educationally and experience wise to see that patient.

and to recognize the need to consult others.

> ...if I am unsure to go to another clinician and pool other resources so that I can cover the whole area in taking care of that person.

There was also the obligation to the employer:

> I have some responsibility to my employers and so I am not going to completely undermine what they are trying do.

Two other participants also mentioned the responsibility to the client:

> I felt I had a commitment to patient care, to the patient.
>
> That [the nurse-patient relationship] is a big responsibility and it needs to be dealt with a great deal of respect.

The institution also had responsibility to the client:

> ...the first responsibility was to the patient...that not only you as the individual but the institution is doing the best they can to give you good care.

Societal responsibility.

Social responsibility was discussed in the following manner:

> My basic goal, in going into health care, I wanted to make the world a better place.

Responsibility of the client.

Clients also were seen as having responsibilities which were described as follows:

> People are coming in ...so they are responsible for what they do to their bodies and what they do and what their choices are. People do have responsibility.
>
> I had to be able to rely on them [the families] meant they had to show me some level of responsibility of taking care of this child.

One NP tied the client's self-esteem to responsibility:

> Its going to be demeaning to never have to follow through with what your actions are. It certainly not going to be a maturing process for life.

A value of importance that was mentioned by most of the participants was caring.

Caring

Nurse practitioners referred to caring as a value when discussing their interactions with clients. Caring was defined as concern for other individuals and was basic to the response of the NP to the client. Caring manifested itself through actions taken. Although caring was difficult for the participants to define, several made an attempt:

> It involves a feeling that the individual is important.
>
> Sometimes there's affection, there's love involved, I love some of my patients.
>
> Caring is realizing that its not just a person, not just a body sitting there and a piece of paper, I'm going to touch and look at what's behind those eyes, at somebody of importance.

Three practitioners viewed caring as a professional value and spoke of caring in the context of nursing:

> Caring, trying to educate or promote, not necessarily cure, to promote wellness. I see that as part of my role.
>
> [for] nurses the bottom line is care.

Most importantly. caring was seen as a therapeutic tool, unique and essential to the nurse-patient relationship.

> Its therapeutic because part of healing is knowing somebody cares whether you get better or not, its the caring that you convey.
>
> Caring is...the process of healing between two people.

> They feel that somebody understands, or somebody is listening to me and that's the healing, the healing process.

One participant discussed curing and caring and the struggle to balance the two in the clinical setting.

> It takes longer to care for somebody than it does to cure them. You're going to find yourself being pulled more and more into curing because you now have those skills to cure, but you're still a nurse, you're still going to have those skills of caring, of nurturing.

Caring was also perceived as more global than the nurse -patient relationship:

> Its a humanity issue that we care about each other and that we would want to see that everybody is healthy and well.

While many statements about caring from the participants discussed caring in affective terms, caring was also demonstrated through nursing interventions:

> I choose to spend extra time with this person and seeing how they are feeling.
>
> For them [the clients] there's comfort in knowing that you care enough to give them that [the NP's home phone number], they just needed to know that if they needed to call you they could.

Caring involved the nurse practitioner in a distinctive way:

> Its putting aside my own concerns and values and problems for a few moments to get involved with someone else, their concerns, values and problems.

Caring also was very rewarding:

> I think that the ability to nurture and help and be of service only replenishes me...there is a satisfaction there that I don't find in doing any other kind of work.

Sometimes there was a loss of caring:

> I'm in real trouble when my compassion leaves the door

before I do.

Caring surfaced as a very important value to the majority of the participants. The next most frequently mentioned value was that of respect for persons.

Respect for Persons

Respect for persons or the affirmation that each individual has value and should be treated with honor and respect was cited by several of the participants.

> Its not a meat market, I've been saying this for twenty years, this is not a meat market.
>
> People are the most valuable things on the earth...
>
> I approach everyone as the single most important human being.

Five other values, being non-judgmental, advocacy, reciprocity, autonomy, and respecting confidentiality, were elicited from the data analysis and exemplified the broader concept of respect for persons.

Being Non-judgmental.

An important aspect of respect for persons cited by the participants was that of not casting judgment on an individual based on the nurse practitioner's own personal belief.

> My own personal feelings cannot affect my treatment towards them [clients], if I have personal biases... that cannot come into the health care system with me.
>
> Not judging them for certain values that they may have and [that I may] disagree with.

Being non-judgmental promoted the nurse-patient relationship and enhanced the care that was delivered:

> If I had been judgmental, I might not have been as compassionate, might not have heard the woman have heard the woman's need of wanting help.

Advocacy.

Another manner in which respect for persons was expressed was that of advocacy. Advocacy implied a sense of support for and protection of the client and as a value of significance to the profession of nursing:

> I feel morally obligated to protect them [clients] if I'm involved.

Autonomy.

Autonomy or the right to self-determination, was also reflected under the value of respect for persons. Statements by the participants indicated that autonomy was an esteemed value for themselves as well as the client:

> [I] believe in a woman's right to choose.

> I feel that people always have the ability to say: I don't want to do this anymore, this is the way I want my health care to go from now on, that ultimately they have the choice to make over their treatment.

Interestingly, education of the client was viewed as promoting the client's autonomy:

> ...the more you are afraid, the more information [you are given], the more you can control the situation, supposedly the less frightening it is.

The NPs also saw autonomy as important for themselves as well:

> No matter what I'm doing, whether its related to my work or my personal life, I don't have to do anything that I don't believe in. I feel that I have enough autonomy [to be able to do that].

Choice also implied consequences:

> There may be consequences for those decisions that they make.

Reciprocity.

Reciprocity was described by the participants as putting one's self in the place of the other, in most cases in this study, the client's place. This value surfaced for four participants as they thought about the moral dilemma.

> What if I were in this position? I think about how I would want to be treated.

> If I were sitting there as a patient, I would hope that whoever was talking to me showed that they really cared.

Confidentiality.

Confidentiality was discussed by the participants in this way:

> I feel really strongly that I respect people's confidentiality and felt really bound by my obligation to him, to confidentiality.

These five values-being non-judgmental, advocacy, reciprocity, autonomy, and confidentiality-characterized the ways in which the participants acted on the value of respect for persons.

Justice

Justice, or fairness and equality, was discussed by one participant. This value was described within the context of the issue of equality of health services provided to clients.

> Is it fair to offer [it, a special casting material] only to the person who can afford to pay for it and

> have some other kid with the same fracture be put in a regular cast because their parents couldn't afford it? Our society would like to think that everyone will be given the same care whether you're the President's son or a homeless person's child. What our society is saying is that we're all equal.

Four nurse practitioners identified the issue of the right and/or access to health care as an motivator of justice as a value.

Right/Access to health care.

The right of all individuals to health care and the ability to access that health care was discussed. The participants voiced a belief that everyone ought to have health care and further that it was a societal obligation:

> I think that we have a responsibility. as a society to be sure that these people [without health care] are taken care of.

Access to quality health care was also an issue:

> If I am going to hold true to a value that I care about people and that I want to be sure that they are receiving quality care, then I can't turn around and say, I'm gonna take you over here, but you in the middle, you have to leave because I don't like you.

Not only the access to health care but also the quality of that health care was discussed by the NPs:

> Patients have the right to expect that when they have appointment that they're going to receive adequate and safe care and part of that would be to have the staff available to give them that care.

> Coming from the gold standard which is you always do your best to help your patient, or client to the best of your ability and the best of your medical knowledge at that time.

To summarize, justice as a value emerged from the data analysis, as well as the issue of right/access to health care for all individuals, which might be viewed as the operationalization of justice as a value.

Trust

Trust or the ability to have confidence or conviction in someone was a value discussed by four of the nurses. Not only did the NP have to trust others, but also to:

> Put a lot of trust in what the woman would do and what the people were telling me, saying okay sign the paper nothing bad is going to happen.

In addition, the client had to place trust in the NP:

> This person is putting a lot of trust and faith in me.

Additionally, others in the setting placed their trust in the nurse practitioner:

> The physician has to trust me pretty completely.

Honesty

A value closely related to trust that of honesty was brought up as follows:

> I'm always truthful with people.

Helping

Helping or the act of aiding or giving assistance to others was a minor theme within the major theme of values. Helping was associated with being a nurse:

> Nurses like to think that they are helping people, a need to be helpful.

> I went into nursing because I wanted to help people.

A personal sense of helping was also expressed:

> I was highly motivated to help people.

Other values were also mentioned, although with less frequency, by the participants. These were sanctity of life, empathy, beneficence and religious beliefs.

Sanctity of Life

Sanctity or reverence for human life surfaced from the data analysis as a value for two of the NPs.

> Life has a very high value for me, life is very highly valued and it should be protected and honored.

Religious Beliefs

For one participant, the value of sanctity of life was closely linked with another, that of religious beliefs.

> I believe that from the moment of conception, and even before, because the bible tells us that God knew us before we were formed, that that is a living, growing person, human being.

Empathy

Empathy was defined as the ability to relate to the feelings of others and their situations. One participant stated:

> I was beginning to feel sorry for her. I was really feeling the woman's anxiety and stress and anger.

Lastly, beneficence was mentioned.

Beneficence

One nurse practitioner described "doing good" or beneficence:

> I have a strong belief that people doing alternative kinds of things just the belief that something will do you good is the benefit of it, its the placebo effect.

> That's why I'm much more willing to listen to what people are trying to do for themselves.

While the majority of the participants were able to describe the values that motivated their decisions, one participant could not. This was labelled as an intuitive value.

Intuitive Values

One nurse practitioner struggled to define what the values were that prompted her nursing practice. She was able to recognize that there were values of importance that directed her thoughts and activities in this particular moral dilemma, but she felt frustrated that she was unable to describe more fully. The NP grappled with words to describe what was of importance to her:

> I don't know why its important to provide for a child's potential. I'm not sure of that answer. I don't know how to elaborate more than that.

In summary, there were many values which emerged from the data that were influential in the nurse practitioner's everyday practice.

In addition to values, a second essential feature which played a vital part in the every day practice of the NP were the elements in the contextual framework for moral reasoning.

Elements in the Contextual Framework for Moral Reasoning

The Environment

This major theme of the environment depicted the characteristics of the setting or surroundings where the nurse practitioner practiced as well as other persons who were present in that environment. The environment was viewed as the perceived backdrop in which the ordinary everyday clinical practice of the nurse practitioner took place. All of the participants mentioned factors about their environment. Minor themes of this essential characteristic were the clinical practice and colleagues.

The clinical practice.

The clinical practice detailed features of the environment in which the NP worked. These included the type of practice:

> The community clinics is where I have been working for the past couple of years.
>
> One of the clinics was the Ob-Gyn clinic and was doing abortions.
>
> You can't get that from an office visit, you have to go to the home, you see more than you see in the hospital.

Additionally, the minor theme of perceptions of the clinical practice also encompassed the nurse practitioner's perceived position within the practice such as managing a clinic or a research project:

> supervisor: I had thirteen clinics under me.
>
> managing and conducting research studies: ...convincing people to go into a research protocol.

They're [the research studies] pretty much nurse run.

Inherent in the clinical practice were the goals as described by the participant of the clinical practice:

> The whole philosophy of the health maintenance organization, [is] providing the same level of care for everybody.
>
> Our role on real borderline families is to see if can they take care of their kids.

The funding of the clinical practice was also mentioned:

> I was very ignorant about the community clinics and how they operated....was not aware of how financially they're dependent on federal funds and state funds.

Colleagues.

Colleagues were a second minor theme under the heading of the environment. These were other people present in the environment, who were involved in some way in the ordinary everyday activities of the clinical practice. This minor theme represented all those physically present in the environment as well as colleagues outside the immediate physical environment. These included other nurse practitioners, physicians, staff and a team of health professionals. There were three activities which were described under the minor theme of colleagues: consulting, sharing information, feelings, sharing goals/values and offering support.

Activities involving colleagues in the environment included consulting:

> Sometimes I'll confer with another clinician. I'll go to a nurse clinician and say what do you think about this.

> If I wasn't one hundred percent sure that if I guided them towards a research option that they could be injured by that, I usually went and consulted with whomever I was working with that had more knowledge in that field.

Another activity was sharing information amongst NPs:

> My colleague did give me some very helpful advice as far as who to call, she had a book of everybody's name.

Colleagues also shared feelings:

> We've [the nurse practitioners] have talked about pregnancy before, people have shared scientific and emotional issues.

Another important depiction concerning colleagues in the environment was the sharing and/or not sharing of common goals and values:

> There are so few physicians that will take a stand and will not do any abortions.
>
> Some of the people they had working there didn't have the same values that I had.
>
> He's the most caring physician that I've ever worked with.

Colleagues were there to offer support:

> They [the team] would help me when I needed to bounce things off them.
>
> I'd talk with my co-workers, they would need to know what was going on as other members of the team.

<u>The Nurse Practitioner Role</u>

The nurse practitioner role emerged as an important major theme. This theme referred to the nature of the nurse practitioner's professional functions and educational preparation as well as the individualized embodiment of the

role. This theme was characterized by the "doing and being" of the nurse practitioner's role in everyday practice. Perception of the role and the nurse-patient relationship were minor themes under the nurse practitioner role.

Perception of the role.

Included in the nurse practitioner role were the actual activities the NP performed, some of which were prescribed by the job description. There were several aspects which surfaced within the minor theme of perception of the nurse practitioner role: the job description, the beliefs about the NPs' position within the health care system, experience as NP, educational preparation, and perceived professional obligations.

The job description encompassed what the NP's actual position within the clinical practice was within the setting itself and also the responsibilities of the job description in relationship to activities surrounding clients.

> I was supervisor of outpatient clinics, its more indirect responsibility for that patient care.

> We do physical and medical and growth and development and also incorporate environmental assessment and the nurturing needs.

Some NPs worked within protocols:

> The protocols there are quite spelled out.

Other activities described dealt with illness, crisis intervention as well as health maintenance issues. Activities involved more than meeting the physical needs of

the client:

> I couldn't do just the physical care on the child. I had to do the social stuff that went along with it.

The place of the nurse practitioner in the health care system was also referred to as part of the role.

> NPs are a little bit more than nursing, but not entirely the physician. NPs are in the middle part where they have to decide what is my role here, what is my authority?

Being new to the role was mentioned:

> I haven't been even been an NP for a year.
>
> I am a new practitioner, I have only been a nurse practitioner for 3 months.

Functioning in the nurse practitioner role also required being qualified through educational preparation:

> School prepared me to look at resources and so I could do that to get the information I needed.
>
> That you are qualified and that you'll be able to give them good care.

Knowing one's limitations was important to the description of the role of the nurse practitioner. This was expressed by the NPs as:

> ...know[ing] where your limits are and when you help.
>
> I think one of my strengths is I know what I don't know.

Further, knowing one's limits was equated with giving the optimal care to the patient:

> That we know our limits so that we don't limit a client getting the most that they can get because we don't just know about it.

Some activities that the nurse practitioner carried out were discussed in terms of obligations. Obligations were defined as the commitment or responsibility of the nurse practitioner to provide a service or activity. Although these statements indicated activities carried out by the NP, the tone of the statements indicated a sense of moral commitment to the professional activity.

> I feel an obligation to do the teaching and the explanation.
>
> There was the moral part of it, I felt obligated to do that [pursue the issue of child abuse].

Negligence on the other hand:

> Would be knowingly not telling the person or not doing something. You know it but just didn't want to the time and for some reason didn't convey or do what you needed to do.

Education of the client was, therefore, viewed as a professional obligation of the nurse practitioner role.

The activities described gave insight into the activities the participants performed on a daily basis and further how these activities were viewed in relationship to their role. These activities revealed how the role of the nurse practitioner was operationalized in the clinical environment. Further it characterized how the NPs viewed those activities. An important component of the nurse practitioner role was that of the nurse-patient relationship.

The nurse-patient relationship.

The nurse-patient relationship was a second minor theme within the nurse practitioner role. Defined as the purposeful, therapeutic interaction between patient/client and the nurse practitioner, it was placed as a minor theme of the nurse practitioner role because the relationship of the nurse-patient did not exist outside the professional role. Seven aspects of the nature of the relationship were discussed: the meaning of the relationship, factors that influenced the relationship, gender issues, personal attributes of the nurse practitioner, the professional competence of the nurse practitioner, issues of power and control in the relationship, and results of the relationship.

The relationship with the patient has a great deal of meaning to the NP. It was viewed as the key that influenced the nurse practitioner's effectiveness in impacting a client's health.

> The basic unit is me and the patient, working together with whatever needs to be done.

> What I can do to affect people's health is really based on the relationship that we have. I'll really try to make that strong....

Factors which were described as positively affecting the nurse-patient relationship were who the individual client was, and having contact over a period of time.

> When you start people on studies, you maintain a close relationship with them. The people, I started on this study, ...I had enrolled probably nine months ago.

> I worked with her and saw her for a year, every week, sometimes I'd visit twice a week.

Another consideration was how motivated the client was:

> I think if she wasn't [sic] motivated...but because she really wanted to try and do things, it helped.

The NP also identified similarities between the client and herself.

> I don't know whether its a lot of them are people my age and we could have lived through the same set of life's experiences.

> As I'm seeing more women, I do feel that it depends on the women, how they are, whether they are contemporaries in age and all those things that have more closeness or identification with them.

The issue of gender or the fact that the nurse practitioner was a woman impacted the nurse-patient relationship in terms of identifying with the woman's perspective of issues.

> A man doctor just isn't privy to that stuff, like talking about menstruation and menstrual pain.

> We very often are better equipped psychologically and emotionally to take care of people.

A third aspect of the nurse-patient relationship was that of the personal attributes of the nurse practitioner. Characteristics described were being trustworthy, listening to the client, maturity, self-confidence and asking the right questions.

> Listen to the patient, listen to his needs.

> I also think that my age has something to do with it, having gray hair, the people trust me because I look more mature.

Maybe I poke around and ask certain right questions.

The nurse-patient relationship was also depicted in terms of professional competence:

> Clients come to a professional because they don't know what to do. Its a relationship in that you may know a little bit more about this particular area than the clients do.

Nurse practitioners mentioned the issue of power and control in the relationship with the client. NPs were seen as having a great deal of power in the relationship. Power might be misused and needed to be respected:

> Nurse practitioners have a great deal of power in that we practice very independently and make many, many decisions every day, that are very important that can influence people's lives.
>
> Every time you tell someone what to do you are exerting power.

Results of the use of power were driving people away, withholding medications, and making the wrong decision.

> You don't want to feel that you drive people away with your decision making.
>
> One might be tempted to make a decision that would stop the coercion but not necessarily be in her best interest of her health.

There were results from of the nurse-patient relationship such as changes in the NP's attitudes, personal rewards on the part of the NP, and conversely how the relationship may have negatively affected the nurse practitioner.

> My attitude definitely got changed because of who I was now dealing with. I could not work with this population without changing my attitude towards them.

> Maybe that part of the relationship [developing a friendship] sort of interfered with my obligation as a provider.
>
> I know that days that I see patients and interact with them are the days that I get the most out of work.

Factors in the environment and the nurse practitioner role were important major themes for the participants, which along with the essential feature of values made up the everyday, ordinary practice of the nurse practitioner. These values were often triggered by the factors which influenced a particular situation.

Influencing Factors

This essential feature included the factors that intervened in some way and affected the situation to change it from an everyday, ordinary clinical encounter for the participant to one that was unusual and constituted a moral dilemma. These influencing factors were identified as critical by the nurse practitioners in that they affected and were in turn influenced by the other major themes; thus uniquely affecting the situation in some way. There were four major themes that emerged factors in the work setting, the participants, considerations in the decision making process, and catalysts to the decision.

Influencing Factors in the Work Setting

These were the considerations within the setting in which the nurse practitioner practiced which were reported as significant in contributing to changing the everyday

clinical situation to one of a moral dilemma.

The health care system.

The majority of participants specifically mentioned aspects within the work setting, such as the health care system as it is practiced in this country.

> What we did was that we kept statistics in the clinic of how many patients we each had actually seen as practitioners and at the end of the month they would be tallied and you would actually be told and then from there you could kind of grossly estimate what your income was going to be from that population.
>
> They [Medicaid patients] come a lot of time and not necessarily abuse the system, but have to use the system in order to get over the counter medicines for their child they can't get with their medicaid stickers. Medicaid has ended up getting themselves charged a visit plus the medicine just for something that's over the counter.

There were also outside forces such as the politics inherent within the health care system that affected the setting:

> I think a lot of times decisions are being made, especially with new treatments and things that involve money and politics and health, the decisions are being made way up and we have very little to do with it or even knowledge of.
>
> There's big bucks in all these studies, big bucks.

Other considerations.

There were also other considerations that affected the setting:

> Because we were a large medical center, I was more aware of the PR issues...we didn't need any more bad publicity.

The population in the setting.

The population in the setting also had an influence.

> You often are dealing with clients who are much sicker than what you are going to see in a private practice because they wait before they come in to see you until they just have no choice.
>
> I was constantly getting people telling me about abuse.

Other providers.

The setting was influenced by the absence or presence of other providers:

> My primary physician was on vacation, I was alone in office with the backup physician.
>
> I don't see these patients alone, I wouldn't do this alone, I'm part of a team.

Influencing Factors: The participants

This major theme was reflective of the features about the participants in the dilemma, clients, colleagues and others, who contributed to changing the ordinary clinical encounter to a moral dilemma. All of the participants had responses that fit into this major theme.

The clients.

Three characteristics stood out in the description of the clients: they were needy in some way, there was a strong nurse-patient relationship, and caring for this client was challenging for the nurse practitioner.

> Here is a woman in need, really needed someone, some support.
>
> These families are high risk, low functioning, dysfunctional and non-compliant. I would have to intervene more than the average nurse practitioner would.

Occasionally it was a negative interaction between the nurse practitioner and the client that was the influencing factor:

> She [the client] didn't want to hear, she didn't want to negotiate either, she was inflexible from her side.

Groups of clients were identified who had special needs:

> The business manager said to me: why do you spend more time with the medicaid people than the other people? They pay the least, but you spend more time with them. The answer is because they need more help.

One participant described outside factors that influenced clients in this way:

> When there's money involved, such as in a clinical trial, a hundred dollars to the patient and they need that hundred dollars, they're not going to care, they're not going to see the other side that perhaps their health could be jeopardized even to a small percentage.

Colleagues.

Besides clients, there were others, such as colleagues, who acted as influencing factors.

> One of the employees there objected to it [abortion] under any circumstances for religious purposes, she just didn't want to do it.

> ...here was obviously a person [physician] for whom abortions was a major part of his practice if Operation Rescue was going to be going to his practice.

A few of the participants worked in a setting which used a team approach and the thinking and decisions made by the team became part of the influencing factors.

> We were trying to give them [mom and baby] as much time as we could together and hopefully not have to take the baby away.

Considerations in the Decision Making Process

While the nurse practitioners did not directly discuss making a decision about the moral dilemma, the decision making process was evident in the factors that were taken under consideration in attempting to sort out what to do. These considerations included aspects of legality, risks to NP, clients and others, past experiences, and consulting others about the situation.

Legality.

> [I'd] have a hard time just from a strictly legal standpoint, trying to fire her.
>
> Even if the mom is using heroin, that's not grounds to take the baby away, drugs alone isn't enough to take a child away, because of the statute we needed enough evidence and enough support, because it was such a serious thing to do.

Risks.

Nurse practitioners discussed consideration of the risks involved to themselves, the clients and others as illustrated in the following:

> Be really liable, she could come back and create some liability, some kind of lawsuit.
>
> If he had chosen to be really mad for a thousand different reasons, he could have me black balled from a thousand different places, doctors' offices, hospitals.

Risks to the client were reported as considerations which influenced the decision making process.

> We knew that mom was going to fall apart if we took the baby away. I felt once we took the baby away, it would be hard for her to get her baby back, she would probably never see the baby again.

> What's going to be the worse threat to their health [a pregnancy or taking the pill]?

There were also risks to others voiced:

> I was thinking of my physician too, what are the ramifications for him, if I sign this paper?
>
> She [the employee] could have been fired.

Past experiences.

The NPs called on their past experiences, personal and educational, to help them with the dilemma.

> I thought about other experiences I've been in, because it wasn't new. I could pull back from my past experiences and say, hey how are you going to deal with this?
>
> I think I learned from what I had learned in the other kids, the six other kids [taken from the home], and I built on that to help me with her, how to document well and what things are considered crossing the line.

A new nurse practitioner expressed the feeling that more experience was needed to help come to a resolution.

> I feel like I don't have enough experience behind me to say that's its okay [giving the patient thirteen months worth of the pill]. I feel like I needed to work with somebody else who's done it longer and feel more comfortable in making these decisions.

Consulting others.

Consulting other professionals was another influencing factor in the decision making process as follows:

> I talked to my boss [who] was the assistant chief nurse, I think I talked to two other supervisors...
>
> I called one of my friends who's been an NP for a long time. I felt like I needed to talk to somebody about this situation.

Sometimes the advise received was not what one wanted:

> What she told me was not what I want to hear.

There were also barriers to seeking advice:

> How can I talk to the office staff, they don't know what I'm going through.

Catalysts to the Decision

Catalysts to the decision was another major theme under influencing factors. These were the one or two pivotal factors that were crucial in moving the participants to make a decision about the situation. While the other influencing factors were essential to the situation, these catalysts seem to be the turning point. Almost all of the catalysts were events directly related to the relationship between the client and the nurse practitioner. The catalysts are exemplified by the following quotes from the participants:

> I attended an AIDS conference, and heard arguments on both sides of the issue. What are an HIV positive woman's rights to bear children?

> I've got a sick six month old and he's got pneumonia and I'm treating him and I need to be sure that I can keep him out of the hospital...then what do I do for follow-up, when the parents have no money?

In summary, influencing factors played a part in the moral reasoning of the nurse practitioners in elucidating those features that moved the ordinary everyday clinical encounter into one of a moral dilemma.

Recognizing the Dilemma

The moral dilemmas as recounted by the nurse practitioners were another essential feature in this study. Dilemmas were those perplexing situations related to right

or wrong, where there were two or more courses of action, none of which was clearly satisfactory or unsatisfactory. The dilemmas are presented here in the practitioners' own words.

> How do you weigh those two responsibilities [to the client and society]? The nurse as an advocate of society, or of the patient, a person's right to privacy versus the public's right to protection...
>
> It was the issue of patient safety and patient care versus the employee's feelings about participating in an abortion.
>
> That was where most of my dilemma came in, is how do I make an income, generate an income for the clinic, and at the same time be able to provide a service to patients who were poor and still offer quality coverage. That straddle within our society of those who can afford insurance, those who can't afford insurance to me is not fair, so what can I do about it?
>
> Should I or should I not put my name on the line [sign the form] in order for her to get this care?
>
> The dilemma for me was I felt like I was in a tight corner and that I wanted to give her the pills...but then I felt like I couldn't because of the protocol and the fact that she was trying to coerce me.
>
> Should the baby be taken away and when should the baby be taken away?
>
> The moral dilemma was not to be actively associated somebody who did abortions which I am wholeheartedly against.
>
> What made it difficult was that he was coming to me and was telling me secret information that he didn't want me to share with anyone else. Although I understood and agree with what he wanted to do, it was sort of running up against the requirements of the study, we were sort of straddling the fence there, at least I felt I was.
>
> The time pressure that you feel in seeing patients, to get them in and get them out. This is people and you never know who's going to have a problem.

> There can be a dilemma as to whether its in the client's best interest to enter into a research protocol as opposed to just getting care. The times that I have not felt comfortable is when there's a placebo control trial.
>
> If the HMO is saying that this is the kind of care that we give to all our patients ....Then is it fair to offer only to the person who can afford to pay for it [special casting material] and have some other kid with the same fracture be put in a regular cast...

Outcomes

Defined as the responses evoked by the moral dilemma, outcomes were further divided into deciding to act, affective responses, cognitive responses, and evaluative responses.

Deciding to Act

These were the activities, both professional and personal, which were considered by the participants a result of the moral dilemma situation during the process of moral reasoning. Also included in this major theme were those actions which were undertaken by others in the situation.

Professional actions.

These were responses which were consistent with the professional role of the nurse practitioner. One response was the use of client education to help resolve the situation. This activity was utilized to fulfill several purposes. One participant relied on client education when the family could not afford to take a sick child to the hospital and had to be treated at home.

> Always education was like top on the list, education was very, very much in the plan of treatment.

Educating the families also had some personal benefits for the NP:

> That [the education of the families about carrying out the treatment] was kinda in the way my buffer... in order for me to feel comfortable that I could even go to sleep that night.

Client education had other benefits as well:

> Having to educate them, was going to be the best method of keeping their kids healthy.

> You teach them [the families] self-responsibility as well...the more they are educated the more responsible they become.

Education was viewed as a way to deal with the dilemma of health care access for clients. The more education that the clients received the more likely it was that the families would utilize the health care system in a more efficient way, thus stretching the family's limited funds for health care.

> Rather than running in the door with the first couple of sniffles, saying my baby has a cold...the whole purpose of educating them so that they knew the difference with the health maintenance...

Discussion was also used by the participants. Some explored the issues with the clients.

> Looking at the woman's own health, pregnancy increases the risk of getting ill faster with earlier mortality.

> I'm pretty clear in saying, you may not get anything out of being in this project, telling people that you may get nothing out of this, you might even end up with some bad side effects.

Other participants described trying to reach a compromise.

> We talked for a long time. In that time, we had to work out something that would be agreeable to me that

was safe.

Sometimes the dialogue was between professionals:

> I realized every side has their yeas and their nays... to be able to discuss the issues, not with banners, not with guns, not with blowing up buildings, just one on one.

One participant chose to wait the situation out:

> For the time being we can just let him stay on the study and take his drug and just see what happens.

She combined this with giving out her home phone number to the client in order to be kept abreast of any changes in the situation.

> That was the first time I had ever given my home phone out.

The health care system was manipulated at times to achieve the most desirable outcome.

> Nurse practitioners have always tried to utilize samples of medications to help those people who can't afford and would not take medications otherwise.
>
> ...when somebody needs something I bend the rules and I get it for them.
>
> What I actually ended up having to do was to bring the baby back at a time when it was not a regular appointment so that I still could generate income with my appointment slots...we would be able to see them free of charge.

Other actions included refusing patient's participation:

> There were a couple of times where I said no I don't think you should go on this research protocol because and gave them a reason.

Other actions described collaborating with clients:

> All major decisions that we make on our research and how we're going to do something we run it through this

board [patient participation board].

Sometimes an undesirable outcome was chosen because it was the right thing to do, which is exemplified as follows:

> We called child protective and reported her and the baby was taken.

One NP took action:

> I put my name on the form. I ended up just doing it.

One NP whose dilemmas revolved around the time needed to deal with client's needs, chose to change the focus of her approach to clients.

> The first thing you ask is what are you concerned about today cause usually people have a list of things that are on their mind.

Another action outcome was documentation of the events that occurred.

> I would document in my chart that the family was unable to afford a chest x-ray...

Following the protocols utilized in the setting was chosen by one NP:

> I feel its important that this is what the protocol says.

Personal actions.

Some of the actions reflected more of a personal level of response. These were activities the participants took on personally and were different from those actions performed within the professional role. These included prayer and scripture readings:

> In solving my dilemma, first thing I did was pray, I did a lot of prayer.

Choosing not to be involved in the research study was cited by one participant:

> When I was doing clinical trials, if I really didn't believe that the medications were safe, efficacious, if I didn't like the phase one, two or three data that had been presented, if I didn't feel that it was really safe and optimal I would not have elected to be involved with those, even though I was getting paid for them too.

One participant felt that an outcome of the moral dilemma was:

> I paid for it, I lost a job for it.

Actions by others.

These were actions taken by others as recounted by the nurse practitioners.

> The administrator came to see me, the administration was upset with me.

> The doctor said he would not sign it and advised NP not to sign it, just leave it alone, forget about it.

Sometimes the nurse practitioner chose to follow up after the dilemma was over.

Actions after the situation.

These actions were undertaken after the situation was over. The participants sought out colleagues for reassurance and support of their responses to the dilemma.

> When my physician came back I told him what happened. He totally supported me in my decision.

> I called my friends and told them what I had done, they gave me support.

While all of these outcomes were actions to be taken in some form or another, other responses to the dilemma were

reported.

Cognitive Responses

The outcomes in this major theme were those reactions to the situation that reflected the thinking of the participants. Some of the NPs ruminated about their participation in the dilemma and reflected on the outcomes of the dilemma.

> I thought I tried my best.
>
> I think that I did the right thing in this situation, I feel ultimately that the right decision was made.

Another participant expressed a sense of risk taking:

> I really put myself on the line for this woman.

One nurse practitioner talked about being detached and objective and using rationalization as responses to the dilemmas inherent in the work she did:

> I tell myself its for research. So there's lots of rationalizations that can be used but I don't always feel comfortable at the time that I am doing it. If I can be detached enough, objective enough...that's real important that I can be at that place all the time and not feel like I really have to do a hard sell on every single person.

Affective Responses

These outcomes reflected the feelings that the participants had as a result of the moral dilemma. All the nurse practitioners related affective responses to the moral dilemma. There was a wide range of feelings expressed.

> I began to feel more sure, more confident of my decision.
>
> I reprimand myself, I didn't realize how important a pregnancy was to her.

> Emotionally I wanted the mom to keep the baby, but I knew that she couldn't.

A variety of feelings resulted from the involvement in the moral dilemmas as is indicated from the responses of the NPs. These situations also caused the participants to review and weigh the situation.

Evaluative Responses

These were responses in which the situation was examined, reviewed and weighed. The participants discussed alternatives to the outcomes chosen, what was learned from the experience and the benefits derived from the situation. The participants commented on whether they would do things differently another time.

> I would definitely offer them care the same way I was doing, still fenagling if I had to. I wouldn't change a thing.

> I would always try to somehow work out whatever the problem was between what I was representing and what the patient needed.

A participant verbalized the need to have answers:

> I would like to know why she doesn't want to see me.

Acknowledging that there were no easy answers, she continued:

> Do some research on this question, if its true that knowing your HIV status doesn't prevent pregnancy, what does?

Several NPs mentioned learning from these experiences.

> You can learn to maybe do what you can and say well, I'll get back later or we are going to work on this one.

> Its sort of painful to have that experience, to have that growing experience, and learn and get seasoned.
>
> I think you learn a little bit about yourself, just how far you can go, you learn about your limitations.

Aside from learning from the experience, there were other benefits cited:

> It was a nice affirmation that I was a pretty good administrator.
> It probably strengthened my beliefs a little bit more.
>
> ...a lot of personal satisfaction.

Another benefit was the strengthening of the NP's relationship with the client.

> The relationship that I had with this patient benefited probably because it was able to withstand what was going on.

There was an opportunity to share feelings and opinions:

> The benefits were being able to express myself to somebody, how he responded so positively.

The larger issue of providing health care was verbalized by the participants as a benefit:

> You know that you have helped to take care of someone and that was definitely a very nice benefit.

In summary, outcomes were those responses which were considered as resolutions to the moral dilemma and were an essential characteristic of moral reasoning. Outcomes reflected how the participants in this study not only decided to take action, but also their feelings, thoughts and personal growth from the experience. Outcomes were one of five essential features of moral reasoning which surfaced

from interviews with nurse practitioners.

Interrelationship of the Essential Features of Moral Reasoning

Elements in The Contextual Framework for Moral Reasoning

The Environment and the Nurse Practitioner Role

These two major themes set the stage for the ordinary everyday practice of the nurse practitioner. These major themes described the uniqueness as well as the commonalities amongst the practice settings. The environment served to define the role of the NP in that particular setting, not only in what types of clients the nurse practitioner was working with but also how the everyday functioning of the entire setting impacted on the nurse practitioner role:

> Part of it [how the NP utilizes her time] is the whole setting, how its set up.

The environment and the nurse practitioner role were obviously essential to each other. One did not exist without the other, the nurse practitioner functioned within some kind of setting. The two were intertwined.

Values

Values were an essential feature of moral reasoning that were integrated into the ordinary everyday practice of the nurse practitioner. Values were described in terms that linked them to the NP's role.

> It comes down to your value systems. I try to hold true to that value system itself. It comes down to why did you become a nurse practitioner.

In addition, values were discussed in terms of a personal belief system. Values were integral to the nurse practitioner's role, since who she is as a person comprised part of that role. Further, when discussing the source of their values, the NPs clearly stated that the values they held were long standing, came from family and religious upbringing, and experiences including past nursing experiences.

> [My beliefs] probably come from all of my experiences, from my parents, my teachers, church, some of it from society too.

This suggested that values were ideals which motivated the participants as persons and as nurses. Values, therefore, played a part in nurse practitioner role and the nursing role in turn played a part in the values.

In addition, values played a part in the clinical environment. Practitioners talked about the importance of sharing and/or not sharing like values with colleagues.

> One of the nicest things about working there when we were all together was that pretty much we had the same value systems of how we were going to provide care, so there was very much a common goal to take care of this community, it needed services.

Further, the work environment was cited as a source of values. Hence, the relationship between the environment, the nurse practitioner role and values was inter-related.

Influencing Factors

Influencing factors were those factors which changed a clinical encounter in the everyday clinical practice of the

nurse practitioner into a dilemma. These factors were cited by the NPs as intervening in the setting, or with the participants in the setting, or influencing the situation as to make this everyday encounter problematic in some way and thus a dilemma. There were also a category of influencing factors which were catalytic to moving the participant into making a decision.

The Work Setting

These characteristics directly affected the environment in which the NP worked. Such factors as the system of western medicine and the need to generate income, outside forces such as the politics of research funding, colleagues in the setting, as well as the types of patients being seen played a part in uniquely influencing the situation:

> We get locked up into western medicine, the only drugs worthwhile are the drugs that we are researching.
>
> The federal agency determines how things are going to be done.

This influence of the setting was also inter-related since some of the these factors were already a part of the clinical environment, and in some way became particularly important in the context of this specific situation. So not only was the clinical environment influenced by factors in the setting, the influencing factors were also molded by the environment.

The Participants

These influencing factors represented those

characteristics about persons, other than the NP, who participated in the dilemma. Again, these were factors which in combinations with other factors changed the everyday clinical encounter into a moral dilemma. Many of the factors cited related directly to the client: the client was needy, there was a strong nurse-patient relationship, and caring for the patient was challenging for the NP:

> That's another issue that I had to deal with, having alot of illegal clients, so they're not gonna be able to go to a hospital because they're not covered by Medicaid.
>
> Here is a woman in need, really needed someone, some support.

Other factors referred to colleagues in the setting:

> Our perspective [the health team's] is that patients [HIV positive women] should not have another baby.

These influencing factors were directly responsible for affecting the nurse practitioner role and the environment in such a way as to change the everyday ordinary practice of the nurse practitioner into an unusual situation. In turn, these factors were part of the environment and the NP role so that the influence was again bi-directional.

Considerations in the Decision Making Process

While the nurse practitioners did not discuss a decision making process as such, it was obvious throughout the interviews that the situation the participants were in necessitated making decisions. This decision making process

was influenced by several factors. These were the factors that were considered, weighed and sorted in order to decide on appropriate responses to this particular dilemma. Some of the factors discussed by the NPs included considerations of legality. What was the appropriate decision to make legally? What were the risks to the NP, clients, and others involved in the dilemma? Were there past experiences which were similar in some way to this present dilemma and how had they been resolved? What might be some of the alternative courses of actions?

> The biggest risk was...that I send this baby home and he gets himself in respiratory distress and dies at home.
>
> Making the decision to separate mom and baby I learned from experience.

These factors were pondered by the NPs as they deliberated about what to do in this situation. Often there was one element which became a turning point in the situation, this became the catalyst to the decision.

Influencing Factors: Catalysts to the Decision

The catalyst seemed to be a pivotal factor in the situation which caused the participant to respond. It might be said that the catalyst was the critical point, where, in combination with other influencing factors, the participants felt that this was a situation which was in some ways different from the ordinary, everyday situations encountered in practice. The participants sensed at this moment that a

decision must be made. Seven NPs were able to pinpoint a factor that seemed catalytic:

> There's a real fine line on can this mother handle this baby and can she not...the line is drawn for her and when it got to that point that was our motivation for taking the baby no matter how hard it was.

> The parents say, we only have $25.00. $25.00 is going to cover a very minimum basic treatment or even just a visit. Then what do I do for follow-up? I've got a very sick six month old and he's got pneumonia and I'm treating him and I need to be sure that I can keep him out of the hospital which means that they have to have close follow-up.

The catalysts to the decision, surfaced from the process of weighing the factors that were influential to this situation. The participants sorted through the issues surrounding the dilemma and the responses available and ultimately made a decision. This decision was often based on one value which was verbalized, during the interview, by the NPs as being most important, although they may not have been conscious of the fact that it was one or more values which motivated them towards a decision as the situation was occurring.

> I always feel in the end that my ultimate responsibility is to him [the client], irrespective of the study, or whatever is involved, to him, to his well being, or to that person. I just feel really strongly that as a practitioner, where I'm a nurse or whatever I am, that that's a really strong obligation that I have.

> I felt like I had to help her or no one else would.

To summarize, the combined influencing factors contributed to make the situation a moral dilemma. This

precipitated examination of the situation, weighing the options and often one factor emerged as most important and was the basis for the response of the NP to the dilemma.

Outcomes

Outcomes were another essential feature of moral reasoning of the participants in this study. Choosing outcomes were those responses evoked by the dilemma. These responses were further classified into deciding to act, affective responses, cognitive responses, and evaluative responses.

Deciding to Act

Professional actions.

Professional actions were those activities undertaken by the participants as part of their professional position as a nurse practitioner. At times the professional action included patient education which might be used to help a parent cope with a sick child who in other circumstances might have been hospitalized. But once the NP realized that the option of hospitalizing this sick child was not possible, then client education provided a means of sharing the responsibility of monitoring that child with the parent. By giving in depth instructions to the care giver, the risks to the child were minimized.

Other types of professional activities included discussions with clients about their options and the risks involved.

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Other types of professional activities included discussions with clients about their options and the risks involved.

> The way I dealt with it [HIV positive mother wanting to become pregnant] was to tell about the high risk of having an infected child...forcing the person to think about the long term future.

Sometimes the decision to act might result in consulting with colleagues about the situation and the potential outcomes available. This provided a mechanism for the NP to discuss her concerns with others physically present in the environment, or using the telephone to consult if there was

no other provider in the setting.

At times the setting was manipulated in order to resolve the dilemma. As described earlier, nurse practitioners "bent the rules and the system" to achieve the outcome most valued by the NP for the client. These types of professional actions had a direct relationship with the environment and the nurse practitioner role, thus forming a feedback loop to the elements in the contextual framework for moral reasoning.

Personal actions.

Personal actions were those activities which reflected a response by the nurse practitioner to the dilemma that was outside the realm of professional practice and was a personal, individualized way of responding.

> I sought out scripture, seeking the Lord's will as how do I proceed?

Actions after the situation.

Some of the participants discussed actions which were taken after the dilemma was over. These often occurred after some reflection on the situations.

Actions by others.

There were others in the environment who also acted in some way or another a result of the dilemma. The outcomes in this one particular situation most likely would serve as a reference point in the future should another similar dilemma arise. So choosing outcomes then, functioned to

provide the nurse practitioner with feedback to the elements in the contextual framework of the moral dilemma and probably shaped influencing factors in a variety of ways for dealing with future moral dilemmas.

Cognitive Responses

Cognitive responses were those responses that reflected the NP's thinking about the dilemma:

> I'm still not feeling comfortable with my decisions, did I do the right thing?

Affective Responses

The nurse practitioners shared their feelings about the dilemma through affective responses as follows:

> This was probably the hardest thing that I had to do so far as a moral decision goes.
>
> I felt very, very alone.

Evaluative Responses

Evaluative responses were those statements that reflected on the situation and reviewed alternatives to the outcomes chosen. These responses often discussed what had been learned from the experience and how it might affect a similar situation in the future. These reflections directly related to how the NP might function in her setting in the future.

> I learned that you don't need to worry so much and that people have some responsibility for themselves...

Outcomes, then, was a result of making decisions based on one or more values which helped sort out the options for

the participant. In turn, the evaluative responses indicated that the NPs took what they learned from this dilemma and utilized this information in their settings within their role as nurse practitioners. Evaluative responses, in turn, also affected future influencing factors:

> I think that my interpretation [of the protocols] might change [with more experience].

The interrelationships between the essential features of moral reasoning have now been established. All of the participants discussed these five essential features. A close examination suggested, however, there were differences among the participants in the way in which these five essential features were operationalized. Two patterns of moral reasoning surfaced from this part of the data analysis, independent reasoning (independents) and lateral reasoning (lateralizers).

Patterns of Moral Reasoning

The independent pattern of moral reasoning was used by the majority of participants. A pattern of independent reasoning was one in which the individuals carried out decisions concerning the moral dilemma base on a self-chosen set of values. The independents' moral reasoning was oriented to values they viewed as most important even though doing so might jeopardize them personally and/or professionally in some way.

Participants utilizing the lateral reasoning pattern were those individuals who also identified the same five essential features of moral reasoning. They, however, described activities which appeared to defer the outcomes of the dilemma and moved instead laterally to be in concert with some other factor in their settings. Some differences were found within those individuals using the lateral reasoning pattern. These will be discussed and compared with those participants who employed the pattern of independent reasoning for each of the five essential features of moral reasoning.

Elements in the Contextual Framework for Moral Reasoning

The environment was mentioned by all the participants and there did not seem to be any disparity between the two patterns of reasoning. The nurse practitioner role was also mentioned by all ten participants. However, when discussing the minor theme of perception of the role, both lateralizers spoke of the role:

> As a nurse practitioner in some ways my role actually felt fairly transcribed or prescribed.
>
> The protocols there [in the setting] are quite spelled out.

One participant who used the lateral reasoning mentioned the newness of her role, in that she had only been practicing as an NP for a few months. Both these participants conveyed a sense that their role as NP within the setting was one of following prescribed protocols. This is contrasted with an

independent reasoner who described an NP role which is dynamic and full of challenge:

> It was my job to try to keep the child out of the hospital, to give the baby well child care and treat all of the acute infections and monitor chronic illnesses.

Interesting distinctions were also apparent when the NPs using the pattern of lateral reasoning discussed the nurse-patient relationship. In discussing this relationship, the issue of power was verbalized by both lateralizers. For one, power in the nurse-client relationship was one of struggle with the client and surrounded the moral dilemma:

> Its a power struggle, there is a power struggle there. I had the power to either give her her pills or not give her her pills.

For the other lateralizer, the NP's position of power could be detrimental to the relationship:

> You don't want to feel that you drive people away with your decision making, you're not ending with a beneficial result [when you try to influence the client's decision].

Only one of the independents mentioned the power in the nurse-patient relationship. Her statements accentuate the NP's power in a more a somewhat different light:

> Nurse practitioners have a great deal of power in that we practice very independently and make many, many decisions every day, that are very important that can influence people's lives...

Here rather than using words such as "struggle" in association with power, the nurse practitioner's concept of

power is one of a sense of autonomy in her professional role.

The relationship itself was viewed differently by both groups. The independent reasoners perceived the nurse-patient relationship as basic to the client's response to the encounter:

> What I can do to affect people's health is really based on the relationship that we have.

In contrast, one lateralizer described the relationship in terms that implied a relationship where the client comes to the provider to obtain information. While this is certainly an important part of the nurse-client relationship, one does not denote the vitalness of the interaction in this statement:

> Clients come to a professional because they don't know what to do. Its a relationship in that you may know a little bit more about this particular area than the clients do.

This lateral reasoner also felt some frustration with clients, particularly in trying to educate them in order to maintain their health, such as, discussing quitting smoking with clients.

> There's only a certain amount you can do, I can't go home with that person and take their cigarettes and throw them in the garbage.

To review, the lateralizers appeared to verbalize a relationship with clients that seemed different in that it seemed somewhat more removed as contrasted with those who use the independent reasoning pattern. Those participants

who used the lateral pattern verbalized their role as nurse practitioners as narrower than the independent moral reasoners who described their roles as dynamic, encompassing and the relationship as one of close solidarity with the client. The nurse practitioners in both modes of reasoning were affected by the values they held.

Values

There did not appear to be a pattern of values held by either the independent or the lateral reasoners. Most of the values were cited by participants with either pattern of moral reasoning. The exception was the value of trust which was not mentioned by the lateralizers, however, trust was only mentioned by five of the independent moral reasoners.

Responsibility was discussed by the majority of the participants. Again, it is interesting to note the ways in which responsibility was discussed by members of both groups. Independents described responsibility to clients, employers and society and often had to weigh those responsibilities to make decisions:

> I always feel in the end that my ultimate responsibility is to him [the client], irrespective of the study, or whatever is involved, to him, to his well being, to that patient or that person.

One lateralizer talked about what the client's responsibility was in the encounter and the other recounted her frustrations when clients were not responsible.

> Its the patient's responsibility to be informed and to make informed consent to what they want to do.

> Its very frustrating and disturbing dealing with people who are irresponsible.

It is difficult to hypothesize about why the groups differed in this instance, however, it did appear that the independents were more closely aligned to the responsibility to the clients and other professional responsibilities whereas the lateralizers described responsibility differently. In one instance, it is understandable that the lateral reasoner might discuss responsibility in this manner, as the dilemma she experienced was one of a power struggle with a client. The NP felt that the client was unwilling to take any responsibility in this situation. There were other values such as caring that also reflected differences between the two patterns of reasoning.

Caring as a value was expressed by the majority of the participants, including the two lateralizers. Lateralizers tended to discuss caring using detached generalizations:

> Show that I'm concerned and have the patient come back.
>
> You want the best for a patient, happiness and well being, have an active life...

The NP in the lateralizers' group then moved to discussing a particular client:

> I really care and want the best for her.

Independent moral reasoners, on the other hand, described caring in more affective terms.

> Its [caring] having had the privilege of sharing someone's life, touching their life in some way, hopefully helping them in some way.

Caring is basically being aware of the whole person. For the independents, caring was nurturing, supporting the client, being available for that person, and was basic to the relationship between the NP and the client. The NPs who use the pattern of lateral moral reasoning expressed caring in a manner that seemed to have more generalizations and more distance from the client. Other values were also somewhat different for the two groups.

Reciprocity was mentioned by the nurse practitioners who employed the pattern of independent reasoning. For one lateralizer, perhaps it was the issue of the power struggle with the client and the anger she acknowledged feeling that interfered with being able to put herself in the client's place. However, four of the independents did not discuss reciprocity either. Access/right to health care was discussed similarly.

Influencing Factors

Influencing factors were similar for the two patterns of moral reasoning, except for one striking difference. The two lateralizers both sought out colleagues to discuss the dilemma either during or afterward the dilemma was over. The two lateralizers, in fact, deferred the decision of the dilemma to others.

One lateral reasoner was well able to verbalize a value of importance to her:

I believe in a woman's right to choose.

However, in a situation where the woman client might make a choice that was not, in the eyes of the health care team, in her best interest, the participant decided to follow what the health team has espoused.

> Our [the health team's] perspective is that patients [HIV positive women] should not have another baby.

Even though the participant was able to eloquently verbalize a woman's need to have a child, she elected to agree with the team who were active in trying to convince HIV positive women not to become pregnant. This participant's moral reasoning, therefore, looked somewhat different than the independent reasoners. She moved to a value after sorting out the options: however, instead of moving towards an outcome, she moved laterally back to one of the influencing factors, that of the consensus of the health team and then to an outcome.

The second lateralizer became caught up in a power struggle with a client. The NP sought advice, followed the protocol, but was unable to resolve the dilemma herself. She instead deferred the decision to the physician.

> I didn't feel like I could make that decision based on based on the protocol that was set up so I deferred it to him. The ideal situation was there by having a physician there and it kind of sidestepped all of these protocols.

The nurse practitioner verbalized her feelings about this client:

> I wouldn't have given her the pill for reasons maybe besides the fact that she did have migraine activity but because she had started in trying to make it my

> fault if she got pregnant and threatening, that sorta thing and I didn't feel, I felt like she was being coercive. I didn't like that. I was angry that she was trying to coerce....

Interestingly, this lateral reasoner cited three values during the interview, caring, responsibility and helping. The caring statement was one of showing concern:

> Show that I'm concerned and have the person come back.

Helping was part of her professional role in that she was:

> ...using every resource to help that person.

The value of responsibility for this lateralizer focused on the client's obligation in the nurse-patient encounter and on her professional responsibilities as an NP. She was greatly influenced by her angry over the power struggle with this client. This may then account for the fact that the values statements appear to be removed and impersonal; indeed not directed towards the client she was discussing. She moved through the process of moral reasoning much like the others, recognized the dilemma and activated the decision making process, yet she did not move beyond this stage to identify one value that was basic to her belief system. She instead acknowledged that she sidestepped the dilemma and returned to the protocol within that setting, deferred to the physician and then an outcome was achieved.

To summarize, two patterns of moral reasoning surfaced from the data analysis: the independent and the lateral modes of reasoning. While the lateralizers cited the same

five essential features of moral reasoning, they constructed them in a somewhat different way. The choice of language for the lateralizers often seemed to distance them from the independent reasoners' primary focus, the client. A further discussion of the two groups of moral reasoners will be presented in Chapter five.

This completes the discussion on the process of moral reasoning of the nurse practitioners. Five essential features of moral reasoning were identified and discussed as well as the interrelationship between the essential features. The moral dilemmas experienced by the nurse practitioners will now be addressed.

Dilemmas Experienced by the Participants

All the nurse practitioners interviewed were able to identify a moral dilemma, with one participant sharing two dilemmas. The majority of the NPs discussed a specific situation that had occurred in the clinical setting. This incident was then the springboard for the discussion of the moral reasoning utilized by the participant. Interestingly, two nurse practitioners instead of talking about one specific incident, talked about the dilemma more as a general issue in their clinical practice and used several examples from the setting to illustrate their point. For example, one participant began in this way:

> " think I'll talk about something ...in general. ...And that is the concept that comes up with time pressure that you feel in seeing patients. And that comes from certain employers and they are out for the

> buck basically and you have to see x number of people and you have somebody that's got a certain problem and you're trying to help them, and there's this pressure to get 'em in and get 'em out type of thing. And I have a lot of trouble with that. Because I think as a practitioner and trained to be a caretaker and that it takes more time to do that. I'm not necessarily into curing, I'm into caring.

She then proceeded to discuss several clinical encounters where she felt that the sense of time pressure in the practice interfered with the meeting the needs of the client. In essence then, these two practitioners moved from a more general topic to a specific situation, while the majority of the participants moved inductively from a specific situation to a more general discussion. Regardless of the approach to the discussion, the majority of the situations recounted were centered on the client.

The majority of the nurse practitioners experienced dilemmas that involved clients. One NP's dilemma focused primarily on conflicts of her personal religious beliefs versus those of colleagues with whom she worked. Another participant discussed a dilemma which involved an employee under the NP's direct supervision, however, the dilemma concerned client safety as well as the employee's wishes not to participate in procedures which she felt were morally wrong. In fact, many of the dilemmas revolved around issues of patient safety and advocacy for the client. One nurse practitioner felt caught between wanting to help the client and risk to herself professionally:

Should I or should I not put my name on the line [sign

the form] in order for her to get this care?

while another questioned where the NP's responsibilities lay, with the supporting of the individual client's wishes or protection of society:

> How do you weigh those two responsibilities [to client and society]? Nurse as advocate of society, or a person's right to privacy versus the public's right to protection?

These two examples illustrated the conflicts that the participants related.

A closer examination of the dilemmas shared by the participants revealed issues that relate to the broader themes frequently cited in the bioethics literature, those of maleficence versus beneficence, rights versus responsibility, and justice.

Many of the participants felt that the particular dilemma that had been described was resolved. However, a few of the nurse practitioners, particularly the two who had discussed broader moral dilemmas in practice, gave the sense that some of the dilemmas were ongoing. Issues such as access to health care, soliciting patients for research studies, and having enough time to meet the psychosocial needs of the clients were continuing issues inherent in the health care system the NPs worked in. Another participant felt her dilemma was ongoing because her personal religious beliefs often differed with others on the health team and therefore had to worked out with colleagues on an ongoing

basis. So for some nurse practitioners then, the situations which contained potential dilemmas would continue to occur. There were other important findings which emerged from the analysis of the data.

Incidental Findings

While these findings which were extracted from the data were not essential features of moral reasoning, their description does offer insight into the participants' values and their origins.

Description of Values

Two nurse practitioners attempted to describe values as forming a basis for decision making and made the connection from personal values to the professional role as follows:

> It comes down to your value systems. I try to hold true to that value system itself. It comes down to why did you become a nurse practitioner.

One of the participants continued by describing how values may become re-prioritized as the individual moves out into the world.

> [Its a] time to adjust your values because you may not find all of them coincide with what your family was believing during the time that you were in the household, once you're in the work setting, rather than developing new ones.

Another interpreted values as follows:

> Its just one of those internal principles that you're sort of guided by...my own personal belief system as a person and as a nurse...

While only two participants tried to define what values are, five NPs talked about where values came from.

Source of Values

Half of the participants attempted to describe the source of their values as follows:

> I think its part of my upbringing to be helpful to people. It has a lot to do with my religious beliefs.
>
> Probably from your settings, definitely from your work settings, the experiences you have and the patients you meet.
>
> I think that really does come form your family background, I think that's where you probably formulate most of your beginning value system.

Some acknowledged that values were acquired and reinforced within the profession of nursing and from the work setting:

> Its something [that] I learned in nursing, that I've grown up with, its probably a combination of everything.

Other nurse practitioners, when discussing values, related that it was important to stand up for and act on the values one held.

> My feeling is that you stand up for your convictions the way you do things [the way you lead your life].
>
> And that verse and several others were saying to me: you may have something you believe is important but if you don't go and share that, what good does it do to hide in your house and never go back to this doctor and explain where you stand.

Taking this idea of acting on one's values one step further, one nurse practitioner connected this with acting as a role model for patients:

> If I'm going to say something [to patients] then I would want to have it based on something that I am going to do...[that's] one of the things that I have learned as a nurse practitioner, if you're going to become a role model for health for your patients.

This concludes the discussion of the findings of the research study. The implications of these findings will be discussed in the next chapter.

CHAPTER 5

DISCUSSION OF THE FINDINGS

Values

In this study, values were defined as personal ideals that motivated the individual in making decisions and choosing the courses of actions surrounding the moral dilemma. This definition resembles the classic definition in the bioethics literature, which describes principles as basic, general and fundamental justifications for actions chosen during the moral dilemma (Beauchamp & Childress, 1983, Thompson & Thompson, 1985). Principles as defined by Omery (1985) appear very similar to both of the above definitions of values and principles. Clearly these definitions reflect the same essential feature of moral reasoning, that is, a basic reason or reasons which explains why an individual acts in a certain way(s) within a moral dilemma. The term values was used in this research study because it best reflected the language of the participants. This researcher found values to be so significant and foundational that they were assigned to a separate essential feature, even though it might be argued that values as influencing forces to the moral reasoning might also have been categorized under influencing factors. However, values seemed such a strong influence as to be pervasive through

the moral reasoning process.

When discussing the rationale for their actions, the NPs used the word "values, value, or value systems". Only three of the participants used the term "principle" throughout all of the interviews to describe what values were and when describing the formal education received in ethics.

> I know that there's some theory to it [ethics], I never remember what all principles are. Beneficence, and there's a few other things but I can never remember what they are.

It is significant to note that the term "principle" was not in the everyday language of the participants. Since the majority of participants had masters degrees in nursing and most likely had some formal preparation in ethics, most likely bioethics, one might expect that the discussion of moral dilemmas would elicit terminology associated with that ethical framework. This may be reflective of a finding in Omery's (1985) study, which was called educational experience, which described the ethical content received in the educational setting by the acute care nurses. It was reported to have had a negative impact on their moral reasoning because the participants maintained that the educational experience portrayed situations of a moral nature as unrealistic. While the participants in this study who mentioned their educational preparation in ethics were not necessarily negative, it is clear that the language of

bioethics was not part of the nurse practitioners' vocabulary in discussing moral dilemmas.

In addition, when the participants were asked to define what values were; for some of the NPs a melding of personal and professional values occurred. Participants came to the nursing profession with their own set of personal values, and acquired and/or changed values to fit their professional role. Further it seemed that the personal and professional values were so intertwined for some that role modeling their beliefs became a part of the nurse practitioner role. For example, one NP felt strongly that advocating a healthy lifestyle for clients must be something that she believed in and emulated.

Not all participants' personal values were in harmony with other professionals' values, for example, one participant struggled with a strong value of sanctity of life in a health care system where abortions are performed which she viewed as the taking of life. This placed her in ongoing conflict as she encountered new situations and new health care providers.

None of the nurse practitioners mentioned the Code of Ethics for Nurses in any way, let alone as a source for their professional values or as a reference to guide them in their actions in resolving moral dilemmas. The implication may be that the NPs were unaware of their code of ethics or more likely that it was viewed as a document that belonged

in the halls of academia and was not useful in the clinical practice as a model for ethical conduct.

Emergence of One Value

During the process of moral reasoning, the independent reasoners sorted through several values and depending on the influencing factors in the situation, often the catalysts, ultimately chose one value which for them was the personal moral ideal which served as the basis for the decisions made during the moral dilemma. In contrast the two practitioners utilizing the pattern of lateral moral reasoning did not do this, instead they moved back to a particularly significant influencing factor as a basis for their decisions.

The description of values by the participants as personal, hierarchical, motivational, moving the individual to act in a certain way in a given situation, and evoked in relationship to human experience is consonant with the definition of values in the literature (Omery, 1989, Thompson & Thompson, 1985). Further, values appear to be contextual to the situation, as well as generalizable. The same value might be expressed in both ways by the same participant:

> I felt more for her [italics added].
>
> I feel a lot for *these people* [italics added] who are in these situations.

That is to say that similar situations might not necessarily elicit the same values, depending upon the factors which

existed in the context of that particular situation and influence the moral dilemma.

Cooper's (1990a) themes of justice and care also are quite similar to the values elicited from the nurse practitioner participants in that Cooper's (1990a) themes were interactive, dynamic and contextual. Similarities in the features of values or principles, therefore, do appear to exist amongst nurses when moral dilemmas has been examined and have emerged as important essential features of moral reasoning.

The idea of values or principles as contextual was divergent from the criterion of universalizability that is said to be one of the essential characteristics of principles: "any moral judgment...must...apply universally in relevantly similar circumstances" (Beauchamp & Childress, 1983, p. 16). According to the participants in this research study, certain values surfaced from the moral values held by the NP specifically due to the circumstances which were contextual to that particular situation. Another similar situation, with similar, but not exactly the same circumstances surrounding it, might elicit different values for the nurse practitioner.

Responsibility

Responsibility as a value was mentioned by the majority of the nurse practitioners. The levels of responsibility were depicted as layers, not separate, but interconnected.

For these nurses, the responsibility was to be of service, to help others. Interestingly, helping as a value was mentioned by half of the nurse practitioners. Helping was portrayed as an obligation or responsibility to be of service and a blending of the practitioner's personal and professional values.

> I felt like I had to help her or no one else would.
>
> Being of service is ingrained in me...
>
> I went into nursing because I wanted to help people...

While these two values, responsibility and helping, were separated during the initial data analysis, when Gilligan's (1982) work is re-examined it is apparent that these descriptions of responsibility and helping mirror Gilligan's (1982) characterization of morality as being responsible to others. The fact that responsibility was a predominant minor theme under the essential characteristic of values also fits Gilligan's (1982) model of women's moral development with responsibility and care as its major themes. Further, the depictions of responsibility was based on recognition of the individuality of need in others, the uniqueness of human beings rather than a rights orientation based on the sameness of individuals.

> ...responsibility is being flexible, its being willing to open oneself up to new concepts, ideas, values, information, knowledge minute by minute...

Responsibility was also mentioned by all of the acute care nurses in Omery's (1985) study of moral reasoning, although it was implemented differently by Omery's (1985) two groups, the accommodating and the sovereign reasoners. Likewise there was some distinction of the description of responsibility between the independents and the lateralizers which has already been discussed in the previous chapter.

Caring

Given the focus on caring in nursing, it is not surprising that caring was mentioned by all but one of the nurse practitioners. Caring was not referred to by one practitioner who used the pattern of independent moral reasoning, The basis for this is not clear, perhaps it is because the dilemma she discussed involved an employee and not a client and although she had a great deal of empathy for the employee which she supervised and was very concerned with her feelings; she did not use caring when discussing the dilemma.

The caring statements always occurred within the context of relationship to others. Most often the caring comments related to a specific client, but some NPs made comments of a global nature about caring, these were also inter-relational.

> I nurtured her [the mother] to make sure she had her normal physical needs that she needed and the baby needed.
>
> Its a humanity issue that we care about each other and that we would want to see that everybody is healthy and

well.

Caring expressed itself in a variety of ways. Caring was characterized as nurturing and compared to the role of the loving parent or as a societal consciousness. Typically, caring was seen as the thing that nurses do and do well.

> That [caring] makes me different from any other provider.

This involved being holistic in one's approach to the individual.

> For nurses, the bottom line is care.
> caring is basically being aware of the whole person, looking at the whole person, and the illness, not divorcing it from the illness.

The most powerful expressions of caring were those which equated the caring relationship of the nurse and client as one of healing. Listening to these women discuss caring about clients, one could feel the power of the relationship:

> I'm convinced that that's [caring] what makes people better or makes them able to tolerate whatever illness they are going through.

This idea of caring as possessing potential for healing is espoused by Watson (1989) in her nursing theory of Human Caring. Watson (1989) further advocates caring as the moral ideal for nursing ethics. It would appear that the nurse practitioners in this study emulated caring as a powerful, healing tool available to the nursing profession.

Caring is also synonymous with Gilligan's (1982) theory

of moral development which she has coined an ethic of care. For Gilligan, caring is the ultimate principle and is a universal obligation. The caring for others that the participants displayed is evidence that caring for others as a value has powerful potential for the profession as well as being reflective of women's moral reasoning.

In Cooper's (1990a) study, caring was one of two major themes. "[t]hese nurses' own personal interpretation of their moral experience as it was revealed in their stories disclosed a primary reliance upon the private concepts of care." (Cooper, 1990a, p. 182). Cooper found that the nurses used a justice perspective when the relationship tended to be non-reciprocal, such as when the patient was unresponsive. Caring became more evident as the relationship between the nurse and patient grew.

Care was also a principle of importance in Omery's (1985) study. All of the sovereign reasoners discussed caring and lack of caring by others in the setting caused the sovereign reasoners to feel anger.

To summarize, caring was found to be a major component under the essential feature of values. Caring was not only directed towards the client(s), but the practitioners felt a need to extend the caring to society. Caring was representative of their profession of nursing and of their gender as women. These characterizations of caring are reflective of Watson's nursing theory of humanistic caring

and lend credence to Gilligan's model of moral development which addressed women's moral reasoning as distinct from the male perspective. Further, other research studies have elicited similar themes of caring, supporting the assertion that caring as a value is vital to nursing and is basic to moral reasoning. Another set of values closely associated with the value of caring are those grouped under the value of respect for persons: being non-judgmental, advocacy, reciprocity, autonomy, and confidentiality.

Respect for Persons

The group of values categorized under respect for persons were all associated with ways in which the participants conceptualized the clients in order to see their humanness, to see the client as a whole person with a belief system and rights of their own.

> If they don't feel the same way you do, even visa versa, that person doesn't have a right to say to you your beliefs are wrong and mine are right.
>
> None of us wants to feel like cogs in a wheel.
>
> I see people very much in the light that they are an individual and have rights of their own.
>
> Being non-judgmental helps me to know the person better.

All of these statements sought to make the client a human being who was very much like the nurse practitioner. These values promoted the nurse-patient relationship in that the client was someone the NP can easily relate to and set the stage for a caring interaction to occur.

This activity of humanizing the client is closely related to what Watson (1989) referred to as: "...an ideal of intersubjectivity between the nurse and patient [that] is based upon a belief that we learn from one another how to be human by identifying ourselves with others or recognizing their dilemmas as in our own" (p. 233). Gilligan (1982) also described being non-judgmental as a part of women's response to moral dilemmas, maintaining that this reticence to judge others is itself representative of the care and concern women have for others.

While Omery (1985) and Cooper (1990a) studies found similar themes as these, there were some distinctions. Reciprocity, for example, was cited only by Omery's accommodating reasoners and had a somewhat different interpretation. For the accommodating reasoners, reciprocity meant doing good to others so that others would in turn treat them well. The sovereign reasoners identified the themes of advocacy, autonomy, respect for persons and fairness. These were described very similarly to the nurse practitioners' responses except for fairness which was found to be similar to Kohlberg's concept of justice. However, a relationship between these values and caring was not delineated.

Cooper's participants saw reciprocity as having two dimensions, the nurse received reward and satisfaction from patient care, but also reciprocity was important in

establishing the nurse-patient relationship and paving the way for a caring interaction. Reciprocity along with obligation, fair play and others were interpreted as being associated within a justice framework.

The practitioners appeared to reflect a caring morality as described by Gilligan (1982). They moved to caring from a perspective of humanizing the client by identifying them as worthy individuals similar to themselves. These themes were also similar to other nursing studies on moral reasoning, although the interpretation of the themes was somewhat different. It is obvious that these values are recurrent themes when nurses describe the process of moral reasoning. Another value, justice was also mentioned by the nurse practitioners.

Justice

Justice as a value emerged as an interesting concept in this study. Justice, or fairness and equality, as a major theme was only discussed by one participant. If the issue of right to health care, equal access and equal quality are added as exemplars and minor themes of justice, then four participants discussed justice as a value. Perhaps this is reflective of the unfamiliarity and discomfort the nurse practitioners had with the language of bioethics, where justice is a principle of primary importance. Another interpretation might be that justice for many is equated with the legal system and used frequently in this context.

These women were more comfortable using the term fairness rather than justice. Nonetheless it is obvious that issues of justice, particularly access, right and quality of health care is an important issues to the NPs.

The concept of justice is often equated with Kohlberg's (1984) model of moral development, with justice being the principle that is characteristic of the highest level of moral development. Nurses have often failed to reach that highest level when measurement tools based on Kohlberg's (1984) model has been used in research studies. It is apparent from this study that the issue of justice is important to these practitioners, however, justice is deliberated using language that is different from Kohlberg's (1984).

Gilligan (1982) felt that women's morality reflected caring and responsibility. Interestingly, the nurse practitioners used these words when discussing right to health care:

> I think that we have a responsibility as a society to be sure that these people are taken care of.

The nurse practitioners illustrated the assertion made by Gilligan (1982) of women's "different voice" when discussing moral dilemmas. This language exhibits a closer alignment with a relationship of caring and responsibility than one of objectified justice, leading support to Gilligan's claim of a different morality for women based on caring.

Omery's (1985) sovereign reasoners described the principle of fairness which was equated with Kohlberg's principle of justice, and was very similar to the discussion of justice by one independent reasoner in this study. Justice was an essential theme in Cooper's (1990a) research study of moral reasoning with acute care nurses. Cooper (1990a) found that for these nurses: "[j]ustice set the stage for the response of care by the nurse. In this sense, a justice framework constituted a necessary condition for care." (p. 99). This concept of justice is somewhat different from the use of justice in this study where justice, fairness and equality were not pre-requisites to caring. Rather justice as a value surfaced most often when objectively discussing the health care system, particularly the right and access to health care which was an issue of concern to the NPs. For the nurse practitioners, this was the objectified voice, whereas the minor theme of not judging others was the personal voice, which allowed the participants to see the humanness in others, thus moving them into caring for the client.

The right/access to health care as well as the quality of that care was mentioned as an significant value by four of the participants, independents and one lateralizer. None of the participants in the two studies on moral reasoning in acute care nurses (Omery, 1985, Cooper, 1990a) mentioned right or access to health care as an issue. Most likely

this is reflective of the fact that once a patient enters an intensive care setting, the decision about eligibility for care has been made, usually by others rather than the nurse. For the nurse practitioner as primary care provider, however, this issue was ever present in some settings. One practitioner who worked for a large HMO, where access is not an issue to its members, was concerned about the quality of care being equal amongst all the patients. These issues were also part of the dilemmas the nurse practitioners shared and will be discussed in detail later in this chapter.

Honesty and Trust

These two closely related values were referred to by half of the NPs, all of whom were independent reasoners. The relationship between these values and the independent reasoners is not clear. Most of the comments on honesty and trust were directed at the trust the client placed in the provider, some comments were directed at the trustworthiness of the practitioner as provider.

Honesty was an important principle for all of Omery's (1985) acute care nurses. It was the implementation of this value that differed for the two modes of reasoners. Accommodating reasoners rationalized when necessary that dishonesty was permissible to be accepted by the peer group. Since the lateralizers in this study did not discuss honesty and trust, it is not clear what significance if any this has

or how this relates to Omery's findings.

Likewise, Cooper's (1990a) respondents mentioned trust and truth telling, both synonymous with the values in this study. Trust was essential to moving from a justice perspective to a caring perspective. Trust and truth telling were closely related to the degree of the nurse-patient relationship.

To summarize, values were an essential feature of the moral reasoning of the participants in this study. Similar studies on moral reasoning (Omery, 1985, Cooper, 1990a) elicited many of the same values. Of particular importance is the emergence of caring and responsibility as essential features in all three studies, giving credence to Gilligan's (1982) model of moral development for women based on an ethic of care. Justice did not appear to be as essential to the participants as the value of caring, although both appeared in all three studies.

The Elements in the Contextual Framework for Moral Reasoning

This essential feature, the elements in the contextual framework for moral reasoning, contained the major themes of the environment which made up the nurse practitioner's every day practice and the nurse practitioner role. The environment included two minor themes, the clinical practice and colleagues.

The Clinical Practice

The minor theme of clinical practice was implicit because it

helped dictate what type of activities the NP engaged in every day. All the participants discussed various aspects of this minor theme. This was, for most of the NPs, the beginning point of the discussion. It was obvious from these discussions that the type of practice, that is whether it was a community clinic, women's health center, or a pediatric practice, impacted on the NP's every day clinical practice and therefore influenced the types of dilemmas encountered. Further, the administrative policies of the environment, what type of funding was available and so on, also had an impact on the nurse practitioner and in turn, played a part in influencing the context for the dilemma and subsequent moral reasoning that occurred.

This is of importance because it suggests that moral dilemmas occurred within the context of the nurse practitioner's daily practice. The moral dilemmas one might read about in texts, journals, and newspapers often portray moral dilemmas as unusual and extra-ordinary situations that may develop occasionally in the practice setting. Perhaps the sensationalism of the mass media has created an image that moral dilemmas in health care happen like "a bolt of lightning".

What the participants in this study described were ordinary, everyday encounters that because of certain influencing factors became moral dilemmas. It is unclear whether the NPs realized at the onset that this situation

was becoming different from the usual encounter. It is most likely that some of the participants recognized the fact that a moral dilemma was occurring earlier than other participants. One participant acknowledged that the situation only became a moral dilemma after the fact, when she had more information which caused her to deliberate on previous actions.

This depiction of the moral dilemmas in practice more closely resembles the morality of every day life as described by Haan, Aerts, & Cooper (1985) and Macguire (1978). Both authors characterize morality and moral dilemmas as a part of life's every day choices. A survey on the ethical issues in primary health care by Robillard, High, Sebastian, Pisaneschi, Perritt, & Mahler (1989) supports the findings in this study: "...the most frequently occurring ethical issues cited by primary care providers represent day-to-day, pragmatic concerns of clinical practice. These issues are generally neither dramatic or newsworthy, yet they frequently occur" (p. 15). Every day life is full of moral choices that one must make and occasionally there are situations when making a moral choice is more difficult than others.

It seems an appropriate place here to mention that since the moral dilemmas encountered by the participants all began as part of an ordinary encounter in their practice, the decision making process initiated by the NPs was no

different than the clinical decision making process utilized consistently in practice. So the process used to make decisions about moral dilemmas is initially no different than the process of thinking critically about clinical issues. The process of moral reasoning may differ somewhat in that the underlying reasons for making choices are based on moral values held by the individual. However, the point must be made again, that these situations happened within the usual practice setting and were not extraordinary events, thus lending credence to a morality as embedded in everyday life. Mayberry (1986) in her research found that nurses used "an intuitive approach" in solving moral dilemmas. It may appear "intuitive" only because it is initially no different a process than problem solving with clinical problems and thus is described very similarly by nurses.

Colleagues

Colleagues were also an important part of the practice environment. Most of the participants worked along side other providers in the setting. These nurse practitioners independently saw a case load of clients on any given day and used colleagues as consultants, to share feelings with and to get and give support to each other. Three of the participants functioned as part of an interdisciplinary team, with more than one member at a time seeing the same client. Two of these NPs often used the word "we" instead

of "I" during the discussion of the moral dilemma and its resolution. One of the practitioners who worked within a team setting was characterized as utilizing the pattern of lateral moral reasoning. For her the team's mind set was influential because even though she questioned the team's decision, ultimately she chose to follow the team's directives. The other practitioner who worked in a team setting was one of the participants who was identified as using the independent pattern of moral reasoning and used her team colleagues in order to help her assess a difficult situation. Ultimately, she was able to come to her own decision based on her own values. How much being part of an interdisciplinary team influences team members in making decisions about moral dilemmas cannot be ascertained from this study and might serve as a focus for a future research study on moral reasoning.

There was one participant who used the independent pattern of moral reasoning, but who could easily have been seen as a lateral moral reasoner had only one factor changed. This participant moved through the process of moral reasoning like the others, however, if one factor had been changed, that is the opinion of the physician employer, this would have caused her to make a different choice.

> ...if he was still extremely adamant about me not signing it then I umm, I probably wouldn't have done it.

Even though she could identify a basic value for herself in

this situation and acted upon it to resolve the dilemma, she would have chosen an outcome contrary to her values due to the influencing factor of the physician employer.

A discussion of colleagues in the practice environment would not be complete without considering the nurse-physician relationship. Previous qualitative studies on moral reasoning (Omery, 1985, Cooper, 1990a) cited conflicts between nurse and physician as a source of moral dilemmas for nurses. This was not the case for the nurse practitioners in this study. There was no indication that conflict between physicians and nurse practitioners precipitated or were the focus of a moral dilemma. When the topic of physicians was discussed, the focus of this discussion centered on the differences between the nurse practitioner's and the physician's approach to clients.

> Physicians and nurses differ in their thinking process as far as the physician is more in tune with, with the physical or with the physical person. The lab work, the really concrete things that they can see and really work on and things like that and nursing, I think, is more behavioral and looking at the whole person as far as psychological, biological, environment, family. Everything that is in a relationship to that person.

Another NP emphasized the differences in this way:

> I'm not necessarily into curing, I'm into caring. I think alot of employers don't see nurse practitioners that way. They see us as mini-doctors for people to cure, and wanta to get em in, run em in, and get em out.

For this participant, the lack of understanding about the differences in approaches between nursing and medicine

caused some conflicts in the setting. However, again the dilemma was the issue of the time the practitioner felt she needed to adequately care for some clients and not a conflict between the physician and the nurse practitioner over moral values.

Nurse practitioners seemed to have carved a role for themselves in the practice environment. The ideal setting seemed to be one in which all involved in the practice environment shared the same value system concerning the clients, however, when this was not the reality, the NPs worked around this or sought out a more favorable system. The participants viewed the physician in the setting as a colleague who was needed for consultation with medical problems that the NP could not manage. For the NPs, the physician's role was well delineated and was not a source of moral dilemma as it was for the acute care nurses in Omery's (1985) and Cooper's (1990a) studies. Another factor that most likely contributed to the lack of issues surrounding the nurse-physician relationship was that the NPs' role was also viewed as well delineated.

The Nurse Practitioner Role

Most of the participants functioned quite autonomously giving direct care to clients, often without a physician present. The majority viewed the role positively and saw it as somewhat different from the role of the hospital based nurse. As was mentioned in the previous chapter, the two

practitioners who were categorized as employing the lateral moral reasoning pattern tended to view the role as an NP as more prescribed and constrained. The independent reasoners described a more dynamic role for themselves, caring not only for the physical needs of the client, but meeting the psychosocial needs also. One independent mentioned her nursing education as preparing her to feel comfortable meeting these needs of the client. Being comfortable in talking with and educating clients as a nurse before becoming an NP was felt to be a distinct advantage. Educational experience will be addressed again under influencing factors as well.

Three of the participants interviewed had one year or less experience as an NP. All of them mentioned this factor as important when describing their role and their degree of comfort in the role. Of significance is that this lack of clinical experience may have contributed to changing an ordinary clinical encounter into a moral dilemma for two of these new practitioners. In all likelihood the two scenarios reported by the new NPs would not have been a dilemma for a more seasoned clinician.

Conversely, three seasoned practitioners discussed the obligation as a clinician to know one's own limitations in order to give quality care to clients. It would appear that the increase in clinical experience not only altered what the practitioner viewed as a dilemma, but additionally

focused the practitioner on having a sense of the boundaries of her role. Further, knowing one's limitations was seen as an obligation in order that the client could be assured quality care.

This is an interesting finding in light of the quantitative studies (Crisham, 1981, Ketefian, 1981b, Mayberry, 1986) cited in the review of the literature which found that nurses with more experience scored at a stage lower in Kohlberg's cognitive development model than nurses with less experience. The majority of the participants in this study had several years of clinical experience and this may account for why the practitioners had dilemmas which were more likely to be considered dilemmas by the majority of NPs in practice. The newer NPs presented dilemmas which on closer examination would most likely not have been problematic or considered a moral dilemma by a more seasoned practitioner. The dilemmas of the new nurse practitioners seemed to center around procedural issues within the clinical environment and the health care system. A more seasoned practitioner would have, most likely, dealt with these issues repeatedly and would have acted based on past experiences without considering the situation a moral dilemma.

What is important to note is that moral dilemmas appear be very different for the new practitioner than for the seasoned NP. This does not negate that the new NP is

experiencing a moral dilemma, but that it is of a somewhat different nature and more than likely based on a lack of experience as an NP.

It is difficult to compare these findings with previous quantitative studies (Crisham, 1981, Felton & Parsons, 1987, Ketefian, 1981a, 1981b, 1985, Mayberry, 1986, Munhall, 1980) which have repeatedly correlated higher levels of education with higher scores on moral development scales. It is likely, as was previously discussed in the review of the literature, that the quantitative research results may be reflective of measurement tools that do not adequately measure moral reasoning (Parker, 1990). However, how seasoned nurse practitioners might have scored as compared to the new NPs utilizing similar quantitative measures is not known.

The Nurse-Patient Relationship

This significant minor theme under the nurse practitioner role described the relationship between the NPs and their clients. While there were specific individual factors that influenced a particular relationship, this minor theme contained general characterizations of the meaning of the interaction between client and nurse practitioner.

The participants generally viewed this relationship as very meaningful. The interaction between provider and client was seen as the key, not only to a successful

encounter with the client, but was viewed as basic to the success of therapeutic interventions. A great deal of power was ascribed to this relationship because it was linked to the goal of the encounter, that is moving clients towards health. It further solidified the connection between the nurse-patient relationship and values, such as caring and responsibility, which were essential to make the interaction meaningful. The relationship became more meaningful the more contact over time there was with the client, or if the client had pressing needs. This triggered values of wanting to help and caring for the client.

One participant saw the interaction between nurse and client as a privilege:

> It really is a privilege in that people do open up their lives to us in many different ways. They allow us to enter for that short amount of time and interact and hopefully make it [the problem] go away.

The NP also gained personally from the nurse-client relationship. They verbalized getting much personal satisfaction from these encounters. One participant credited the nurse-client relationship with helping her to alter long held stereotypes:

> I realized that my attitude completely changed over this system [medicaid]. I could not work with this population without changing my attitude towards them. I was looking at a population and saying: all these things that I've always heard about isn't true. My attitude definitely got changed because of who I was now dealing with...

In other words, knowing these clients as people encouraged her to examine the stereotypes she held and to dismiss them. So it was not just the clients who benefited from the relationship but the nurse practitioner did as well. The acute care nurses in Cooper's study (1990a) identified similar responses to the nurse-patient relationship. Called reciprocity in Cooper's study, this described not only the reward and satisfaction that nurses received from the interaction with clients, but also that reciprocity as defined by Cooper helped sustain the relationship as well.

There is no question that the nurse-patient had significant meaning to the participants in this study. It was seen as basic to the nurse practitioner role which had the potential to have a profound effect on both client and provider. This relationship was seen as so vital as to take precedence over other factors. The relationship between the NP and the client often was the characteristic that changed the context of the clinical encounter and charged it with special meaning. It is understandable then that the relationship the nurse practitioner had with a client might be catalyst for a moral dilemma. Cooper (1990a) similarly found that: "the primary factor impacting on the nature of the moral response of the nurse was the character of the nurse's relationship with the patient." Omery's (1985) findings also acknowledged interpersonal relationships between individuals as an important influence in a moral

dilemma situation.

The nurse practitioners were cognizant of their own power inherent in this relationship. Participants felt that the power was inherent because practitioners made many decisions concerning clients. That power needed to handled very carefully because there might be negative ramifications if abused. As a matter of fact, one participant's dilemma centered around a power struggle with a client.

This acknowledgement of power in relationship to the client is not typical of the stereotypic view of nursing as lacking power. Perhaps the nurse practitioners felt this sense of power more because of the independence in their practices where they were seeing clients autonomously, receiving input from colleagues when it was sought out. Whatever the reason, several of the participants discussed the power that their role gave them with clients. This differed from the sense of powerlessness of Omery's (1985) accommodating reasoners who conveyed a lack of authority or influence in the moral situation.

Gender issues also surfaced in reference to the nurse-patient relationship. These discussions concerning gender centered around the idea that women are more nurturing, more concerned about others and might be better prepared to meet the psycho-social needs of clients. This was particularly true if the client was a woman because the NPs felt that women could relate better with other women and were more

connected to other women:

> She's a woman and I'm a woman, that's the main thing.
>
> ...a woman's perspective. I'm much more attached [then men] to what the emotions are behind pregnancy and what it means to people...

This association of nurturing, concern and caring for others with the female gender is reminiscent of Gilligan's (1982) moral development theory which has its basis in the nurturing attributes of women. The participants saw these female characteristics as bring something unique to the nurse-patient relationship and to the role of the practitioner.

Influencing Factors

Influencing factors were of paramount importance because these were the factors which changed the context of the situation from an ordinary everyday clinical encounter to a moral dilemma. As stated earlier, the moral question is not necessarily: "What ought I do?" but "what ought I do in this particular situation, given these particular circumstances?" This view of a moral dilemma agrees with Gilligan's (1982) paradigm for women's morality which is contextual instead of the objective, principled approach espoused by Kohlberg (1984). The impact of influencing factors parallels both Omery's (1985) and Cooper's (1990a) studies which cited similar findings. Omery (1985) called factors which influenced the situation "mediating factors". While Cooper (1990a) does not list a separate category of

influences, it was acknowledged that the context tempered the situation, in particular the nurse-patient relationship.

Influencing Factors in the Worksetting

Some of the factors that influenced the everyday clinical encounter were within the practice setting itself. Two of the NPs specifically mentioned the Medicaid system as being an influence. Some of the issues resolved around how the Medicaid system was operated, while other issues were centered around the clients themselves who were on Medicaid and the fact that many physicians would not accept Medicaid clients. It would appear that this system of health care insurance fostered situations that raised issues of a moral nature for the participants.

The nurse practitioners who worked on research studies also mentioned unique factors in their settings that influenced the ordinary clinical encounter. Some were outside factors that made the practitioners feel powerless in the situation:

> ...I think a lot of times decisions are being made, ...the decisions are being made way up and we have very little to do with it or even knowledge of it.

Other factors were inherent in the type of activities that the research project required, such as offering monetary rewards to clients, and performing tests that were painful and only necessary to monitor the client for the drug study.

The Participants

The people involved in the situation were also a strong

influencing factor. The nurse-patient relationship particularly was a strong mediating force in the moral dilemma. The majority of the NPs specifically indicated factors directly related to the client as being instrumental in influencing the ordinary clinical encounter. Findings such as these as well as the importance of the nurse-patient relationship were found in Cooper's (1990a) study and the interpersonal interactions in Omery's (1985) contributes to Gilligan's assertion that women's morality is based on relationships between individuals.

Others in the setting influenced the situation also. This was particularly true for those NPs with the lateral moral reasoning pattern, both of whom, deferred to colleagues in the clinical environment. For one lateralizer, the values of the team were a forceful influence, the other deferred to the physician in the setting. For Omery's (1985) accommodating reasoners, also, the opinions of the dominant group were influential in what decisions were made in moral dilemmas. The participants as an influencing factor, therefore, had a powerful impact on the ordinary clinical encounter, contributing to creating a moral dilemma.

Catalysts to the Decision

Catalysts to the decision were an interesting finding. These were one or two factors which became pivotal in moving the nurse practitioner to make a decision about the dilemma.

It was as if the addition of the catalyst tipped the scales towards making a decision. For example, the NP might have a very sick infant in the office; as the situation unfolds, she begins to understand that the parents have no money, are illegible for assistance, and now understands that as illegal aliens they will not seek health care for this infant elsewhere. The catalyst of this additional ingredient, that the parents are illegal aliens, motivates the NP to act, in this case by bending the health care system to provide the best care possible, given the situation. The majority of the nurse practitioners identified a catalyst(s) that was associated with the nurse-patient relationship. Again, the interpersonal aspect of the catalyst as an influencing factor echoes the contextual and relational nature of women's morality (Cooper, 1990a, Gilligan, 1982, Omery, 1985). The catalyst also was instrumental in making those utilizing the independent reasoning pattern sort through important values and chose one or two values most meaningful to that NP. Decisions about outcomes to the dilemma were based on these one or two crucial values.

Looking at the catalyst(s) gives insight to the composition of these crucial values. Several of the catalysts addressed issues of wanting to help, safety, doing good and avoiding harm to clients. All of these easily can be interpreted as being analogous to Gilligan's (1982)

highest level of moral development, the morality of non-violence where not hurting is valued as most important and is balanced between the self and others. The nurse practitioners considered not only the harm to the client, but also to themselves and others in the moral dilemma.

Considerations in the Decision Making Process

The majority of the nurse practitioners considered the legal issues that pertained to their particular dilemma during the decision making process. Legal constraints were also identified as mediating factors [Omery's term] by all of Omery's (1985) respondents, although the accommodating reasoners used legal constraints to justify avoiding making a decision. Sovereign reasoners resembled the nurse practitioners in this study more closely, because legal issues were identified but were not necessarily the impetus for a decision in the moral dilemma.

The risks in the situation were also considered by the majority of the NPs. Again, risks to the safety of the client were very strong considerations in the decision making process, evoking the theme of not hurting others associated with Gilligan's (1982) theory of women's moral development.

Past experiences, both personal and educational, were given as considerations in the decision making process. This type of experience is somewhat different than what was described by the acute care nurses (Omery, 1985) in terms of

educational experience, which referred specifically to nursing education. It is interesting to note, however, that past experiences, including education, were considered in deciding on an outcome. While some of the NPs discussed calling up their past experiences to help in the decision making, one new practitioner, a lateralizer, felt that the lack of experience was a factor in her being unable to sort out the dilemma. Past experience, both educational and clinical, have been previously been studied only in quantitative research on moral reasoning. It is difficult from this limited data to discern what impact these experiences had on the moral reasoning of the NPs. Suffice to say that experience appears to be an important factor in moving the new practitioner into a becoming a more expert clinician, better able to deal with the dilemmas that arise.

Recognizing the Dilemma

It is clear from the data that nurse practitioners recognized and were able to articulate the moral dilemmas in their clinical practice. The essential features and their relationships as delineated in the previous chapter are a result of the data analysis of the ten participants in this study and demonstrated evidence of a complex process of critical thinking which had its inception within the clinical decision making process. There is no question that the NPs were able to use critical thinking to resolve moral dilemmas.

While the specific moral dilemmas the nurse practitioners discussed appeared to come to a resolution, the broader issues on which the particular dilemma was based, such as access to health care and so forth, are still prevalent within the health care system. Although these issues are not unique to primary care providers, it is interesting to note that several NPs choose to remark on this lack of resolution of dilemmas, while the acute care nurses did not (Omery, 1985, Cooper, 1990a). As a matter of fact, two of the participants choose to begin their discussions of moral dilemmas in their practice from a broad issue perspective and used specific examples to illustrate their points. Interestingly, both of these practitioners were independent reasoners and both had more than ten years of experience as nurse practitioners.

The meaning of this finding is not clear, perhaps these participants had spent a great deal of time over the years thinking about the similarities between moral dilemmas in their clinical practice and had examined the basic issues underlying the dilemmas. This may also reflect the level of education that these nurses possessed, since both were Masters prepared. Regardless, it is evident that there are multiple, ongoing issues inherent within the primary health care system that are problematic for nurse practitioner providers and which complicate the provision of quality health care. The economics of health care, for an example,

may be an area where issues may arise. The nurse practitioner may feel ill prepared to deal with these issues. A survey of providers on ethical issues in primary health care, of which 13% were nurse practitioners (Robillard et al, 1989), found that financial constraints within the health care system received the second highest ranking as an ethical issue by the non-physician group. This lends support to the issues concerning the economics of health care discussed by these nurse practitioners.

An examination of the dilemmas reported by the participants reveals that most were centered around client issues. Often the NP had to balance between distinctive responsibilities: to the client, to herself, to colleagues, to the employer, and sometimes to society. Robillard et al's (1989) survey found that conflicts over how time was spent, that is balancing the time between the patient in the exam room and the others waiting, was the most frequently ranked dilemma among non-physicians. This is once again an example of balancing conflicting responsibilities. This conflict in responsibilities at the heart of the participants' dilemmas parallels the theme of responsibility in Gilligan's (1982) theory of women's moral development. Furthermore, the values of helping and not hurting elicited in the dilemmas are reminiscent of the other major theme in Gilligan's work, that of caring.

It is apparent from the data analysis that moral

reasoning evoked affective as well as cognitive reactions from the participants. The nurse practitioners shared a good deal of emotion about these dilemmas. Throughout the discussion of the dilemma, the NPs moved between the subjective and more emotional voice, and the objective and more rational voice. It is clear that both were essential components of working through the moral dilemmas. This is somewhat different from the logical, objective approach advocated by the rule and principle approach of bioethics and the ethical decision making models found in nursing ethics texts and articles on bioethical dilemmas in nursing journals (Bunting & Webb, 1988, Erickson, 1989, Fleetwood, 1989). Callahan (1988), however, saw emotion as vital as reason in ethical decision making, as was evident for these nurse practitioners. It appears that emotions likely play a part in the process of moral reasoning, influencing which outcomes are chosen.

Outcomes

Deciding to Act

This last essential feature of the moral reasoning of the participants proved to have significant findings. All of the NPs discussed taking some kind of action, however, one of the most interesting was the use of client education for the resolution of the moral dilemma. One practitioner educated families to care for a sick child in order to keep the child out of the hospital. Education was also used to

deal with economic constraints faced by the families by teaching them simple means to maintain the child's health and appropriate use of the health care system, so that their health care dollar could be utilized as appropriately as possible:

> Having to educate them, was going to be the best method of keeping their kids healthy.

Education served other purposes as well, it fostered self-responsibility in parents and improved the quality of health care all around. Therefore, client education, which by the practitioner's own description the nurse excels at, was used to resolve dilemmas that might currently be occurring, but also to prevent dilemmas from happening in the future and ease the burden on the health care system as well. Further research is necessary to determine whether client education as an intervention is utilized by other NPs to resolve moral dilemmas.

Another interesting action taken by the nurse practitioners to resolve dilemmas, particularly those dilemmas involving access to health care and economic constraints of client, which were inherent in the health care setting and were likely to re-occur; was called "bending the system." Initially for the NP, this involved learning the system and where, when and how to bend the rules. Nurse practitioners learned this by trial and error and from colleagues. This activity is not unique among NPs, but is utilized by all nurses (Hutchinson, 1990) and was

probably learned when the participants worked as RNs. Bending the rules was not seen as unethical:

> I don't find that [bending the system] an ethical problem or a moral problem, although you could stretch it and say if they don't fit the criteria, you're doing something wrong, I personally don't believe that.

Hutchinson (1990) studied this behavior among nurses and called it "responsible subversion" (p. 3). The NPs bent the rules and the system to provide care for the client. It was caring that motivated their actions. Clearly this is reflective of the common thread that runs throughout these interviews, wanting to help, not wanting to hurt "...and the hope that in morality lies a way of solving conflicts so that no one will be hurt" (Gilligan, 1982, p. 65).

Evaluative Responses

Evaluative responses also emerged as outcomes chosen in the moral reasoning process. The nurse practitioners assessed the moral dilemma and its outcome, citing potential alternative outcomes and what had been learned from the situation that could be applied to a similar dilemma in the future. These evaluative responses served to add to the NPs' experience with these difficult situations and project how they might respond in the future. It was evident from the discussion under the influencing factors that the participants past experiences played an essential part in moral reasoning. This experience may very well be one of the differences between the novice and the seasoned practitioner. Further research is necessary to ascertain if

evaluative responses continue to be an important minor theme in the process of moral reasoning.

Review of Stated Assumptions

It is clear from the results of this study that nurse practitioners demonstrated the ability to recognize, discuss and resolve moral dilemmas within their clinical practice. These moral dilemmas were pragmatic, not sensational, occurring within everyday clinical practice situations. The dilemmas were contextual in that they were greatly influenced by factors in the environment of the practitioner. Both moral orientations of justice and caring were expressed by the volunteers in this study. Caring was, by far, the more predominant value of the two, which was expressed by the nurse practitioners.

The role of the nurse practitioner, which requires that she often function autonomously, in a variety of clinical environments did appear to impact the type of dilemmas the NP experienced. This was evident in the types of dilemmas, specifically the dilemmas of health care access, discussed by the participants.

The analysis of the data demonstrated that the context of the situation influenced the moral dilemma and its resolution in each and every instance. Likewise, a caring nurse-patient relationship was seen as basic to any therapeutic intervention. The importance of this unique relationship between NP and client was a major influencing

factor in the process of moral reasoning. It was the type and strength of the relationship between nurse and client that often was a strong influencing factor in changing the clinical encounter into that of a moral dilemma. The relationship that the NP had with the client was also at times the catalyst for decision making in the situation.

The nurse practitioners in this study expressed a sense of confidence in their unique position in the health care system and the expansion of the traditional role of the nurse did not appear to pose any ethical dilemmas for the participants. Further, the nurse-physician relationship was well delineated by the NPs and was not a source of conflict. While physicians might have been a part of the circumstances surrounding the dilemma, the NPs did not verbalize dilemmas that implied that physicians were the direct cause of the dilemmas.

Whether these dilemmas and the process of moral reasoning discussed here are reflective of the dilemmas experienced by nurse practitioners in general remains to be determined through further research.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to identify the essential features of the moral reasoning of nurse practitioners when faced with moral dilemmas in their clinical practice. This was accomplished by describing five essential features and their interrelationship.

Limitations of the Study

Given the limited number of participants in the study, it is not possible to generalize findings or to generate definitive implications for a theory of nursing ethics. Further, because the participants volunteered for the study and in effect were self-selected, it is not possible to know whether the motivation for volunteering affected the data collected on moral reasoning. The clinical settings were not representative of all clinical settings in which NPs work; therefore, settings different from those in which the participants practice may have inherently different moral dilemmas within the settings.

In addition, because the qualitative interview focused only on the dilemmas in the clinical environment, it is not known what other intrinsic and extrinsic variables contributed to the dilemma and its resolution. Moreover, since the focus of this study was on the process of moral

reasoning recounted by the participant of a specific dilemma(s) in practice, this only allowed the participants to touch on the factors which might contribute to the moral development of individuals, whether inside and outside of the profession. These areas need to be explored further to determine how moral values are incorporated into the nurse's professional values.

Only women were included in this study, further study is indicated to research the moral dilemmas male NPs encounter and how these dilemmas are resolved. Given these limitations however, some general observations are appropriate.

Conclusions

One of the most striking findings of this research was the occurrence of moral dilemmas embedded in everyday, ordinary clinical practice situations. This would suggest that the sensationalism of moral dilemmas found in the literature and in the news media is not what troubles these nurse practitioners.

Rather, issues basic to our current health care system is at the root of the moral dilemmas for NPs. This finding fuels the need for radical reform of the health care system in order to meet the moral obligations championed by the profession of nursing and specifically of concern to this group of primary care providers.

In addition, the language of rules and principle ethics

did not emerge as the framework by which NPs resolved their moral dilemmas. While the principle of justice was evident in discussing the more objective health care access issues; when searching for values to rationalize their choices in the moral dilemma, nurse practitioners returned again and again to the values of caring and responsibility. Caring was seen as empowering nursing to evolve a special relationship with clients in order to be therapeutic. This is a significant finding and substantiates nursing's long tradition of caring. These values of caring and responsibility were similar to those found by Gilligan (1982) of women's moral development. These values have also emerged in other nursing qualitative studies as well (Cooper, 1990a, Omery, 1985).

Another significant finding that is reminiscent of Gilligan's paradigm and Omery's study was the influence of the context of the situation in precipitating a moral dilemma.

Clearly, the findings of this study, as well as other research cited in this paper, suggest there are several values that are part of the profession of nursing. The nurse practitioners seemed to meld their own personal values with values acquired in nursing and in the work setting. These values were reflected as motivation for making certain choices in a moral dilemma. Values such as caring, responsibility, respect for persons and honesty surfaced

time and time again as essential to the discipline of nursing. Caring has been the focus of a great deal of attention in nursing in the last decade and it is apparent from these practicing nurses that it is a value associated with and embraced by nursing. Other values such as trust, helping, empathy, cited by the NPs have received less attention in nursing and when these are the focus of discussion, they are values associated with a principled based ethics. However,it would appear that these values are very important to nursing, particularly on how they relate to the nurse's ability to care for the client. A closer examination of what is necessary in order for the nurse to create a caring environment will assist the profession in further understanding of and continuation of its long tradition of care.

Discussions with the nurse practitioners have made it evident that the current models of moral reasoning are not adequate to explain the moral reasoning of the nurse practitioner. There does appear to be distinctive characteristics to the moral considerations of nurses. These need to continue to be clarified through further research.

Implications and Recommendations

Nursing Education

It is evident from the results of this research study that nursing education must broaden its approach to nursing

ethics. Several implications for nursing education in general and nurse practitioner education in particular emerge from the results of this research.

First, it is apparent that the nurse practitioners did not relate to bioethics or rule and principle ethics in any way, except to mention that it was content that they had had in the past. In other words, this content on bioethics did not appear to be utilized by the NPs while deliberating their particular dilemmas. It is important for this content to be presented as it represents, at this point, the mainstream in health care ethics in order for nurses to be familiar with the language of bioethics so that they may communicate with their colleagues and participate in discussions about dilemmas in a knowledgeable fashion. However, nursing can no longer continue to rely solely on this content in ethics as the basis for resolution of the moral issues that nurses are facing in clinical practice. Content must include a broad perspective of views currently under discussion in the field of health care ethics. While Kohlberg's model of moral development is essential for nurses to be familiar with, nursing can not risk presenting Kohlberg's (1984) model as the only framework by which to understand moral development. Gilligan's (1982) model of moral development as well as Kohlberg's (1984) must be included, particularly since the language that nurses use is much more closely aligned with Gilligan's model of women's

morality than to Kohlberg's justice based morality. It is important as well to offer critiques of both of these model in order for the student nurse to appreciate that the area of moral reasoning is still undergoing discovery of new ideas.

Since nursing is still predominantly a woman's profession, there is a need to discuss gender issues which are inherent within the health care system so that the nurse can begin to appreciate the concerns as well as understanding the distinctive view that is associated with women. Appropriate content from women's studies can be included to meet these needs.

Although values clarification seems to have currently gone out of fashion, it needs to be re-introduced as an important part of content on ethics in nursing practice. As is evidence in this and other studies, there are moral values which act as basic motivation as the nurse attempts to resolve dilemmas. The nurse practitioners were very capable of identifying those values with urging and appropriate in depth questioning. Many of the participants in this study voiced a better understanding of their actions, thoughts and feelings because values had surfaced during the interview process that were previously unconscious and as a result of the interview were now made known. Exercises in values clarification while the nurse is a student would help illuminate essential values for that

individual and teach the process of values clarification for use in clinical practice.

Affective responses and emotions were evident from the interviews with the practitioners. Hand in hand with values clarification, the role of affective responses must be discussed with the nursing student. No longer can the profession espouse a detached, objectified approach to dealing with moral dilemmas. The nurse's emotions cannot be removed from emotionally charged situations. These emotional responses of the nurse often mirror the interconnectedness of the nurse's and the patient's relationship. What makes the relationship work is this connectedness. Far better to acknowledge and discuss the feelings generated by these situations and examine them in terms of responses to values that are deeply cherished, again to help clarify the values that motivate responses. This can help to prepare the nursing student for the real world of clinical practice where she will be bombarded with emotions as she cares for clients.

Likewise, ethical decision making models so popular in nursing ethics need to be re-evaluated. Often the impression that these models give is that moral dilemmas are distinct occurrences that are somehow different from other situations in which the nurse must make decisions. No one in this study referred to these models. It is not helpful to present them along with ethical content when doing so

gives the impression that following these steps will lead to an answer. The models ought to be introduced to familiarize the student with them and may suggest a beginning framework for resolution of moral dilemmas. However, nursing education needs to take the student beyond the models to help the beginning nurse formulate strategies for resolving dilemmas in practice.

The Code of Ethics for Nurses (ANA, 1985) is a document which is essential to nursing and its image as a profession. However, none of the nurse practitioners mentioned the Code of Ethics for Nurses when discussing their moral dilemmas. This may suggest that similarly to the bioethical principles, the code does not seem to be part of the NP's language when discussing moral dilemmas. The Code for Nurses is an important document and must be interwoven within conversations about not only about dilemmas, but also about what it means to be a professional person in this society. The appropriate uses of a code of ethics must be taught and utilized as part of the clinical decision making process about what nurses ought to do. Presented in this way will demonstrate the relevance of a profession's code of ethics.

Nurse Practitioner Education

Because nurse practitioners were the focus of this research, specific recommendations for nurse practitioner education emanated from these findings. How much content on

health care ethics the average nurse practitioner receives is not known, it is evident, however, that the ethical content described in the previous section needs to be a requirement. The content could be supplemented on the graduate level based on what the typical baccalaureate curriculum provides on health care ethics.

In addition, since it is obvious from the interviews with these practitioners that moral dilemmas occur frequently in and as part of everyday, ordinary clinical situations; discussion of these dilemmas in primary care must be made a part of all clinical decision making seminars. Real and potential dilemmas must be identified by knowledgeable faculty in order for the NP to become familiar with recognizing the dilemmas inherent in primary care. Obviously, discussion would also include clarification of values, and potential resolution of the situation. Since there is some indication from the participants in this study that previous educational and work experience was an influencing factor to the moral dilemma and was also used as an evaluative response, frequent analyses of the clinical practice situation as a potential place for a moral dilemma could provide a training ground for resolution of later moral dilemmas.

Such seminars might also provide an arena for dialogue about the nurse-patient relationship as it applies to the nurse practitioner role. The participants in this study

described the power of this relationship, both positively and negatively, and saw it as integral to their role as an NP. The educational setting therefore, must prepare the nurse practitioner to understand the nuances of this relationship in primary care and how this therapeutic relationship can be utilized to its fullest.

New nurse practitioners shared dilemmas which might not have been a dilemma for someone more seasoned. Approaches such as those listed above might very well help the new practitioner make a smoother transition from student to provider.

There was much concern among the participants about issues inherent to our system of health care, such as right and access to health care and the quality of the health care received. It would seem that the more knowledgeable the practicing NP is about the issues in health care the more likely she is to be part of making the necessary changes within the system which precipitate these moral dilemmas. A health care policy course should be a requirement for all nurse practitioner students, in order to be informed about the issues and ways in which to effect change.

This course would also be an appropriate avenue in which to discuss values within the health care system and values held by other health care providers that may be different from those the NP has. Listening to the practitioners in this study, one could surmise that they are

being educationally prepared as nurses who hold very different values from those present in the health care system and from other providers. Discussions about the differences in values may ease the transition from student to practitioner and prepare the NP for the issues that currently exist within our health care system.

Nursing Practice

From the analysis of data it is evident that the nurse practitioners, particularly those utilizing the independent pattern of reasoning, generally depicted themselves as having a good sense of their role as an NP within the health care system. Most importantly they appeared to have a strong sense of the nursing role on the health care team and the assets that the nurse brings to a primary care setting. There has been some fears that nurses who moved into the nurse practitioner role would become "mini-doctors". These NPs, most of them Masters prepared spoke eloquently about their role as nurses, and especially their expertise with the health education of clients. Since health education, particularly concerning health maintenance issues, has been the focus of nurse practitioner education, it can be said of this group of NPs specifically, that they are meeting these goals.

Further, the nurse practitioners have brought with them into this expanded role nursing's focus on the nurse-patient relationship as meaningful, powerful and therapeutic. This

must continue to be fostered in order to preserve the uniqueness of the nurse practitioner in the primary care setting. What may be more problematic is the intrinsic power that the practitioner has within this relationship. It is obvious from these participants' interviews that they are well aware of this power. Unfortunately, this is often not discussed within the setting, because the nurse practitioner may be practicing in a setting where she is the only NP. When NPs get together at monthly institutional and regional meetings, the topics of discussion are most often about therapeutics and not topics related to the nurse practitioner role. These issues, such as the power the NP has as a provider in the nurse-patient relationship and the potential for moral dilemmas within this relationship must begin to be the focus of discussion in order to assist practitioners in averting and/or resolving the dilemmas.

Many of the issues discussed by the nurse practitioners were those problems within the health care system such as access to health care and so on. NPs who are versed in health care policy issues either through their educational programs or through their local NP group can strategize to channel their influence within the settings, and politically locally, statewide, and nationally to remedy some of these problems. By being actively involved in changing the system on a political level, NPs may in the future no longer have to agonize over dilemmas of access to health care and may no

longer need to subvert the system by bending the rules in order to provide care.

Another area where nurse practitioners can help each other, even though the settings in which they practice may be different, is to initiate group meetings where moral dilemmas are brought for discussion. In this way, practicing NPs can explore values that are important personally and professionally. Many dilemmas were influenced by factors in the setting and dialogue about issues and values may facilitate the resolution of dilemmas when they arise. These discussions could also take place with other health providers in order to explore commonalities and differences in values. This may be of great benefit to the those NPs who used the pattern of lateral moral reasoning who may know their own values, but choose to go with the group consensus. Frank dialogue may assist the lateral reasoners to understand just what their own values are and what those of other professionals within the team are.

Nursing Research

The scope of this research is limited to the ten nurse practitioner participants, and cannot be generalized beyond this group. However, these findings have raised many issues which would be fruitful ground for further study. While all the possibilities cannot be listed here, a few are presented to furnish direction for future research.

The most obvious question is whether replication of

this qualitative study would yield similar essential feature of moral reasoning. Research such as this needs to continue to be carried out in order to sample a larger number of nurse practitioners before this can be determined.

Another question that can be raised as a result of these findings is whether a sample of new nurse practitioners would yield dilemmas that are significantly different than those of experienced NPs. If this distinction does indeed exist, it can offer valuable insight to educators and practice settings on the needs of the new graduate practitioner.

The majority of nurse practitioners in this study were Masters prepared. One wonders whether the findings would be significantly different with a sample of non-Masters prepared nurse practitioners in terms of the essential features of moral reasoning and the dilemmas encountered in practice. A study with non-masters prepared NPs might be insightful in providing information about what is necessary for continuing education for practitioners in terms of content in ethics.

Gender issues were a finding in this study, specifically around nurturing and caring as a female trait. Since all the participants were women, male nurse practitioners responses about nurturing and caring cannot be determined. What would a study of moral dilemmas in clinical practice of male nurse practitioners elicit?

Nurse-physician relationships were not the source of moral dilemmas for the nurse practitioners as they were in other studies (Cooper, 1990a, Omery, 1985). However, there was some indication that NPs see the physician's value system as different from their own value system. Further research is essential to determine if this finding is reliable. Knowledge about the differences and similarities between physicians and nurse practitioners who practice in the same settings would provide valuable data in order to help prepare NPs for these settings and the issues inherent in the health care system.

Finally, the results from this research study suggest that moral dilemmas occur within ordinary, everyday clinical practice situations and that the decision making process appears similar at least initially to other decisions that the nurse practitioner must make in practice. Does the process of moral reasoning resemble the process of critical thinking in clinical situations for another group of nurse practitioners? What are the differences and/or similarities between the processes? The more that is known about moral reasoning the more likely that the nurse practitioners who practice in the future will have more knowledge about moral dilemmas in practice and how to resolve these.

This inquiry has contributed to the profession of nursing by elucidating the moral reasoning of a group of nurses who to date had not been included in a study of moral

dilemmas and moral reasoning. Any study that clarifies this process adds to the body of knowledge and thus the understanding of this important aspect of the nursing profession. In addition, the understanding of women's moral development has been expanded by this study in which many of the findings are comparable to research findings by others in the area of women's moral reasoning. Continuing this area of research can assist nursing, as well as other disciplines such as women's studies and psychology, gain valuable information of women's moral reasoning.

The insights into moral reasoning provided by these ten nurse practitioners assist the nursing profession in gaining an understanding of moral reasoning. It is from the actual experiences of practicing nurses and not only through theoretical dialogue that nursing will identify and develop its nursing ethic.

REFERENCES

Addleson, K.P. (1987). Moral passages. In E.F. Kittay & D.T. Meyers (Eds.), Moral and moral theory (pp. 87-110). Totowa, NJ: Rowman & Littlefield.

American Nurses' Association. (1988). Committee on ethics: Guidelines on withdrawing or withholding food and fluid. Kansas City, MO: American Nurses' Association.

Aroskar, M.A. (1989). Community health nurses: Their most significant ethical decision-making problems. Nursing clinics of North America, 24(4), 967-975.

Aroskar, M.A. (1988). Curriculum revolution: A bioethical mandate for change. In Curriculum revolution: Mandate for change (pp. 123-135). New York: National League for Nursing.

Aroskar, M.A. (1977). Ethical dilemmas and community health nursing. Linacre Quarterly, 44, 340-346.

Auerbach, J., Blum, L., Smith, V., & Williams, C. (1985, Spring). Commentary: On Gilligan' in a different voice. Feminist studies, 11(1), 149-161.

Bandman, E.L., & Bandman, B. (1985). Nursing ethics in the life span. Norwalk: Appleton-century-Crofts.

Baumrind, D. (1986). Sex differences in moral reasoning: Response to Walker's (1984) conclusion that there are none. Child development, 57, 511-521.

Beauchamp. T.L., & Childress, J.F. (1983). Principles of biomedical ethics (2nd ed.). New York: Oxford Press.

Bebeau, M.J., & Brabeck, M.M. (1987). Integrating care and justice issues in professional moral education: A gender perspective. Journal of moral education, 16(3), 189-203.

Benhabib, S. (1987). The generalized and the concrete other: The Kohlberg-Gilligan controversy and moral theory. In E.F. Kittay & D.T. Meyers (Eds.), Women and moral theory (pp. 154-177). Totowa, NJ: Rowman & Littlefield.

Benjamin, M. & Curtis, J. (1981). Ethics in nursing. New York: Oxford University Press.

Benner, P., & Wrubel, J. (1988, August). Caring. American journal of nursing. 1073-1075.

Benner, P. (1983). Uncovering the knowledge embedded in clinical practice. Image:The journal of nursing scholarship. XV(2), 36-41.

Bishop, A.H. & Scudder, J.R. 91987). Nursing ethics in an age of controversy. Advances in nursing science. 9(3), 34-43.

Blum, L.A. (1988). Gilligan and Kohlberg: Implications for moral theory. Ethics. 98, 472-491.

Bogdan, R. & Taylor, S.J. (1975). Introduction to qualitative research methods: A phenomenological approach to the social sciences. New York: John Wiley & Sons.

Brown, M.A. & Waybrant, K.M. (1988). Health promotion, education, counseling, and coordination in primary health care nursing. Public health nursing. 5(1), 16-23.

Bunting, S.M. & Webb, A.A. (1988). An ethical model for decision-making. The nurse practitioner. 12(12), 30-34.

Bussey, K. & Maughan, B. (1982). Gender differences in moral reasoning. Journal of personality and social psychology. 42(4), 701-706.

Calahan, S. (1988). The role of emotion in ethical decision making. The Hastings Center report. 18, 9-14.

Cassidy, V.R. (1991). Ethical responsibilities in nursing: Research findings and issues. Journal of professional nursing. , 7(2), 113-118.

Cassells, J.M. & Redman, B.K. (1989). Preparing students to be moral agents in clinical nursing practice. Nursing clinics of North America. 24(2), 463-473.

Chenitz, W.C. & Swanson, J.M. (1986). From practice to grounded theory. Menlo Park: Addison-Wesley.

Churchill, L. & Siman, J. (1986). Principles and the search for moral certainty. Social science and medicine, 25(5), 461-468.

Code for Nurses with interpretive statements. (1985). Kansas City, MO: American Nurses Association.

Cohen, M.Z. (1987). A historical overview of the phenomenological movement. Image: Journal of nursing scholarship. 19(1), 31-34.

Colaizzi. P.F. (1978). Psychological research as the phenomenologist views it. In R.S. Valle & M. King (eds.). Existential-phenomenological alternatives for psychology.

(pp. 48-71). New York: Oxford University Press.

Cooper, M.C. (1990a). An interpretive analysis of the moral experience of the critical care nurse. Unpublished doctoral dissertation. Charlottesville: University of Virginia.

Cooper, M.C. (1988). Covenantal relationships: Grounding for the nursing ethic. Advances in nursing science. 10(4), 48-59.

Cooper, M.C. (1989). Gilligan's different voice: A perspective for nursing. Journal of professional nursing. 5(1), 10-16.

Cooper, M.C. (1990b). Reconceptualizing nursing ethics. Scholarly inquiry for nursing practice: An international journal. 4(3), 209-218.

Corbin, J. (1986). Qualitative data analysis for grounded theory. In W.C. Chenitz & J.M. Swanson (Eds.), From practice to grounded theory (pp.91-101). Menlo Park: Addison-Wesley.

Cox, J.L. (1985). Ethical decision making by hospital nurses. Unpublished doctoral dissertation. Wayne State University: Detroit.

Crisham, P. (1981). Measuring moral judgement in nursing dilemmas. Nursing research. 30(2), 104-110.

Curtin, L. & Flaherty, M.J. (1982). Nursing ethics: Theories and pragmatics. Bowie, MD: Robert J. Brady Co.

DeSilva, P. (1988). Public health nursing: phenomenologic

meaning and dialectic theory. Unpublished doctoral dissertation. University of Texas at Austin: Austin.

Donnenberg, G.R. & Hoffman, L.W. (1988). Gender differences in moral development. Sex roles. 18(11/12), 701-717.

Ericksen, J. (1989, August). Steps to ethical reasoning. The Canadian nurse, 23-24.

Felton, G.M. & Parsons, M.A. (1987). The impact of nursing education on ethical/moral decision making. Journal of nursing education. 26(1), 7-11.

Fleetwood, J. (1989, March). Solving bioethical dilemmas: A practical approach. Nursing, 89, 63-64.

Fry, S.T. (1989a). Teaching ethics in nursing curricula. Nursing clinics of North America. 24(2), 485-497.

Fry, S.T. (1988). The ethics of caring: Can it survive in nursing? Nursing outlook. 36(1), 48.

Fry, S.T. (1989b). The ethics of compromise. Nursing outlook. 37(3), 152.

Fry, S.T. (1989c). Towards a theory of nursing ethics. Advances in nursing science. 11(4), 9-22.

Gadow, S.A. (1985). Nurse and patient: The caring relationship. In A.H. Bishop & J.R. Scudder, Jr. (Eds.), Caring, curing, coping: Nurse, physician, patient relationships. Birmingham, Al: University of Alabama Press.

Gaul, A.L. (1989). Ethics content in baccalaureate degree curricula. Nursing clinics of North America. 24(2), 475-

483.

Gilligan, C. (1982). In a different voice. Cambridge: Harvard University Press.

Gilligan, C. (1986). Remapping development: The power of divergent data. In L. Cirrillo & S. Waspner (Eds.), Value presuppositions in theories of human development (pp. 37-53). Hillside NJ: Lawrence Erlbaum Associates.

Gilligan, C. (1987). Moral orientation and moral development. In E.F. Kittay & D.T. Meyers (Eds.), Women and moral theory (pp. 19-23). Totowa NJ: Rowman & Littlefield.

Giorgi, A. (1985). Phenomenology and psychological research. Pittsburgh: Duquesne University Press.

Glaser, B. G. (1969). The constant comparative method of qualitative analysis. In G.J. McCall & J.L. Simmons (Eds), Issues in participant observation: A text and reader (pp. 216-228). New York: Random House.

Gortner, S.R. (1985). Ethical Inquiry. Annual review of nursing research. 3, 193-214.

Greeno, C.G. & Maccoby, E.E. (1986, Winter). How different is the "different voice"? In viewpoint: On In a different voice: An interdisciplinary forum. Signs: Journal of women in culture and society. 11(2), 310-316.

Haan, N., Aerts, E. & Cooper, B. A. (1985). On moral grounds: The search for practical morality. New York: New York University Press.

Haan, N. (1982). Can research on morality be "scientific"? American psychologist. 37, 1096-1104.

Held, V. (1987). Feminism and moral theory. In E.F. Kittay & D.T. Meyers (Eds.), Women and moral theory (pp. 111-128). Totowa, NJ: Rowman & Littlefield.

Holly, C.M. (1986). Staff nurses participation on ethical decision making: A descriptive study of selective situational variables. Unpublished dissertation. Teachers College, Columbia University, New York.

Huggins, E.A. & Scalzi, C.C. (1988). Limitations and alternatives: Ethical practice theory in nursing. Advances in nursing science, 10(4), 43-47.

Hutchinson, S. (1990). Responsible subversion: A study of of rule-bending among nurses. Scholarly Inquiry for nursing practice: An international journal, 4(1), 3-17.

Hutchinson, S. (1986). Grounded theory: The method. In P.L. Munhall & C.J. Oiler (Eds.), Nursing research: A qualitative perspective. (pp. 111-131). Norwalk: Appleton-Century-Crofts.

Jameton, A. (1984). Nursing practice: The ethical issues. Englewood Cliffs: Prentice-Hall.

Kahn, D.L. & Steeves, R.H. (1988). Caring and practice: Construction of the nurse's world. Scholarly inquiry for nursing practice: An international journal. 2(3), 202-221.

Kerber, L.K. (1986, winter). Some cautionary words for

historians. In Viewpoint. On In a different voice: An interdisciplinary forum. Signs: Journal of women in culture and society. 11(2), 304-310.

Ketafian, S. (1981a). Critical thinking, educational preparation, and development of moral judgement. Nursing research. 30(2), 98-103.

Ketafian, S. (1981b). Moral reasoning and moral behavior among selected groups of practicing nurses. Nursing research. 30(3), 171-176.

Ketefian, S. (1985). Professional and bureaucratic role conceptions and moral behavior among nurses. Nursing research. 34(4), 248-253.

Ketefian, S. (1987). A case study of theory development: Moral behavior in nursing. Advances in nursing science. 9(2), 10-19.

Ketefian, S. & Ormond, I. (1988). Moral reasoning and ethical practice in nursing: An integrative review. New York: National League for Nursing.

Kirk, J. & Miller, M.L. (1986). Reliability and validity in qualitative research. Beverly Hills: Sage Publications.

Knaack, P. (1984). Phenomenological research. Western journal of nursing research. 6(1), 107-114.

Kohlberg, L.(1984). The psychology of moral development. San Francisco: Harper & Row.

Kohlberg, L. (1987). The development of moral judgement and

moral action. In L. Kohlberg (Ed.), Child psychology and childhood. (pp. 259-328). New York: Longman.

Leininger, M. (1984). Care: The essence of nursing and health. Thorofare, NJ: Charles B. Slack, Inc.

Lincoln, Y.S. & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills: Sage Publications.

Luria, Z. (1986, Winter). A methodological critique. In Viewpoint. On In a different voice: An interdisciplinary forum. Signs: The journal of women in culture and society. 11(2), 316-321.

Lyons, N.P. (1983). Two perspectives: On self, relationships, and morality. Harvard educational review. 53(2), 125-145.

Maguire, D. (1978). The moral choice. Garden City, NY: Doubleday.

Marshall, C. & Rossman, G.B. (1989). Designing qualitative research. Newbury Park, CA: Sage.

Mayberry, M.A. (1986). Ethical decision making: A response of hospital nurses. Nursing Administration Quarterly, 10(3), 75-81.

Meyers, D.T. (1987). The socialized individual and individual autonomy. An intersection between philosophy and psychology. In E.F. Kittay & D.T. Meyers (Eds.), Women and moral theory (pp. 139-153). Totowa, NJ: Rowman & Littlefield.

Meyers, D.T. & Kittay, E.F. (1987). Introduction. In E.F.

Kittay & D.T. Meyers (Eds.), Women and moral theory (pp. 3-16). Totowa, NJ: Rowman & Littlefield.

Miller, L.H. (1984, September/October). Alternative approaches to measuring nursing: Gilligan's and Kohlberg's moral development scales. Rehabilitation nursing. 22-26.

Munhall, P. (1980). Moral reasoning levels of nursing students and faculty in a baccalaureate nursing program. Image. 12(30), 57-61.

Munhall, P. (1982). Moral development: A prerequisite. Journal of nursing education. 21(6), 11-15.

Munhall, P. (1983). Methodologic fallacies: A critical self-appraisal. Advances in nursing science. 5(4), 41-49.

Munhall, P. (1989). Philosophical pondering on qualitative research methods in nursing. Nursing science quarterly. 2(1), 20-28.

Munhall, P. & Oiler, C. J. (1986). Nursing research: A qualitative approach. Norwalk: Appleton-Century-Crofts.

Murphy, C.P. (1978). The moral situation in nursing. In E.L. Bandman & B. Bandman (Eds.), Bioethics and human rights. (pp. 313-320). Boston: Little, Brown.

Murphy, C. (1977).Levels of moral reasoning in a selected group of nursing practitioners. (Doctoral dissertation. Teachers College, Columbia University, 1976). Dissertation abstracts international. 38, 593B-594B.

Nails, D., O'Loughlin, M.A., & Walker, J.c. (1983, Autumn).

Introduction. In women and morality. D. Nails, M.A. O'Loughlin & J.C. Walker (Eds.). Social research. 50(3), 487-489.

Natanson, M. (1973). Edmund Husserl: Philosopher of infinite tasks. Evanston: Northwestern University Press.

Nokes, K.M. (1989). Rethinking moral reasoning theory. Image: The journal of nursing scholarship. 21(3), 172-175.

Omery, A.K. (1983a). Phenomenology: A method for nursing research. 5(3), 49-63.

Omery, A.K. (1983b). Moral development: A differential evaluation of dominant models. Advances in nursing science. 6(1), 1-17.

Omery, A.K. (1985). The moral reasoning of nurses who work in the adult intensive care setting. (Doctoral dissertation, Boston University). Dissertation abstracts international, 46(09)3007-B.

Omery, A.K. (1989). Values, moral reasoning and ethics. Nursing clinics of North America. 24(2), 499-507.

Packard, J.S. & Ferrara, M. (1988). In search of the moral nursing. Advances in nursing science. 10(4), 60-71.

Parker, R. S. (1990). Measuring nurses' moral judgments. Image: Journal of nursing scholarship. 22(4), 213-218.

Pence, T. (1986). Ethics in nursing: An annotated bibliography (2nd ed.). New York: National League for nursing.

Polit, D.F. & Hungler, B.P. (1989). Essentials of nursing research. Philadelphia: J.B. Lippincott.

Psathas, G. (Ed.). (1973). Phenomenological sociology: Issues and applications. New York: John Wiley & sons.

Ray, M.A. (1985). A philosophical method to study nursing phenomena. In M. Leininger, (ed.). Qualitative research methods in nursing. (pp. 81-92), Grune & Stratton, Inc.

Rest, J. (1975). Longitudinal study of the defining issues test of moral judgment: A strategy for analyzing developmental change. Developmental psychology. 11(6), 738-748.

Reverby, S. (1987). A caring dilemma: Womanhood and nursing in historical perspective. Nursing research. 36(1), 5-11.

Robilliard, H.M., High, D.M., Sebastian, J.G., Pisaneschi, J.I., Perritt, L.J., & Mahler, D.M. (1989). Ethical issues in primary health care: A survey of practitioners' perceptions. Journal of community health, 14(1), 9-17.

Rose, J.F. (1990). Psychologic health of women: A phenomenologic study of women's inner strength. Advances in nursing science. 12(2), 56-70.

Rowland, H.S. (1984). The nurses almanac (2nd ed.). Rockville: Aspen Publishers.

Sandelowski, M., Davis, D.H., & Harris, B. G. (1989). Artful design: Writing the proposal for research in the naturalistic paradigm. Research in nursing & health. 12,

77-84.

Schatzman, L. & Strauss, A.L. (1973). Field research: Strategies for a natural sociology. Englewood Cliffs: Prentice-Hall.

Shank-Meile, S.L., Shipley, A.C., Collins, P.A. & Tacker, A. (1989, Sept.). Changes in the advertised demand for nurse practitioners in the United States, 1975-1986. Nurse Practitioner. 41-49.

Snarey, J.R. (1985). Cross-cultural universality of social-moral development: A critical review of Kohlbergian research. Psychological bulletin. 97,(2), 202-232.

Spiegelberg, H. (1982). The phenomenological movement: A historical introduction. (3rd ed.). The Hague: Martinus Nijhoff Publishers.

Stack, C.B. (1986, Winter). The culture of gender: Women and men of color. In viewpoint. On in a different voice: An interdisciplinary forum. Signs: Journal of women in culture and society. 11(2), 321-324.

Stenberg, M.J. (1982). Ethics as a component of nursing education. In B.J. Brown & P.L. Chinn (Eds.), Nursing education: Practice, methods and models. (pp. 49-55). Rockville, MD: Aspen.

Stocker, M. (1987). Duty and friendship: Toward a synthesis of Gilligan's contrastive moral concepts. In E.F. Kittay & D.T. Meyers (eds.), Women and moral theory (pp. 56-68), Totowa, NJ: Rowman & Littlefield.

Swanson-Kauffman, K. & Schonwald, E.(1988). Phenomenology. In B. Sarter (ed.), Paths to Knowledge: Innovative research methods for nursing (pp.97-105). New York: National League for Nursing.

Taylor, S.G. (1985, Winter). Rights and responsibilities: Nurse-patient relationships. Image: The journal of nursing scholarship. XVII(1), 9-13.

Taylor, S.J. & Bogdan, R. (1984). Introduction to qualitative research methods: The search for meanings. (2nd ed.). New York: John Wiley & sons.

Thompson, J. E. & Thompson, H. O. (1985). Bioethical decision making for nurses. Norwalk: Appleton-Century-Crofts.

Toulmin, S. (1981). The tyranny of principles. Hastings center report. 11(6), 31-39.

Twomey, J.G. (1989). Analysis of the claim to distinct nursing ethics: Normative and non-normative approaches. Advances in nursing science. 11(3), 25-32.

Vance, C., Talbott, S., McBride, A. & Mason, D. (1985, November/December). An uneasy alliance: Nursing and the women's movement. Nursing outlook. 33(6), 281-285.

Veatch, R.M. (1981, October). Nursing ethics, physician ethics and medical ethics. Law, Medicine & health care, 17-19.

Viens, D.C. (1989). A history of nursing's code of ethics. Nursing outlook, 37(1), 45-49.

Walker, J.R. (1984). Sex differences in the development of moral reasoning: A critical review. Child development. 55, 677-691.

Walker, J.R., de Vries, B. & Trevethan, S. D. (1987). Moral stages and moral orientations in real-life and hypothetical dilemmas. Child development. 58, 842-858.

Watson, M. J. (1989). Watson's philosophy and theory of human caring in nursing. In Riehl-Sisca, J. (ed.), Conceptual models for nursing practice (3rd ed.) (pp. 219-236). Norwalk, Connecticut: Appleton & Lange.

Watson, M. J. (1988a). New dimensions of human caring theory. Nursing science quarterly. 1(4), 175-181.

Watson, M. J. (1988b). Nursing: Human science and human care, a theory for nursing. New York: National League for Nursing.

Wilkinson, J. M. (1987/88). Moral distress in nursing practice: Experience and effect. Nursing forum. XXIII(1), 16-29.

White, G.B. (1983). Philosophical ethics and nursing: A word of caution. In P.L. Chinn (Ed.). Advances in nursing theory development (pp. 35-46), Rockville, MD: Aspen.

Yarling, R.R. & McElmurry, B.J. (1986). The moral foundation of nursing. Advances in nursing science. 8(2), 63-73.

Yeo, M. (1989). Integration of nursing theory and nursing ethics. Advances in nursing science. 11(3), 33-42.

Zablow, R.J. (1984). Preparing students for the moral dimension of professional nursing practice: A protocol for nurse educators. Unpublished doctoral dissertation. Teachers College, Columbia University: New York.

Zuzich, A. (1978). Some frameworks for ethical development. In D.E. Reilly (Ed.). Teaching and evaluating the affective domain in nursing programs. Thorofare, NJ: Charles B. Slack, Inc.

APPENDIX A

SAMPLE INTERVIEW QUESTIONS

1. Tell me about a time or an incident when you had to make a moral decision in your clinical practice. Talk about it as completely as you can. Give as much information about it as you can, what you remember, how you acted, what you thought and how you felt.

2. What was the specific conflict or dilemma for you in this situation? Why was it a conflict or dilemma?

3. How did you decide what to do? What did you consider? Was there anything else that you considered? Considered and rejected?

4. Who did you talk to about this dilemma? What was the outcome of the conversation? What were the factors that influenced you to accept or reject his or her (the person you talked with) suggestion on what to do? Can you tell me why you chose not to talk to anyone about this dilemma?

5. After you decided what to do, what happened?

6. Was the choice you made, the "right" thing to do? Why or why not? Would another NP make the same choice given the same circumstances?

7. What were the risks for you in this situation? For other persons who were involved?

8. What were the benefits for you in this situation? For other persons involved?

9. If you were in a similar situation again, would you do the same thing? Why or why not?

10. Are there other ways to view this dilemma, to respond to this situation?

Adapted from Cooper, 1990a

APPENDIX B

Information Letter

May 9, 1990

Dear Colleague:

My name is Diane Viens. I am a nurse practitioner who has practiced for several years in family practice. I am currently working part-time as a nurse practitioner in an employee health setting. I am also working towards my doctoral degree in nursing at the University of San Diego.

I have long had an interest in ethics, the moral dilemmas that confront practicing nurses and how nurses resolve those dilemmas. Since I am a nurse practitioner, I know that NPs encounter these types of perplexing situations in their clinical practice. Unfortunately, there is very little known about how nurses resolve these dilemmas. A few nurse researchers are beginning to go to practicing nurse to ask about how the nurse resolves these dilemmas. To date, no one has approached nurse practitioners to find out how NPs resolves these issues.

As part of my doctoral work, I am currently doing a study whose purpose is to identify the moral reasoning that nurse practitioners use to resolve their moral dilemmas.

Obviously, I need the help of practicing NPs!! I am interested in interviewing nurse practitioners about the moral dilemmas they face in their practice. The interview would be scheduled at your convenience and would last one to two hours. The interview will be audiotaped. There is the possibility that I may wish a second interview some time after the first interview. You also may request a second interview if there is anything you wish to add to the first interview. All interviews will be kept strictly confidential. Your participation is voluntary and will not be connected to your employment in any way. There is no payment for participation.

If you are willing to participate, please sign the sheet that is being circulated or call me at either of the numbers listed below and I will call you to discuss your participation and to answer any questions you may have.

This is an opportunity for nurse practitioners to share some of the difficult issues which arise in practice. But more so, it is an opportunity to help the nursing profession

understand the thinking that is involved to resolve moral dilemmas. Perhaps, this understanding can help other NPs with their moral dilemmas.

I thank you for your time and consideration in this matter. I look forward to talking with you very soon.

Sincerely,

Diane C. Viens, RN, CFNP

APPENDIX C

INFORMED CONSENT
The Moral Reasoning of a Group of Nurse Practitioners

PURPOSE OF STUDY

The purpose of this study is to describe the moral reasoning used by a group of nurse practitioners. In order to do the study, the researcher, Diane C. Viens, doctoral candidate at the University of San Diego, will conduct interviews with nurse practitioners.

Procedure

I agree to an interview which will be audiotaped and will last one to two hours. There is the possibility that a second interview may also be scheduled two to four weeks after the first, either at the request of the researcher or by me.

Risks/Discomforts/Benefits

There are no known risks for participation in this study. If the discussion of the subject matter is upsetting, the interview will be stopped. The researcher will assist me to work this through. If further assistance proves necessary, a qualified nurse counselor is available to provide assistance. There is no compensation for participation. The benefits are that most people like the opportunity to discuss their experiences and nurses, particularly nurse practitioners may benefit from this study.

Confidentiality

In order to maintain confidentiality and anonymity, any personal identification will be coded in all research materials. The coding will be known only to the researcher. The audiotapes from the interviews will be transcribed by a paid transcriptionist or by the researcher. The coding will be used throughout the typed manuscript of the interview so that no individual can be identified. All tapes and information containing identifying information will be kept in a locked cabinet accessible only to the researcher. All tapes will be destroyed after the study is completed. If any excerpts from individual interviews are used in subsequent publication in professional journals, all personal identifying information will be changed so as to make the identification of any one participant impossible.

I have had the opportunity to ask any questions about the study prior to signing this consent. I understand that my participation is voluntary and that I can withdraw from participation in the study at any time without jeopardy. My consent on this form does not constitute any other agreement, verbal or written, beyond that expressed in this consent form.

Authorization

I, the undersigned, understand the above explanations and on that basis, I give consent to my voluntary participation in this research.

_____ _____

Signature of Subject Date

_____ _____

Signature of Researcher Date

_____ _____

Signature of Witness Date

APPENDIX D

DEMOGRAPHIC DATA SHEET

NAME: _____ AGE: ___

_____

DATE: _____

ADDRESS: _____

_____

PHONE: _____ (Home)

_____ (Work)

BASIC NURSING PREPARATION: _____

YEARS OF NURSING PRACTICE BEFORE BECOMING NP: _____

NURSE PRACTITIONER PREPARATION (check which applies):
Certificate program ____
Masters program: ____
Other (specify): _____

YEARS OF PRACTICE AS AN NP: _____