University of San Diego
Digital USD

Dissertations Theses and Dissertations

1996-05-01

Ethical Decision-Making among Critical Care Unit Nurses

Mary Ellen Bowen DNSc, MN, RN, CNAA
University of San Diego

Follow this and additional works at: https://digital.sandiego.edu/dissertations

Part of the Nursing Commons

Digital USD Citation
Bowen, Mary Ellen DNSc, MN, RN, CNAA, "Ethical Decision-Making among Critical Care Unit Nurses" (1996). *Dissertations*. 255.
https://digital.sandiego.edu/dissertations/255

This Dissertation: Open Access is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

UNIVERSITY OF SAN DIEGO
Philip Y. Hahn School of Nursing
DOCTOR OF NURSING SCIENCE

ETHICAL DECISION MAKING AMONG CRITICAL CARE UNIT NURSES

by

Mary Ellen Bowen, MN, RN, CNAA

A dissertation presented to the

FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the

requirements for the degree

DOCTOR OF NURSING SCIENCE

May 1996

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Ethical Decision Making Among Critical Care Nurses

Mary Ellen Bowen, MN, RN, CNAA

University of San Diego

Philip Y. Hahn School of Nursing

May, 1996

ABSTRACT

The health care business has created complex relationships between consumers and health care institutions. Rising health costs, rationing of health care and medical technology have put critical care unit (CCU) nurses in complex environments where they must face ethical conflict. CCU nurses find themselves ill equipped to make sound decisions concerning ethical dilemmas. Nurses must ensure the patient's choices are respected and honored due to the duties inherent in the nurse-patient relationship.

The purpose of this study was to explore the process of ethical decision making (EDM) as it is experienced by CCU nurses. Gaining an understanding of this process may assist nursing education programs, and provide a basis for ethical nursing practice in the critical care setting.

The grounded theory method described by Glaser (1967) and Strauss (1978) guided data collection and analysis. The sample was comprised of 10 full-time critical care nurses. Data were collected over the course of two academic semesters using methods common to field research. The constant comparative method of data analysis was used.

Results indicated that critical care nurses identified ethical conflict in four major areas: professional values

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

versus personal values, respect for patient autonomy versus duty to do no harm, professional standards versus institutional policies, caring versus controlling. Constraining intervening conditions that inhibited resolution of ethical conflicts were: legal issues, professional relationships, paternalism, medical futility, and physician burnout. The intervening conditions that facilitated resolution of ethical conflicts were: cultural perspectives, open communication, and caring. Strategies for responding to the ethical conflicts evolved from the data: "opening up," "getting people to talk," and "supporting the patient." Consequences of these strategies were described as: "reaching understanding," and "sensing harm." The inter-relationship of these categories resulted in a core category of "facilitating resolution." Facilitating resolution, the basic social process, describes the linking of action/interactional sequences as they evolved over time.

The major implications of this study are that shared decision making in ethical conflict will result in positive outcomes for patients and nurses involved in ethical dilemmas. Relationship enhancement methods increase perceptual abilities in EDM. Further nursing research should include inquiry into the use of power in interactions, therapeutic empathy, and permeability of nurses' internal and external boundaries in the "opening up" phase of EDM.

Dissertation advisor: Patricia Roth, Ed.D, RN.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

To my husband, Jim

...for always believing I could do it, and for his willingness to travel with me on this journey for knowledge.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ACKNOWLEDGEMENTS

An inspired mind is a creative mind. For most people, the idea of inspiration deals only with those engaged in the creative arts, such as poets, playwrights, writers, and composers. However, as I prepared this manuscript, I realized great inspiration from the process of discovering new knowledge about the ethical decision making process that occurs within the nurse-patient relationship. From this process of discovering new knowledge, I shall think new ideas, perceive new vistas, take on greater challenges, and drink deeply from the wells of life.

This inspiration toward creativity did not occur without the assistance of others. Every great teacher has warned his students to beware of self-satisfaction. The three nursing faculty who served as my committee for this project piqued my curiosity and inspired me to elicit meaning from the ethical decision making process among these critical care nurses. These faculty also encouraged me to allow for understanding that would emerge from the data and the interactions of these nurses themselves. Dr. Patricia Roth, my chairperson, has been a wonderful source of support and inspiration to keep on with the creative process of discovering new knowledge. Dr. Roth, Dr. Janet Harrison, and Dr. Diane Hatton provided me with constructive feedback that was immensely helpful in discovering the process of "facilitating resolution."

The critical care nurses who shared their stories of ethical conflict must be acknowledged for their willingness to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

disclose these meaningful and personal accounts of ethical decisions they participated in. Without these stories, this research would not have been possible. In many instances, it took much courage to conjure up and re-live their experiences. Their willingness to support a peer is very much appreciated.

Other special people whom I wish to acknowledge are my husband, Jim, and my fellow doctoral students. My husband is appreciated for many things, but his belief in my ability, and his constant encouragement on this journey for knowledge has given me the support I needed the most to finish this educational undertaking. My fellow doctoral students and friends also have supported and encouraged me through this process. Through them, I have grown to know myself and grow.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS

DEDICATION ii

ACKNOWLEDGEMENTS iii

LIST OF FIGURES viii

LIST OF APPENDICES ix

CHAPTER

1. Introduction 1
   - Statement of the Problem 2
   - Research Questions 5
   - Significance of the Study 5

2. Review of the Literature 7
   - Perspectives of Ethical Decision Making in Nursing 7
     - Professional Accountability 7
     - Economic and Social Trends 11
     - Frameworks for Ethical Decision Making 14
     - Caring as a Foundation for Nursing Ethics 18
   - Moral Development and Ethical Decision Making in Nursing 22
     - Kohlberg's Theory of Moral Development . 23
     - Limitations of Kohlberg's Theory 24
     - Gilligan's Cognitive Developmental Model 29
     - Limitations of Gilligan's Model 34
   - Nursing Research in Ethical Decision Making . 38
   - Analysis and Critique 48

3. Methodology 57
   - Grounded Theory 57
   - Research Strategies 59
     - Sample 59
     - Characteristics of the Sample 61
     - Data Collection 62
     - Ethical Considerations 64
   - Data Management 66
     - Recording and Storage of Field Notes ... 66
     - Validation of Data 67
     - Data Analysis Strategies 69

4. The Process Model 73
   - The Context of Ethical Dilemmas 74
     - Professional Values versus Personal Values 76

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS, Continued

Respect for Patient Autonomy versus Duty to Do No Harm 79
Professional Standards of Practice versus Institutional Policies 87
Caring versus Controlling 91
Intervening Conditions 93
Constraining Conditions 94
Professional relationships 94
Medical futility 97
Legal issues 99
Paternalism 100
Physician burnout 102
Facilitating Conditions 103
Open communication 103
Clarification of resuscitation status 106
Patient care conferences 107
Cultural perspectives 107
Respect for religious values 110
Caring 111
Strategies for Ethical Decision Making 112
Opening Up 114
Getting cues 115
Hearing the patient talk 116
Empathizing with the patient/family 116
Respecting the patient's view 118
Getting People to Talk 118
Building relationships 119
Negotiating between 121
Reaching closure 126
Supporting the Patient/Family 127
Alleviating pain 128
Praying for him 129
Protecting the patient 130
Consequences 131
Reaching understanding 132
Sensing harm 134
Facilitating Resolution 136

5. Discussion 143
Strategies 144
Opening Up 145
Getting People to Talk 151
Supporting the Patient/Family 155
Consequences 157
Facilitating Resolution 160

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS, Continued

6. Conclusions and Recommendations 164
    Strengths and Limitations of the Study 164
    Conclusions 168
    Recommendations for Nursing Education 171
    Implications and Recommendations
      for Nursing Practice 173
    Implications for Nursing Research 175

REFERENCES 178

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF ILLUSTRATIONS

Figure

1. Facilitating Resolution of Ethical Conflict Among CCU Nurses 75

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF APPENDICES

Appendix

A. Interview Guide 194

B. Human Subjects Approval Form 196

C. Consent Form 199

D. Letter of Agreement to Provide Counseling Service.. 200

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 1

Introduction

The health care business has created a complex fabric of relationships between consumers, health care institutions, employers, employees, and the community served. Not only are there economic decisions made in the exchange of health care services, there are ethical decisions being made. Some of the societal influences impacting this decision making process include: rising health care costs, increasing patient acuity, rationing of health care, and sophisticated medical technology. These technologic advances and diminishing resources have leaped beyond society's ability to cope with the ethical dilemmas they produce. No where are these challenges more evident than in the critical care units (CCU).

Critical care nurses practice in these progressively more complex environments where they must face an increasing number of ethical and medical-legal dilemmas. It is no surprise that the numbers and complexity of ethical issues have left critical care nurses vulnerable to ethical conflicts.

According to Reigle (1992), the nurse's role is increasingly more influential in ensuring that patients'

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

choices are respected and honored. For example, critical care nurses collaborate with physicians, patients, and patients' families in making decisions regarding the withdrawal of life support systems and establishment of "no code" orders. However, many critical care nurses find themselves ill equipped to make sound decisions concerning ethical dilemmas (Thelan, Dave, & Urden, 1990). Wlody (1990) states that part of the difficulty in caring for these critically ill patients is that critical care nurses are unsure of their roles in addressing ethical issues. Consequently, CCU nurses find themselves in highly stressful environments, caring for acutely ill patients, facing ethical conflicts for which they may feel ill prepared and uncertain.

Statement of the Problem

The CCU nurses' duties of fidelity, veracity, and confidentiality are present in every nurse-patient interaction (Curtin, 1990; ANA, 1976). However, these duties often place the CCU nurse in conflict between a moral duty owed to the patient versus a duty owed to the physician or institution. The nurse can not delegate this moral duty to the patient to another. Breach of this duty can impose irreparable damage to the individual CCU nurse and the profession of nursing, when the trust of the nurse-patient relationship has been violated.

Fidelity, veracity, and confidentiality are considered the ethical basis of the nurse-patient relationship. At

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

stake in ethical conflict for CCU nurses is the nurse-patient relationship. The nature of that relationship is fundamental to the nursing process. Furthermore, it is a necessary foundation for a nursing ethic. Because nurses are employees of institutions, it has been argued that they are not free to act apart from the risk of serious harm to their own well being (Yarling & McElmurry, 1986). In other words, nurses do not have free exercise of moral agency. Yarling and McElmurry (1986) argue that nurses must be free of the confines of the hospital or institutional dominance in order to assert their nursing ethic.

Yet how can it be said that CCU nurses are not free to fulfill their moral obligations to their patients, when in a sense they are already choosing between interventions via the use of their sophisticated knowledge and technical skills. They are in some sense free to choose. CCU nurses are also culpable for their action or inaction. Hudack, Gallo, and Lohr (1986) state: "the essence of critical care nursing lies not in special environments or amid special equipment, but in the nurses's decision-making process and willingness to act on decisions made." CCU nurses are constantly challenging established authority structures through patient advocacy in ethical decision making.

Omery's (1986) phenomenological study of CCU nurses identified that these professionals used values not generally discussed in the moral reasoning literature as components of their moral reasoning. These values include

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

veracity, paternalism, and autonomy. Additionally, the decision making process that CCU nurses use seems to be indirect, in that certain mediating factors may be internal, such as character attributes, or external, such as the nurse-physician relationship. Only a few studies have addressed the ethical decision making process among critical care nurses.

Ray (1987) studied the nature of CCU nurses' lived experience of ethical decision making through phenomenological inquiry. Ray described and analyzed the dialectal process between a technical-ethical modality of care and an integrated techno-ethical human caring modality. He determined that the fact that critical caring is mediated through ethical choice is important.

Critical care nurse decision making does not seem to rest upon whether or not the profession as a whole is autonomous, but upon the fact that through the intense human experience each individual CCU nurse is an autonomous moral agent, and is therefore free to make decisions. Additionally, the process and certain mediating factors of ethical decision making differ from the established models of moral reasoning. Therefore, the purpose of this study was to identify and describe the process involved when critical care nurses make ethical decisions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Research Questions

The research questions guiding this study were:

1. How do critical care nurses make ethical decisions?
2. What are the essential characteristics or components of the ethical decision making process?
3. What are the interrelationships between these essential characteristics or components of ethical decision making?

Significance of the Study

This research study is significant in that it attempted to describe the complex process of ethical decision making among critical care nurses. It is essential that nursing begin to describe the process of ethical decision making. This study is a beginning step towards development of a substantive theory for predicting and explaining ethical decision making among CCU nurses. The profession's movement toward a nursing ethic will help differentiate for nursing and society the uniqueness of the discipline (Omery, 1989).

Without grounding in data, any theory about ethical decision making among critical care nurses will merely be speculative. Strauss (1990) states that social phenomena are complex and require complex grounded theory or, in other words, conceptually dense theory that will account for a great deal of variation in the phenomena studied. Swanson and Chenitz's (1986) concept of "surfacing nursing process" by taking grounded theory and making practice theories will

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

guide the critical care nurse in making ethical decisions in practice.

On a practical level, the theory described in this study may be used by nursing educators and nurse administrators to better understand how CCU nurses make ethical decisions. Historically, ethical decision making has been taught based on the ethic of justice using such principles as beneficence, truth, fidelity, and equality. As a result of being more aware of CCU nurses' ways of making ethical decisions, nurse educators will be able to rethink the teaching of ethics to incorporate other approaches of ethical decision making. Nursing, as a profession, has an obligation to prepare practitioners for an ethical practice. Accordingly, nurses need knowledge of the ethical processes of critical care decision making.

In looking toward the future, developing a theory of ethical decision making will serve to explain reality and predict phenomena and this would provide a philosophical basis for a research-based ethical practice (Fry, 1989). Additionally, research conducted on ethical issues is of interest to many disciplines inside and outside of health care. Research into the ethical decision making among CCU nurses may be of benefit to other disciplines. With the current interest in ethical issues in all professions, there seems to be a societal mandate for professions to examine their own ethical practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 2

Review of the Literature

The review of the literature stimulates theoretical sensitivity, and provides ways of approaching and interpreting data (Strauss & Corbin, 1990). Additionally, the literature can stimulate questions that may be asked of the respondents and guide initial observations. Similarly, the literature can direct theoretical sampling. A further reason to review the literature is to clarify the relevance of the problem, what is presently known about the problem, and what waits to be discovered (Morse, 1989, p. 292).

First, historical perspectives of ethical decision making in nursing will be reviewed. Second, moral development and ethical decision making in nursing will be examined. Finally, nursing research in ethical decision making is reviewed and critically analyzed.

Perspectives of Ethical Decision Making in Nursing

Professional Accountability

In the early history of nursing the commitment of the nurse to the patient was diluted by the nurse's relationship to the hospital and to the physician. However, today CCU

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and other practicing nurses are far removed from the ethical practice of nurses during the nineteenth century.

Florence Nightingale's training schools emphasized character development, the locus of health, and strict adherence to orders passed through a female hierarchy (Reverby, 1987). Reverby (1987) describes Nightingale's model of nursing as being built on a concept of duty rather than rights. This duty became translated into the demand that nurses merely follow doctors orders. This tradition of obligation made it impossible for nurses to speak about rights at all (Reverby, 1987, p. 8).

At the turn of the century, absolute and unquestioning obedience was the foundation of the nurse's work, and it was expected from her professionally at all times (Dock, 1966). Nurses were expected to do what they were told, and loyalty to the physician was premier (Aikens, 1925). Even after the turn of the century this theme continued. The 1929 case of Lorenza Somera is an exemplar case wherein a nurse was sentenced to a year in prison for the death of a 13 year old girl undergoing a tonsillectomy (Grennan, 1930). Somera acted precisely as she had been trained and did not question the orders of a physician except to verify it. Nevertheless, she was held criminally liable for her action. This case was significant in the evolving role conception of the nurse. The court made it clear that following orders was not a defense available to nurses. Grennan (1930) states that this court's decision lifted nursing from a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

subservient place to one of equality in responsibility and dignity with that of the doctor.

The 1929 Somera case (Grennan, 1930) is an example of the shift in locus of accountability within nursing from the physician to the patient. Somera verified the physician's order for cocaine intravenously, when in reality the physician wanted procaine. Somera acted in the manner she had been trained, which was to follow doctors' orders. In the end, Somera was pardoned. However, the case brought to light that following doctors' orders was not a defense available to nurses. The nurse is professionally accountable and responsible to protect the patient and provide safe care, and should not be subservient to other professionals in this accountability.

Yarling and McElmurry (1986) state that for nurses to be free to be moral, two necessary, but not sufficient, occurrences must take place: "a) emergence of a strong sense of professional autonomy, and b) a shift in the locus of accountability from the physician to the patient" (p. 66).

The hospital or other health care institution may have moral commitments of its own from which it attempts to structure the nurses' ethical obligations. This raises the question of whether the nurses' moral duty and that of the health care institution are always compatible. The nurse as an employee has had the ethical dilemma over time of deciding whether to go on strike or fulfill her commitment to the patient. Muyskens (1982) believes that economic

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

issues are not detachable from quality of care issues and that quality of patient care is an ethical obligation of the nursing profession.

Yarling and McElmurry (1986) state that perhaps the most symbolic evidence of the changes that were afoot was the American Nurses Association (ANA) Code for Nurses adopted in 1950. Prior to 1950, the 1926 suggested Code for Nurses stated that: "No worker is welcome to the ranks of nursing who does not put the ideal of service above that of remuneration" (American Nurses Association, 1926). The 1940 suggested code declared that hospitals have "no claim for unremunerated service" but recognized the obligation of nurses for continuity of service to patients (American Nurses Association, 1940). The first official code adopted by the ANA in 1950 said: "The nurse is entitled to just remuneration for services rendered and has a corresponding obligation to make a conscientious return in services" (American Nurses Association, 1950). In 1953, the ANA Committee on Ethical Standards stated the following: "While the strike is considered an ethical means for many groups of workers, the danger to patients makes it undesirable and usually also unethical for nurses" (American Nurses Association, 1953). Since 1950, each version of the Code for Nurses has reflected the emergence of professional autonomy and a shift in accountability.

According to the Nursing Code of Ethics, the goal of nursing is "to support and enhance the client's

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

responsibility and self-determination to the greatest extent possible" (American Nurses Association, 1976). The ANA Code of Ethics would be a key factor in many patient care decisions where ethical dilemmas exist. However, ethical codes for professions do not necessarily settle the question of what is right or wrong in any particular situation. Decisions regarding values can not be reduced to appropriate applications of universal principals such as those listed from the Code for Nurses (ANA, 1985), such as: autonomy, beneficence, nonmaleficence, confidentiality, fidelity, and justice. Assuming that all questions of ethics can be answered using the so-called universal principles is reductionist in that it distorts and oversimplifies the ethical dilemmas nurses find themselves in (Cunningham & Hutchinson, 1990).

Economic and Social Trends

Historically, medicine in the time of Hippocrates was a holistic science. However, the discovery of the germ theory in the mid-19th century steered medicine into a tightly focused biochemical orientation that stressed causation and treatment of specific disease within a mechanistic view of the body (Allen & Hall, 1988). The germ theory revolutionized medicine and continued its commitment to the Cartesian belief in opposition of mind and body (Allen & Hall, 1988). Medicine has always functioned as an agent of social control, especially in trying to normalize illness and return people to their functioning capacity in society.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Some of the problems that have evolved in this effort to normalize illness are economic mismanagement and inequitable resource allocation. Problems in equitable distribution of manpower, technologies and funding surfaced in the 1960's with the advent of socio-political-economic changes. These changes include some of the following value shifts: the elimination of poverty, economic growth, full employment, the burgeoning growth of a social security system, and health as a right (Allen & Hall, 1988).

An example of the results of these value shifts during the 1960's is the beginning of kidney dialysis for end-stage renal disease. The scarcity of this life sustaining technology necessitated the establishment of selection committees in centers offering dialysis. Several selection panels came under severe criticism when social worth criteria were used to choose patients for dialysis (Pinch, 1985). The federal government responded in 1972 with an amendment to the Social Security Act bringing treatment for dialysis patients within the medicare/medicaid program (Caplan, 1981). The economic impact of this social policy move was originally estimated to be $35 million. It now costs the federal government greater than $2 billion to dialyze 80,000 patients (Callahan, 1987).

In the late 1980's, 11 percent of the nation's acute care hospital beds were critical care beds with occupancy rates averaging 14 percent above the average hospital occupancy rate (Searle, 1988). Critical care is

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

approximately four times more expensive than routine hospital care and admission to CCU's is increasing (Strosberg & Fein, 1987). However, since the implementation of diagnostic related groupings (DRG's) and payment based on fixed categories of cost for medicare patients, CCU Medicare patients have represented financial losses to many hospitals (Strosberg & Fein, 1987). Furthermore, it is predicted that there will be a continued shortage of CCU nurses which will only intensify as complex technologic advances in critical care occur (Curtin, 1986).

Most Americans believe that every citizen has a right to a decent minimum of health care and that society should be equipped with some mechanism that would provide a minimal standard of health services (Larkin, 1988). Additionally, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982) stated that society has an ethical obligation to ensure equitable access to health care for all. However, what was once considered extraordinary care is now considered routine care in many settings. Advancing technologies are resulting in dramatic benefits to larger numbers of people. Limits may need to be placed on these practices, if not for ethical reasons, at least for economic reasons. These societal trends have wide reaching implications for ethical decision making among CCU nurses, such as the following: a) increasing patient acuity, b) decreasing resources, and c) rationing of critical care services (Curtin, 1986).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Frameworks for Ethical Decision Making

Several theoretical frameworks for assisting the ethical decision making process for CCU nurses have been utilized. Yeo (1989) states that "nursing ethics can be divided into two streams, each borrowing its conceptual paradigm from different sources" (p. 38). The first approach borrows from ethical theory. The second approach relies heavily on developmental psychology and will be explored in a later section.

Yeo (1989) states that nursing ethics primarily borrows its framework for ordering ethical theories from medical ethics (p. 39). Medical ethics has focused almost exclusively on the theories posited by Immanuel Kant and John Stuart Mill (Beck, 1959). These two major schools of thought are delineated as a deontological theory and a utilitarian theory for ethical decision making.

Kant's deontological theory poses questions about what kinds of acts are right, and asserts that rightness and wrongness are inherent in the act itself independent of the consequences (Beauchamp & Walters, 1989). Fulfillment of duties and adherence to rules take priority over their consequences. The major principles of deontology identified in nursing literature have been justice, autonomy, beneficence, and nonmaleficence.

Justice is the dominant ethical principle of health care. Veatch and Fry (1987) state that taken in the sense of fairness in distributing goods and harms, justice is held

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

by many to be a right making ethical characteristic even if the consequences are not the best (p. 8). The deontological view would hold that justice is a right-making characteristic independent of utility and does not require a calculation of benefits and harms before concluding that unequal distribution of goods is prima facie wrong in regards to fairness.

Autonomy focuses on respect for persons and the right of persons to self-determination. The principle of autonomy confirms the patient's right to refuse beneficial medical treatment. Respect for autonomy is one of the most frequently mentioned moral principles in the literature of bioethics (Beauchamp & Walters, 1989). This principle is rooted in the liberal western tradition of importance of individual freedom and choice (Beauchamp & Walters, 1989). Nursing has included this principle in the American Nurses' Association Code for Nurses: "The fundamental principle of nursing practice is respect for the inherent dignity and worth of every client. Nurses are morally obligated to respect human existence and the individuality of all persons who are the recipients of nursing actions...Truth telling and the process of reaching informed choice underlie the exercise of self-determination, which is basic to respect for persons" (American Nurses Association, 1985, pp.2-3).

Beneficence focuses on doing good for others (Veatch & Fry, 1987). However, forecasting long term societal good is not a simple matter. The goals of patient centered

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

beneficence and the full beneficence of societal good as a whole can create ethical conflicts. Moreover, the dilemma is complicated further by nurses' obligation to adhere to the principle of distributive justice. Fair and equitable distribution of goods and nursing services which promote public good needs to be addressed in nursing practice.

Nonmaleficence encompasses doing no harm (Veatch & Fry, 1987). The ethical codes of health care professionals have given special emphasis to this principle. The Hippocratic Oath of physicians states that the physician will work for the benefit of the sick according to his/her ability and judgment, and will keep them from harm and injustice (Edelstein, 1967). The Florence Nightingale Pledge includes the promise: "I will abstain from whatever is deleterious and mischievous...and devote myself to the welfare of those committed to my care" (Tate, 1977). The American Nurses Association (ANA) Code for Nurses states: "The nurses' primary commitment is to the health, welfare and safety of the client" (ANA, 1985, p. 6). However, ethical conflict may be created between the duty to do no harm to the patient and the ethical principles of respecting autonomy of the client and distributing resources fairly (Veatch & Fry, 1987).

The second category of ethical theory is utilitarianism. John Stuart Mill argued that the consequences of actions are what is important. Acts are right to the extent that they produce good consequences and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

wrong to the extent that they produce bad consequences (Priest, 1957). The key evaluative terms for this position are good and bad (Veatch & Fry, 1987). Classical utilitarianism determines what kinds of acts are right by figuring the net good consequences minus bad ones for each person affected and then adding up to find the total net good (Bentham, 1967). The infirmity of this theory is that utilitarianism is indifferent to who obtains the benefits and harm.

Classical utilitarianism counts benefits to all in society equally and traditional nursing ethics focuses on the individual patient. The difference between the former and the latter is that the latter concerns loyalty to the patient, and the goal is to what will produce the most benefit and avoid the most harm to the patient and not the whole of society.

Yeo (1989) states that nursing ethics has borrowed from medical ethics not only its list of canonical authors, but also certain ways of relating to ethical issues (p. 39). White (1983) would call these ways of relating to ethical issues as formula ethics, wherein one applies ethical theories to specific situations (p. 42). Yeo (1989) goes on to say that cookie cutter applications or formula ethics is misguided because it over-simplifies and reduces nurses' ethical practice to correct technique and is overly mechanical. Furthermore, Yeo (1989) believes that the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

danger is that the experience of nursing will be distorted or denied.

There is growing criticism of the ethical theory approach to nursing ethics by those in nursing who realize it is important to focus on the moral situation of nursing. Chinn and Jacobs (1983) call for the integration of all patterns of knowing and advocate a holistic ideal that blends with nursing theory. The template from which nursing theories have been judged in the past are the assumptions and purposes of scientific theory. Bishop and Scudder (1987) urge that nursing ethics should begin with the moral sense of nursing rather than with ethical theory (p.42). Packard and Ferrara (1988) state that the moral foundation of nursing will have to derive from bold excursions into the meaning of nursing (p.63). These and other critics have championed that there should be a nursing ethic that issues from nursing itself rather than one borrowed from biomedical ethics or ethical theories.

Caring as a Foundation for Nursing Ethics

Caring has been posited as the essence of nursing. Watson (1985) stated that the core of nursing is caring and defined caring as the moral ideal of nursing, with concern for preservation of humanity, dignity, and fullness of self. Watson (1989) also states that the field of biomedical ethics creates objectivity, detachment, and distance between the professional and the client's human experience. However, ethics as the caring root of nursing is grounded in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

receptivity, intersubjective relations, and human responsiveness. She also states that an ethic of caring has a distinct moral position. Caring is attending and relating to a person in such a way that the person is protected from being reduced to the moral status of objects. Similarly, nursing ethics of human caring can not be reduced to biomedical ethics. Nursing should be distinguished by its philosophy and moral ideals that affirm the personal unique contextual experiences associated with human caring.

A few nurse philosophers have attempted to articulate values other than medical values as foundational for the moral practice of nursing. Gadow (1987) argues that the value of caring provides a foundation for a nursing ethic that will protect and enhance human dignity through the nurse-patient relationship. Gadow (1987) views caring as a commitment to certain ends for the patient. This existential caring is demonstrated in the nursing actions of truth telling and touch. Through truth telling the nurse helps the patient assess the subjective as well as objective realities of illness. This aids the patient in making choices based on the unique meaning of the illness experience. Through touch, the nurse assists the patient to overcome the depersonalization that often characterizes the health care setting. This affirms the patient's idea that he is a person rather than an object and communicates caring. Gadow views human caring as a philosophy of action with unexplained metaphysical and spiritual dimensions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Again, Gadow (1987) and Watson (1985) view caring as a value of central importance to the nature of the nurse-patient relationship. Both theorists see caring as a mode of being, a natural state of human existence in which individuals relate to the world and other human beings. This is similar to Heidegger's (1962) notion of care as a fundamental mode of human existence in the world. As a mode of being, caring is natural. It is neither moral nor nonmoral; it is simply one's way of being in the world. Nevertheless, through the nurse-patient relationship, caring becomes strongly linked to the moral and social ideals of nursing as a profession.

Noddings' (1984) model of caring is based on ethics and social psychology. Noddings (1984) built on Gilligan's (1977, 1982) cognitive developmental model of moral reasoning. However, Noddings (1984) combines a knowledge of ethics with perspectives on moral development in women. Noddings' purpose is feminine in the deep classical sense, rooted in receptivity, relatedness, and responsiveness. Yet, Noddings develops her notion of caring as applicable to both men and women.

Noddings (1984) states "to care may mean to be charged with the protection, welfare, or maintenance of something or someone" (p. 2). This viewpoint begins with an attitude of "being moral or longing for goodness" (Noddings, 1984, p. 2). Caring is not an outcome of ethical behavior but is the root of ethics. Therefore, caring is not necessarily

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

gender dependent. Ethical caring is simply the relation in which we meet another morally, wherein males and females are partners in human relationships, not adversaries. However, Noddings (1984) claims that ethical caring depends on "the maintenance of conditions that will permit caring to flourish" (p. 5).

Noddings' (1984) model of caring is relevant to nursing but it has been basically unexplored by the profession of nursing. Nevertheless, this model is a rich resource for future nurse researchers of ethical decision making in nursing practice. Noddings' notions of receptivity, relatedness, and responsiveness between the nurse and the client is a viable theoretical framework that realistically represents the nature of the nurse-patient relationship (Fry, 1989).

It has often been posed that CCU nurses are uncaring individuals because of the technological and medical treatment orientation of this specialty. Smerke (1990) cites Heidegger's (1962) conceptualization of two modes of caring: 1) inauthentic caring, wherein the nurse takes on the responsibility for others and totally does for others, and 2) authentic caring, wherein the nurse helps the other person to take care of himself. Smerke (1990) feels that many CCU nurses portray Heidegger's (1962) inauthentic caring because the client is supposed to relinquish his/her responsibility for health and well-being to the team of health professionals. The CCU nurse in turn cares for the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patient and makes the best care decisions for the client. However, with caring as the ethical foundation for nursing, the goal of CCU nursing should be to gain a richer understanding of the client, how to assist with his care, and how to promote his well being (Smerke, 1990).

Moral Development and Ethical Decision Making in Nursing

Yeo (1989) states that the moral development approach to nursing ethics differs from the ethical theory approach by being more empirical (p.40). This empirical analytical approach explains ethical decision making among CCU nurses as a mental process that intervenes between the recognition and reaction to a moral dilemma (Omery, 1989). It is the decision making process by which the nurse chooses among her/his moral values to come to some decision as to the appropriate response to some moral dilemma (Omery, 1989, p. 502). The most prominent theories of psychological and moral development propose a model of development where a healthy human is separated, individuated, autonomous, and disconnected (Kohlberg, 1976; Piaget, 1965). However, feminist scholars such as Jean Baker Miller (1986), Carol Gilligan (1982), and Nel Noddings (1984), suggest that morality for women is embedded in a network of personal and communal relationships that define and enrich life. Since nursing is a coalition of professional care-givers comprised primarily of women, it is important to assess the feminist perspective of moral development also. Additionally, this

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

section will critically analyze both moral developmental approaches to ethical decision making among nurses.

Kohlberg's Theory of Moral Development

Kohlberg's (1971) cognitive developmental model of moral reasoning relied on a two-stage model developed by Jean Piaget (1932). Piaget's (1932) view was that justice was the core of morality. Almost 25 years after Piaget (1932) published his first major work on moral development, Kohlberg (1971) began a longitudinal study of the moral development of 84 adolescent males over a 20 year period. Kohlberg's (1971) research methodology assessed the responses of the 84 males to a number of hypothetical moral dilemmas that involved the following issues: life, law, morality and punishment, contract, and authority. Scoring of these responses resulted in two scores: 1) a global stage score (moral reasoning), and 2) a moral maturity score.

Using Piaget's (1932) theory of moral development he found evidence for a structural developmental model of moral reasoning. Kohlberg (1971) proposed the universal six-stage, sequential model described below. Each stage reflects a more advanced social perspective and logical structure. Kohlberg (1971, p. 195) describes this as "justice structure." The basic tenet of this model is that justice is the basic moral principle (Kohlberg, 1971, p. 220).

The first level of Kohlberg's (1976) model is the preconventional level of moral reasoning. Responsiveness to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

cultural rules in terms of right and wrong, avoidance of punishment, and deference to power are key motivators in this first stage. The second stage components are fairness, reciprocity and equal sharing. However, the needs of others will be satisfied only if it is self-serving to consider them.

Level two, the conventional morality level, moves moral reasoning from an egocentric to societal expectation perspective. In stage three, right is doing what is expected of people in their life roles. Stage four is a law and order orientation aimed toward authoritarianism and maintenance of social order.

Level three, principled morality, moves from a societal perspective to universal moral values and principles. Stage five is called social contract morality and has legalistic and utilitarian overtones. A premium is placed on procedural rules for reaching a consensus. Emphasis is on doing the greatest good for the greatest number of people. Stage six is the universal ethical principle orientation. Decisions of conscience in accord with self chosen ethical principles determine what is right. Examples of concepts utilized in stage six reasoning are: justice, fairness, equality, and a respect for the dignity of human beings as individual persons.

Limitations of Kohlberg's Theory

Many researchers have taken issue with Kohlberg's (1976) theory and its insufficiency in explaining moral

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

development (Holstein, 1976; Simpson, 1974). Kohlberg's failure to include the concept of care along with the concept of justice has been criticized extensively. Kohlberg (1971) notes that the only general principle other than justice, that is seriously proposed by moral philosophers, is that of benevolence (p. 220). He admitted that benevolence, like justice, can be universalized. However, he said benevolence is insufficient because it can not resolve a conflict of welfare (p. 220). Nevertheless, Kohlberg acknowledges that without the moral attitude of benevolence, moral conflict can not even be experienced. It is on this point that much of the criticism of Kohlberg's theory turns.

Peters (1971) has discussed the importance of other issues besides knowledge of justice in the moral development of a child. He states: "children might know what justice is, but not care about it much...How do children come to care? This seems to be the most important question in moral education. But no clear answer to it can be found in Kohlberg's writings" (Peters, 1971, p. 262).

Kohlberg (1971) claims universality for his stage sequence model, but those groups not included in his original sample rarely reach his higher stages (Edwards, 1978; Holstein, 1976; Simpson, 1974). One of the limitations of Kohlberg's methodology is that he uses the male experience as a baseline against which all human moral development is judged. Kohlberg's research was done by and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on males exclusively. There is a failure to explain the moral development of women in this model of moral development. One of the most significant findings of Kohlberg's study of moral development was that females arrest at stage three of his model of moral reasoning. Women had difficulty moving beyond stage three's mutual morality level.

Kohlberg (1976) felt that women could progress to other stages but they had to be challenged to see beyond relationships that define their moral experience. His perspective is: as long as females feel they are adequately resolving moral dilemmas at the lower stage they will remain there. He theorized that if women moved into professional and career opportunities outside the home, then women would score much higher on his stage sequence scale. Kohlberg (1971) interprets women's stage arrest at level three as moral weakness and moral diffusion in women.

However, Gilligan's (1982) study of women may explain this phenomenon in terms of gender differences. Gilligan (1982) found that women define themselves within the context of human relationships. Women also judge themselves in terms of their ability to care and responsibility toward others. In looking at moral judgments and hearing the woman's voice, Gilligan discovered that:

> "When one begins the study of women and derives developmental constructs from their lives, the outline of a moral conception different from that described by Piaget or Kohlberg begins to emerge and informs a different

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> description of development. In this conception, the moral problem arises from conflicting responsibilities, rather than from competing rights and requires for its resolution a mode of thinking that is contextual and narrative rather than formal and abstract" (p. 19).

Consequently, one may conclude that Kohlberg's (1971) failure to study a representative sample of all humanity may account for the female deviation from the male model of moral development. This lack of representativeness is a real threat to the generalizability of the model. Kohlberg's theory is limited by the fact that it does not account for the female experience of moral development.

Another source of bias may be in the predominance of male actors in the moral dilemmas used as stimulus materials in eliciting reasoning. Females may have difficulty in relating to these male hypotheticals. As a result, females may exhibit artificially lower levels of moral reasoning. Bussey and Maughan (1982) found more advanced reasoning for male subjects with same sex protagonists. On the other hand, Orchowsky and Jenkins (1979) found more advanced moral reasoning with opposite sex protagonists. Additionally, Garwood, Levine, and Ewing (1980) found no evidence of differential responses when the protagonists' sex was varied. Thus the data regarding same sex actors in posed hypothetical moral dilemmas are ambiguous.

In addition to sexual bias questions, there has been criticism that Kohlberg's (1971) model is culturally biased. Kohlberg felt that cross-cultural studies confirmed his

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

assertion that this model of moral development was universal to all humans, regardless of culture or religion. Simpson (1974) cites Kohlberg's uses of culturally biased data gathering techniques, and his inability to account for all the findings in his research, as evidence of cultural bias. Recent studies have supported these claims and indicate that religion and culture may play more of a role than Kohlberg realized (Erndierger & Manaster, 1981).

Another criticism cited by Simpson (1974), Kurtines and Grief (1974), concerned Kohlberg's test procedures performed after publishing his model in 1971. The original instrument used was developed into three different versions. Additionally, the test-retest reliability has not been strong for any of the versions (Rest, 1975). Furthermore the manuals published by Kohlberg for use of the instrument distinctly states the person scoring the subjects must be thoroughly trained and experienced (Kohlberg, 1976).

Rest (1975) developed the Defining Issues Test (DIT) for stage identification. Initially, the correlation between Kohlberg's tool and Rest's DIT was statistically significant at a 0.68 level. However, recent research articles have correlations as low as 0.24 to 0.41 (Bode & Page, 1978; Davidson & Robbins, 1978). Moreover, both Kohlberg (1976) and Rest (1975) believe the two instruments may be testing different phenomenon. The low reliability and validity of Kohlberg's instrument used in conjunction with Rest's DIT limits the use of Kohlberg's model of moral

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

development. Consequently, the validity of nursing research using these instruments will be reduced.

Gilligan's Cognitive Developmental Model

Belenky (1986) has stated that women make moral decisions not by invoking a logical hierarchy of abstract principles, but through trying to understand the conflict in the context of each person's perspective, needs, and goals. In fact, Gilligan (1977) has interpreted women's stage arrest at Kohlberg's conventional level of moral reasoning as not being deviant but different than male moral development. Gilligan (1977) agrees that men and women develop their moral judgment from their social interactions. However, Gilligan (1977) feels that women focus on context and narrative rather than models of formal and abstract thought. Additionally, Gilligan (1977) states that moral problems for women develop from conflicting responsibilities rather than from competing rights. Due to the female's lack of power in a male dominated culture and resulting dependence that females share with each other and their children, women have had to develop a sense of responsibility based on the universal principle of caring to survive.

Gilligan's (1977) model has three levels with two transitional stages. The lowest level is labeled the orientation to individual survival. At this level being moral is surviving by being submissive to authority. This is an egocentric level of moral reasoning, and one will

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

transition from selfishness to responsibility. Gilligan explains that the person will develop a sense of responsibility for and to others, which becomes more important than surviving through submission.

The second level of this model categorizes goodness as self-sacrifice. If moral development is at this level, one will feel that it is important to not hurt others, with no thought of the hurt that might be done to oneself. The person moves from level two to level three by realizing that one has a responsibility not only to not hurt others but to also not hurt oneself.

Level three is called the morality of nonviolence. The moral principle of all moral judgements is the injunction against hurting. Gilligan (1977) states that at this level there is an equality between self and others. Care, instead of individual rights, becomes the universal obligation.

Gilligan (1977) used open ended interviews with 29 female Harvard University students, ranging in age from 15 to 33. Gilligan feels that these women were diverse in ethnic background and social class. He asked these women, who were considering whether to continue or abort a pregnancy, questions regarding how they were thinking about the decision. These women's moral language was full of words such as: selfishness, responsibility, care, avoiding hurt, and decisions that were weighed in light of their relationships with others. It was from these data that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gilligan developed the above three-stage cognitive developmental model.

Gilligan (1977, 1982) realized, from listening to these women's stories of their own real life moral dilemmas, that they often felt caught between caring for themselves and caring for others. Women looked upon their failure to care as failure to be good women. Gilligan suggested that self-concept and morality may be linked. Gilligan's hypotheses in the study were as follows: a) there are two distinct modes of moral judgment in men and women -- justice and care; b) these modes are gender related; and c) modes of moral judgment might be related to modes of self-definition.

Gilligan (1982) asserts that moral development is a unity of two ethics: 1) the ethic of justice based on the belief that everyone should be treated equally, and 2) the ethic of care -- no one should be hurt. Gilligan (1982) states there is an interplay of both care and justice in both men and women. The care response is not typically female nor is the different voice that she describes characterized exclusively by gender. Gilligan (1982) feels that justice and care are not opposites, but just show different ways of organizing the basic elements of moral judgment.

Having found this second conception of morality, a morality centered on issues of care, Gilligan and her colleagues began to investigate the prevalence of this concept (Gilligan, Langdale, Lyons, & Murphy, 1982a). In

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

describing this research, Nona Lyons (1988) tells of a morality of justice and care in terms of self-concept and in relation to others. In the justice focus of moral reasoning, individuals are autonomous in relation to others. Those who use the justice focus see others as one would like to be seen by them, with objectivity and fairness. This is called the separate/objective self. This self mediates relationships through rules. The care focus stresses interdependence in relation to others. Individuals using the care focus have concern for the good of others and the alleviation of their hurt or suffering (Lyons, 1988). This is called the connected self. Relationships are mediated through the activities of care, sustenance of care, and connection in relationships.

Moral dilemmas are evaluated from the care focus with the following considerations: a) what happened or will happen, b) how things worked out, and c) whether relationships were maintained (Lyons, 1988). This care focus uses the context of relationships in the setting. The individual using a justice framework to solve a moral dilemma will consider: a) how decisions are justified, and b) whether values, principles or standards were maintained, especially fairness (Lyons, 1988). This individual will ask: was it just to do so?

Gilligan et al. (1982a) used a cross-sectional sample of 36 men and women matched for age, education, and social class to investigate the care focus. The subjects were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

asked to describe a personal, real life experience of moral conflict. Next they were asked a series of standard follow-up questions inquiring into how the subject constructed, resolved and evaluated the conflict. Additionally, these thirty-six male and female subjects were interviewed to ascertain their mode of self-definition and of moral choice, and to explore the connection between them.

The results of this study showed that in real life conflicts, males and females use both a justice focus and a care focus to resolve moral conflict. However, women use the care response more frequently than the justice perspective and men use the justice perspective more frequently than the care response in moral decision making (Lyons, 1988). One-third of the men did not consider any care responses in their moral conflict resolution and one-third of the women never used a justice perspective.

The research results supported the hypotheses that there are two different orientations to morality (Lyons, 1988). There is a justice orientation and a care response to moral conflict; however, they are not mutually exclusive. Some individuals use both kinds of considerations in evaluation of moral conflict, but one mode usually predominates. Gilligan cautions that the gender related differences are not absolute since both men and women use both care and justice in moral conflict resolution (Lyons, 1988).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gilligan et al. (1982a) tested males' and females' mode of self-definition in this study. Sixty-three percent of all females described themselves as a connected self, while seventy-nine percent of all men described themselves as a separate objective self. However, some men and women define themselves with elements of either mode. The more exciting result of this study is the relationship between modes of moral choice and modes of self-definition. Clearly, the individuals, mostly female, who describe themselves in connected terms predominantly used the care response in solving moral dilemmas. The people who describe themselves as separate and objective, mostly men, predominantly used the justice perspective in solving moral problems. A definition of self in relation to others is found in both sexes and suggests that research ought to move from a psychology of individuals to a psychology of relationships. Men and women tend to understand and define relationships in different ways.

Limitations of Gilligan's Model

Gilligan's (1977) model has explained some of the possible reasons for women's stage arrest at Kohlberg's conventional level of moral development. However, there has been very little research done on the care and justice focus of moral decision making except for that done by Gilligan and her colleagues. There have been no further types of stage sequence studies, such as longitudinal, cross

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

sectional, or experimental, reported to support Gilligan's research.

One limitation of Gilligan's initial study is that her sample was non-representative. Gilligan has been criticized for ignoring the differences in race, class, and religion just as she criticized Kohlberg for ignoring gender differences. The 29 women interviewed in Gilligan's sample were Harvard University students, clearly an elitist class. In addition, only a few professional women were included in her sample, so the results may not generalize to a professional group of women such as professional nurses. However, the sample did meet the criteria of high levels of intelligence, education and social class. These criteria may fit well for the CCU nursing population.

Another limitation of Gilligan's model is the difficulty in seeing both justice and care perspectives because the terms of one perspective do not contain the terms of the other. Where detachment is seen as the mark of moral maturity in a justice framework, it becomes a moral problem from a care perspective. There are pitfalls in either perspective. Cooper (1989) states the justice framework lays open the opportunity to engage in egocentric thinking, confusing one's perspective with an objective truth. The care perspective has a tendency to enter into another's perspective, seeing oneself as selfless, thereby defining oneself in another's terms. The research done by Gilligan and Lyons confirms that people exhibit both justice

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and care concerns, but focus on one perspective at the expense of the other.

Other criticisms of Gilligan's research center around methodology and content analysis of the moral dilemmas. Equivalency of the subject generated dilemmas are difficult to guarantee (Ford & Lowery, 1986). Ford and Lowery (1986) feel the influence of the content of the posed dilemma is important. Standardized dilemmas that are equated or balanced for the extent to which the content is embedded in justice or care context should be offered to the subjects. In the only study which Gilligan et al. (1982a) directly compared males and females, the subjects were coded for considerations of justice and care. However, the dilemmas were not equated for content. Therefore, these data may only reflect the kind of conflicts the subjects choose to discuss. Gilligan's research does not address the question of whether, in a standardized dilemma, females would focus on care issues and males would focus on justice issues.

Content analysis of Gilligan's abortion study leads one to ask the following question: What about different circumstances with equally difficult choices that confront women daily, such as rape, sexual abuse, and sexual harassment? Perhaps the elements of care reasoning found in the abortion study may be a particular function of the kinds of questions the subjects were asked rather than a function of the way they actually think (Moody-Adams, 1991, p. 204).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Central elements of the care perspective may be inadequate to focus on the moral reflections of the duty of noninterference and respect for the integrity of individuals that is inherent in rape, sexual abuse and sexual harassment.

Gilligan (1982) defends her emphasis on the abortion study as necessary to find places where women have the power to choose and are willing to speak in their own voice (p. 70). However, are women's moral voices only heard within the framework of reproductive choices? What about women who do not define their identity within their capacity for reproduction or caretakers of children? What about the women who decide to pursue careers that take them out of the domestic realm? By defining a woman's moral identity within the framework of reproduction, it is only a short step away from the view that a woman's biology is her destiny (Moody-Adams, 1991). Gilligan makes assumptions about how women as a whole think about morality in general from this abortion study.

Gilligan (1982) claims that the female moral voice is not characterized by gender, but by theme (p. 2). However, later she states that her research is intended to provide psychologists with tools to come up with a clearer representation of women's development (p. 3). At issue here is the danger of stereotyping women's moral voices which may give way to theories of biological determinism (Gilligan &

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Wiggins, 1987, p. 279). Gilligan (1987) claims she has tried to reject any suggestion that one sex is morally superior to the other (p. 282). However, Gilligan and Wiggins (1987) go on to say that there is no disinterested position when it comes to the discussion of sex differences (p. 278).

Many critics would reject Gilligan's theory on the potential danger of stereotyping alone (Nails, 1983). Nevertheless, the critics agree that Gilligan's (1982) significant contribution may not be in the fact that men and women differ in their orientation to moral conflict, but in broadening our definition of what constitutes an adequate description of moral reasoning (Lowery & Ford, 1986, p. 783).

Nursing Research in Ethical Decision Making

Over the past two decades most nurse researchers have relied on Kohlberg's theory of moral development to explain moral decision making among nurses. Ketefian (1981) examined the relationship between moral reasoning and moral behavior in 79 practicing nurses. Ketefian takes the foundational ideas for this research from Sample's (1978) idea that human psyche develops through sequential stages. Ketefian also relies heavily on Dewey's (1965) theory of the nature of morality being placed in a larger context with a process that involves active and personal decisions (p. 7).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Moral reasoning among these nurses was measured by using Rest's (1974) DIT and the Judgment About Nursing Decisions (JAND) instruments. The results of this study support the idea that moral reasoning is positively related to knowledge and valuation of ideal moral behavior. However, these nurses' perceptions of realistic moral behavior's relationship to moral reasoning had a small magnitude of correlation since nurses were placed in the position of predicting someone else's behavior instead of assessing what they would do in the ethical dilemma. What the individual nurses would do in the dilemma is still open to question.

These 79 practicing nurses were also tested for the relationship between critical thinking, educational preparation, and their level of moral judgment (Ketefian, 1981a). The Watson-Glaser Critical Thinking Appraisal Test measured critical thinking and the DIT measured moral judgment. The results demonstrated that the higher the nurses' critical thinking the higher their moral reasoning was likely to be. Nurses with more advanced education had higher moral reasoning than those nurses with technical nursing preparation. These data suggest that the theoretical and philosophical distinctions between professional and technical education is becoming a reality.

In another study, Felton and Parsons (1987) studied 227 baccalaureate and 111 master's nursing students to determine the influence of the level of formal education on three

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

selected factors: 1) moral reasoning, 2) attribution responsibility, and 3) moral dilemma resolution. Kohlberg's (1971) moral development theory and Heider's (1958) attribution of responsibility constructs provided these researchers' theoretical framework. The results demonstrated that the graduate students reasoned at a higher level than undergraduate students. However, both groups scored at a level that equaled that expected for junior high school students. Furthermore, the study results did not suggest that nursing faculty should teach moral development and link it with other variables in an effort to raise the level of moral reasoning in nursing.

Nursing students and nursing faculty were studied by Munhall (1980) to determine levels of moral reasoning of baccalaureate students in different academic years and nursing faculty in the same educational program. Again, Kohlberg's (1971) theory of moral development was used as a basis for the study. The results showed there were no significant differences in moral reasoning between different levels of baccalaureate students. However, there were significant differences between levels of moral reasoning of students and faculty. Nonetheless, both groups still demonstrate relatively low levels of moral reasoning.

The relationship of moral judgment to the incidence of self-reported unethical classroom and clinical behavior was studied by Hilbert (1988) among 63 baccalaureate nursing students using Kohlberg's (1971) theory and Rest's (1974)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

DIT instrument. Hilbert's students' scores were higher than those found by Felton and Parsons (1987), but only 21 percent of the students consented to participate.

Staff nurses of varied educational levels were studied for their response to general hypothetical moral dilemmas and their responses to real-life nursing dilemmas (Crisham, 1981). Crisham used Kohlberg's (1971) theoretical framework as a basis for the study, but developed the Nursing Dilemma Test (NDT) to measure the nurses' moral reasoning. The NDT was modeled on Rest's (1974) DIT scale. The NDT was developed on the experiences of 130 staff nurses, and examines willingness to act, familiarity with the dilemma presented, importance of practical considerations, and level of moral reasoning, and which were made up of nursing principled items for each of six nursing dilemmas. The results of Crisham's (1981) study indicate that the length of time that people worked in nursing was related to the importance given to practical as opposed to ethical considerations. Age was not a factor in principled thinking scores. Nearly all of the nurses were familiar with the dilemmas.

Using the NDT, Winland-Brown (1983) found that CCU nurses had higher principled thinking scores than medical-surgical nurses and non-nurse adults on two dilemmas: forcing medication and uninformed terminally ill adults. Nursing students shared these high scores on the latter dilemma. Nurses with more than 15 years of experience

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

scored higher than did nurses with 5 to 9 years experience. Neither familiarity with the ethical dilemma nor religious preference was associated with scores on principled thinking, but nurses who had taken a philosophy course had higher principled thinking scores.

In a study of critical care nurses, Priest (1983) found that principled thinking scores differed significantly with experience. Nurses with less than 5 years of experience tended to have higher principled thinking scores than did those with more than 5 years experience.

In another study of critical care nurses, 91 CCU nurses were surveyed using the NDT (Corley & Selig, 1992). Corley and Selig found that nurses who volunteered responses scored higher on principled thinking and lower on practical considerations than other nurses. Age and education were not found to be correlated with familiarity, willingness to act, practical thinking, or principled thinking scores. Years of critical care experience correlated negatively with principled thinking. Forty percent of these CCU nurses identified additional relevant issues in the following categories: rights, alternative actions, consideration of others, and quality of life concerns. The vignettes in the NDT seemed to rob the situation of context, wherein the nurses sought more context by writing in comments.

In conclusion, nurse researchers using the NDT have inconsistent findings and a lack of reliability of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

instrument has been found. These researchers recommend modification of the NDT for further testing. Corley and Selig (1992) state that the CCU nurses in their study sought more contextual information through the comments that they wrote on the instruments and reflected more contextual thinking in the options that they added to the NDT.

More recently, Corley, Selig, and Ferguson (1993) determined the extent to which nurses participated in ethical decisions. Seventy-five CCU nurses completed the investigator-developed instrument, Participation in Ethical Decision Making Index (PEDMI). The PEDMI assessed the frequency with which the nurses participated in discussions that affected institutional decisions on ethical issues. In this study, younger age and less nursing experience had a positive correlation to greater participation in ethical decision making. Corley et al. state that this finding may reflect that nursing education is addressing the need to understand ethical issues surrounding patient care. However, the study also found that there was a lack of relationship between participation in ethical decision making and work decisions. Therefore, the researchers feel that these two processes are independent of each other. There was a wide variation in participation in ethical decision making, suggesting questionable preparation for ethical decision making in the clinical setting.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The most recent research using the JAND instrument (Cassidy & Oddi, 1991) validated only three findings from Cassidy and Oddi's (1988) study which investigated the differences in perceptions of idealistic and realistic moral behavior and attitudes toward autonomy, patients' rights, and traditional nursing role limitations among four groups of nursing students. In Cassidy and Oddi's (1993) most recent study on these differences, only age and ethics education had effects on attitudes toward autonomy as measured by the Nursing Autonomy and Patient Rights Scale (NAPRS). Younger students scored significantly higher on autonomy and rejection of traditional role limitations than did older students. Furthermore, students who had taken a formal course in ethics scored significantly higher on autonomy and perceptions of realistic moral behavior. Overall, there was a consistent lack of significant findings on JAND scores among groups studied.

Phenomenological research (Omery, 1986) of 10 CCU nurses working in an adult intensive care unit showed that the moral reasoning for this group of CCU nurses had three major characteristics: 1) principles, 2) mediating factors, and 3) modes of reasoning. Principles provide the justification for the moral decision and the direction for the moral action. Honesty and responsibility were the two principles that all of these CCU nurses identified. Mediating factors either compelled or restrained the moral reasoner in the decision to apply a particular principle.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The following mediating factors were identified by all of the CCU nurses: 1) the situation, 2) level constraints, and 3) the nurse/physician relationship. The two modes of reasoning used were accommodating and sovereign. Accommodating reasoners adapted or reconciled their reasoning to conform with the perceived norm of their identified group. Sovereign reasoners based their judgments on self-chosen and valued moral principles even though the decision may have created conflict with the group norms or principles. The most important conclusion of Omery's (1986) study was that the moral reasoning identified was not consistent with those models of moral reasoning developed by other disciplines which are currently being used to evaluate nurses. Omery (1986) recommended further studies to determine to what degree these findings are generalizable to the entire CCU nursing population. Additionally, findings of this new description need to be shared with other nurses and disciplines.

The meaning of human caring from the perception of eight critical care nurses was conducted by Ray (1987) in a phenomenological study. The unity of meaning from the study is the ability of CCU nurses to use ethics or to distinguish right from wrong in attitude and behavior by the exercise of their moral agency in the uses of technology. The CCU nurses in the study exercised their moral agency both from an experiential or response ethic and from an ethic of principle or ultimate reason. The nurses exercised three

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

prominent ethical principles in bioethics: beneficence, justice, and autonomy. Within the process of technological caring, compassion was the motivation for the change in ethical decision making. Experiential ethics rely on subjective and intuitive insight. The CCU nurses, when making ethical decisions, used a caring response that was enacted from a position of bonding or attachment to the client. Further qualitative research will continue to elucidate this link between caring and principled ethics.

A qualitative descriptive study of 24 nurses using Gilligan's framework to analyze nurses' stories of moral choices demonstrated that both caring and justice orientations were present in the nurses' stories (Millette, 1994). However, neither orientation seemed to be more effective in assisting nurses in making moral choices. Both orientations guided these nurses in provision of quality care and toward a role in client advocacy. Nurses that exhibited the justice orientation were more likely to stay in nursing than those that exhibited the caring orientation. Nurses perceived a lack of power as the most common recurring theme. These nurses reported an inability to act on their own convictions. Specifically, they felt powerless and were in conflict with either the employing institution or a physician. Millette questions if either a justice or caring orientation can guide the practitioner to advocate for the patient, why explore the different perspectives?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

However, in order to clarify ethical decision making among nurses, more needs to be known about the processes used.

Other qualitative research further confirms that nurses perceive themselves as powerless in influencing ethical decisions (Erlen & Frost, 1991). Content analysis of 25 nurse interviews revealed that the degree of power that nurses perceive themselves to have may have implications for how actively they will pursue particular alternatives to resolve the ethical dilemmas. Erlen and Frost's study demonstrated that the nurse informants perceived that physicians were able to use expert, legitimate, and coercive power, and when doctors exerted this power and dominance the nurses perceived themselves to be powerless. Powerlessness was perceived regardless of age, educational preparation or work experience. These researchers state the need to study the differences in the perceptions of the roles of ethical decision making between nurses and physicians and how nurses grapple with issues of powerlessness in ethical dilemmas.

The Collaborative Practice Scale (CPS) and the Decisions about Aggressiveness of Patient Care Scale (DAC) were recently used by Baggs and Schmitt (1995) to study 57 critical care nurses and 33 medical residents. Both nurses and residents felt that the primary decision makers should be the patients. In fact, the findings disclose that there is a perception that patients participated in their care in over 50 percent of the respondents. This indicates changes in practice moving in the direction of support for the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

principles of autonomy and disclosure. However, both nurses and medical residents felt that the attending physician was the power holder in the ethical decision making process despite their feelings that more inclusiveness should occur. The CCU nurses were less satisfied than the medical residents with the decision making process. There was no relationship between perceptions of nurse-resident collaboration and the inclusion of others in the decision making process. Assessment of the relationship between more inclusive decision making processes and patient outcomes were outlined by the researchers for further research.

Analysis and Critique

In summation, nursing research in the early 1980's has looked at the relationships between components of ethical responsibilities by comparing scores on Rest's (1974) DIT instrument with nurse researcher developed instruments. Chrisham (1981) reported significant low correlations between scores on Rest's (1974) DIT instrument and the NDT. Furthermore, Ketefian (1981b) reported significant low correlations between DIT scores and the JAND subscales of idealistic behavior and realistic behavior.

Interpretation of the effects of years of clinical experience by Chrisham (1981) and Munhall (1980) on ethical responsibilities has shown no differences on DIT scores and DIT stage scores. Ketefian (1981b) found no significant differences on JAND realistic behavior subscale scores and years of clinical experience. However Chrisham (1981) did

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

find significant differences on the NDT scores and length of experience. Likewise, Ketefian (1981b) reported significant differences on JAND idealistic behavior subscale scores and years of clinical experience. However, other nurse researchers have reported inconsistent findings related to length of experience among CCU nurses and ethical decision making using the NDT (Corley & Selig, 1992; Priest, 1983; Winland-Brown, 1983).

More recent studies done by Felton and Parsons (1987) suggest less significant differences in moral reasoning between undergraduates and graduate nursing students. Munhall (1980) and Hilbert's (1980) investigation showed similarly low moral reasoning scores for undergraduates. Nokes (1989) states that the relevance of these low moral reasoning scores is more alarming when compared to non-nursing groups. Furthermore, the moral reasoning scores were comparable to those of high school graduates. Munhall (1980) did find that nursing faculty scored higher and within the college graduate level of moral reasoning. Only Winland-Brown (1983) found that nurses scored higher on moral reasoning than non-nurse groups. However, these were findings using a different instrument, the NDT.

In the past, nurse researchers who obtained these low moral reasoning scores among nurses advised nurse educators to develop nursing curriculum that would improve moral reasoning. Felton and Parsons (1987) concluded that formal education had an impact on overall moral reasoning levels

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(p. 9). However, Frisch's (1987) pretest and posttest scores of experimental and control groups demonstrated no significant change in either groups' posttest scores after formal education. Furthermore, the recommendation of formal education may not be warranted since Felton and Parsons's (1987) subjects did not score beyond the high school graduate range for moral reasoning for either group.

Consequently, one should be concerned that few of the limitations of the Kohlberg (1971) model have been identified or discussed in the literature so that readers and nursing educators can fully understand the implications of the research results. The use of Kohlberg's (1971) cognitive theory of moral development in nursing research may present problems that are significant to nursing.

Kohlberg based his theoretical assumptions on data collected from only male subjects. The profession of nursing is comprised primarily of females; therefore the constructs of this theory may not be valid in studying nursing groups. Kohlberg's research strategy reflected the underlying assumption, heretofore unchallenged, that there are no sex differences in moral development (Cooper, 1989, p. 11). Gilligan (1982) has challenged this assumption by recognizing the obvious differences in the sexes in terms of social and economic status and perspectives. Furthermore, Gilligan (1987) asserts that this assumption is problematic from a research procedural standpoint given Kohlberg's

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(1971) assumption of universality while simultaneously failing to account for the feminine moral voice.

Gilligan (1982) posits that the justice perspective of Kohlberg's theory reflects the moral development seen in males, but negates the care perspective reflecting women's moral development. Therefore, when using Kohlberg's tool, "the very traits that have traditionally defined the goodness of women, their care for and sensitivity to the needs of others, are those that mark them deficient in moral development" (Gilligan, 1977, p. 489).

Another major concern about the research using Kohlberg's theory is the reliability and validity of the instruments measuring various aspects of ethical responsibilities (Cassidy, 1991). Many of the nurse researchers using Kohlberg's theory have used Rest's (1974) DIT instrument. Rest (1975) and Kohlberg (1976) have admitted that Kohlberg's theory and the DIT instrument may be measuring different phenomena. Rest (1975) considers his test to be more of a recognition of exercise of moral reasoning, probably resulting in a higher percentage of stage five and stage six scores among the non-nursing population tested by Rest. The DIT instrument has been widely used in a variety of non-nursing populations and does have documented reliability and validity. However, because the DIT was based upon the assumptions of Kohlberg's theory, and given the criticisms of the theory, the validity of the DIT with nursing groups is questionable.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Ketefian (1981a, 1981b) developed the JAND instrument to measure nursing dilemmas, but its reliability and validity are limited. Ketefian (1989) reported that the subscale to measure idealistic moral behavior lacks reliability and should not be used for hypothesis testing. Accordingly, nurse researchers should interpret data obtained from the JAND with reservation. These reservations were confirmed in Cassidy and Oddi's (1993) replication research using the JAND. The NDT has been used in single studies only (Chrisham, 1981) and limited data has been reported on it. Cassidy (1991) states that further refinement of these existing instruments is clearly warranted.

Cassidy (1991) warns that given the conceptual and measurement issues addressed above, the findings of all the studies utilizing Kohlberg's theory of moral development should be viewed as tentative. The measurement of moral development among nurses based on Kohlberg's conceptualization may have underestimated the level of moral development among subjects because of the sex bias described by Gilligan (1982). The continued use of Kohlberg's theory as a conceptual orientation in understanding ethical decision making among nurses must be reevaluated.

Other theoretical orientations may help in more fully understanding the dynamics involved in fulfilling ethical decision making in CCU nurses. In contrast to Kohlberg's theory, which emanates from a perspective of separateness,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

autonomy, independence, and a reliance by the moral agent on universal moral principles of justice, Gilligan's (1982) work arises from a perspective of care. Gilligan's (1982) perspective of care comes from a posture of relatedness and the interdependent nature of relationships. For the females in Gilligan's (1977) research, goodness is service, meeting one's obligations and responsibilities to others, if possible without sacrificing oneself.

Lyons (1988) explains this morality of response and care in terms of individuals being connected in relation to others. Moral issues are couched in issues of relationships and/or of response. By using a perspective of care, one resolves moral problems in terms of how to respond to others and considers the following: a) maintaining relationships and responses, and b) prevention of harm to others, or relieving their burdens or suffering. This is usually done by considering what happened and whether the relationships will be maintained or restored.

Gilligan (1982) is careful to portray the relationship between justice and care as neither biologically determined or unique to women. However, this is a perspective different from the current psychological theories and measurement being used by nurse researchers. Gilligan (1982) clarifies that this perspective of care was defined by listening to both men and women describe their own experiences. Gilligan (1987) explains that justice and care are not opposites or mirror images of one another, with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

justice uncaring and care unjust. They merely denote different way of organizing the basic elements of moral judgment: self, others, and the relationships between them (Gilligan, 1987). These different perspectives have been analyzed in terms of the justice perspective standing back from the problem and the care perspective entering into the problem. Cooper (1989) states it is difficult to see both moral perspectives at the same time, because the terms of one perspective do not contain the terms of the other.

However, Gilligan (1987) asserts that the perspectives of care and justice do not negate each other but offer different perspectives for a more comprehensive moral perspective. Gilligan et al.'s (1982a) research confirms that people do articulate both justice and care, but focus on one perspective at the expense of the other, and is seen in both sexes.

Cooper (1989) cautions nurse researchers in assuming that Gilligan's theory provides a sufficient paradigm for the nurse in moral deliberation; rather an ethic of care should be understood as a necessary but not sufficient framework in understanding ethical decision making. Cooper (1989) states that understood in this way, Gilligan's distinctions are worthy of note by nursing given their illumination of ways in which the forms and experiences illustrative of the moral activities of nursing are displayed (p. 13). Relational caring might inform what

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

currently constitutes a rule and principle bio-medical ethic.

Gilligan (1982) and Watson (1985) share similar views in regard to caring. Watson assumes that nursing transpires within a framework of natural relatedness between the nurse and the patient. Watson also asserts that the human care process in nursing is connected to other human struggles. This is similar to Gilligan's definition of individuals as connected in relation to others. Both Watson and Gilligan agree that caring creates and occurs interdependently; it is a dynamic reciprocal interaction. Human beings are interdependent in nature, and the shared moments of the present has the potential to transcend time and space and the physical, concrete world (Watson, 1985). Furthermore, caring acts arise from one's choice to be caring, not from a helpless attachment to the other (Gilligan, 1986). Autonomy, to Gilligan and Watson, is represented by one's choice to be interdependent, a willingness to be cared for and to care for another.

Gilligan's (1977) research has provided a framework for nurses to explain the centrality of caring to their ethical practice of nursing. Furthermore, her research may provide a paradigm for understanding and explaining ethical decision making in nursing. Cassidy (1991) states that it may be appropriate to begin qualitative explorations of ethical responsibilities. The advantages of qualitative research in the area of nursing ethics include: a) the opportunity for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

nurses to identify and describe the ethical dilemmas that they actually encounter every day, b) an open ended exploration of ethical dilemmas that would better represent the complex nature of ethical decision making, and c) and the possibility of identifying a conceptual orientation for the investigation of ethical responsibilities that may be more appropriate than existing orientations (Cassidy, 1991, p. 118).

Millette's (1994) most recent nursing research utilizing Gilligan's framework to analyze nurses' stories of moral choices suggests that both caring and justice orientations are present in nurses' stories. However, these nurses perceived lack of power in the decision making process as the most common recurring theme. Powerlessness to effect ethical decisions was also a common experience of nurses in Erlen and Frost's (1991) research. However, the processes by which nurses arrive at ethical decisions are far from being fully understood. Further qualitative research on the processes of ethical decision making by critical care nurses in their practice will be helpful in the exploration of nurses' ethical decision making.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 3

Methodology

The qualitative method that guided the design of this study was grounded theory developed by Glaser and Strauss (1967). This inductive approach to research was best suited for this study since my interest was in how critical care unit nurses make ethical decisions. The use of grounded theory was most appropriate to facilitate the discovery of the basic social processes involved in ethical decision making among these critical care nurses. The strength of this qualitative method is in the process of induction, wherein the data emerge to provide substantive theory about ethical decision making among critical care nurses. This section sets forth research strategies, data management, and strategies for data analysis.

Grounded Theory

The grounded theory approach to qualitative analysis was developed by Glaser and Strauss (1965, 1968) in the early 1960's during their study of how hospital staff dealt with dying patients. Grounded theory uses field observations and intensive interviews as data collecting techniques. The researchers from this tradition assumed that change is a constant feature of social life and they

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

focused their attention on the social interactions and social processes of change.

According to Strauss and Corbin (1990), grounded theory is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon. The purpose of grounded theory is to build theory about the phenomenon being studied. The investigator does not begin with a theory, then prove it. The researcher allows the data to emerge and builds hypotheses or theory from it.

Grounded theory is the study of basic social processes (Glaser & Strauss, 1967) and assumes the existence of a process. Process research deals with two basic types of process: 1) socio-psychological, and 2) social-structural (Glaser & Strauss, 1968). Grounded theory studies these processes by using both an inductive and deductive approach to theory construction, wherein the constructs and concepts are grounded in the data (Field & Morse, 1985).

Induction refers to the actions that lead to discovery of a hypothesis (Strauss, 1990). These hypotheses are both provisional and conditional. Deduction consists of the drawing of implications from hypotheses for the purpose of verification. I was able to think effectively and propositionally about these hypotheses because I have experiences to draw upon in thinking about the data, and in making comparisons that further these lines of deduction.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Finally, I verified the data through knowledge about sites, events, actions, actors, procedures, and techniques. This knowledge is again drawn from personal and professional experience. Strauss (1990) states that all three aspects of inquiry -- induction, deduction, and verification -- during the grounded theory approach are essential. All three processes continue to occur throughout the life of the research project.

Research Strategies

Sample

I was seeking to understand the ethical decision making process among CCU nurses; therefore, snowball sampling was done. This method of sampling was used to obtain the support and assistance of a single informant already in the study to assist with the selection of another participant (Morse, 1989). The first informant interviewed was invited to suggest another participant, and the researcher used this referral to approach and invite the second person to be a part of the study. The first informant approached the new informant on the researcher's behalf. Thus, the selection of participants was partly controlled by the participants. The underlying assumption was that those within the group can recognize the insiders and the outsiders, know who is most knowledgeable about certain topics and, therefore, can recommend to the researcher the persons who could provide the most information and best interview (Morse, 1989, p. 119).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Initially, I chose to interview informants whose experience was considered typical (Morse, 1989). Then, as the study progressed and the description was expanded, more specific information was solicited from the informants. Finally, informants with atypical experiences were sought so that the range of experiences and the breadth of the concept of the phenomenon of ethical decision making among CCU nurses may be understood (Morse, 1989. p. 119).

At this point, I continued to sample until saturation was achieved and no new themes appeared in the data. Theoretical saturation was achieved after interviewing ten CCU nurses. No new or relevant data regarding a category emerged from the interviews and the information became redundant. Category development was dense, and the relationship between categories was well established and validated with ten CCU nurse interviews.

Basic criteria set for sample selection in this study were that informants be CCU staff nurses employed full time for at least one year in a critical care unit in an acute care setting. The participants were varied in the following characteristics: 1) type of critical care setting, 2) length of experience, 3) educational background, 4) gender, 5) age, 6) marital status, and 7) ethnicity. This selection process lent itself to investigating the ethical decision making process because all types of experiences with critically ill patients were obtained, such as: trauma victims, open heart

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

surgery patients, cardiology patients, and medical and surgical intensive care patients.

Characteristics of the Sample

Since the intent of this study was to learn about the ethical decision making process among critical care nurses, essential demographic information about the critical care nurse role was obtained. Questions were asked of each informant at the beginning of the interview. Participants were identified by initials only to protect their identity.

The majority of the ten participants had been practicing in critical care for five or more years. Most of these nurses had been employed full time in critical care for an average of 10 years. The range of ages of the individuals interviewed was 33-50. The average age of the CCU nurses interviewed was 41.5. Six out of ten participants were married and the remaining subjects were either divorced or single. The range of length of experience in critical care was 7 to 20 years. The average number of years' experience in critical care was 15 years among these CCU nurses. Nine of the participants were female CCU nurses and one male CCU nurse was interviewed.

The three types of basic nursing education represented in this sample were: diploma in nursing, associate of arts in nursing, and a bachelors of science in nursing (B.S.N.). Five CCU nurses had a diploma in nursing, three had an associate of arts in nursing and two CCU nurses had a B.S.N. One diploma nurse had a certificate as an adult nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioner. Two of the ten CCU nurses were pursuing higher degrees at the time of these interviews. The highest degree of nursing education held by a CCU nurse in this sample was a B.S.N.

I selected settings that facilitated inquiry into the area of ethical decision making (EDM) among critical care nurses. When considering the potential settings, I considered the suitability of the settings and the strategies needed to gain entry. Once the settings were chosen for their suitability for the study of EDM among critical care nurses, the methods of gaining entry and acceptance by the interviewees commenced. The nurses were interviewed in the hospital setting and at pre-arranged private meeting places in a private enclosed area. The CCU nurses encountered the following ethical dilemmas regarding the care of these patients: removal of life support, continuing treatment of end-stage chronically ill patients, restraining of patients, tube feeding of comatose patients, allocation of nursing resources and allocation of critical care beds.

Data Collection

Data was collected by the open-ended interview technique, analysis of relevant documentary films, and ongoing review of related literature (Glaser & Strauss, 1967). As data collection and analysis progressed and the process began to emerge, the interviews became more focused (Schatzman & Strauss, 1973).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

This study employed unstructured or semi-structured interviews as recommended by Morse (1989). This prevented me from reflecting preconceived ideas about the content or flow of the interview (Morse, 1989). I opened the interviews with the following question: "Tell me about the last time you made an ethical decision."

Additionally, I attempted to start out on a superficial level and increased questioning more in depth as relationships within the data emerged (Field & Morse, 1985). At the beginning of the interviews, I discussed the focus of the research and described how data from the interviews would be processed and analyzed. I explained that I would be audiotaping the interview. Finally, informed consent forms were read and signed by the interviewees.

The interviews were scheduled at times convenient for the informants, when they did not feel rushed or pressured (Swanson, 1986). The place for each interview was decided upon at the time each appointment was made. An office at the meeting site, or another private enclosed area was obtained for the field interviews in order to provide privacy and minimal distractions (Swanson, 1986). Interviews lasted approximately one hour in length.

Demographic data was collected from each interviewee at the beginning of each session. The demographic data collected was comprised of the following: 1) length of critical care experience, 2) length of experience at their present work location, 3) educational preparation, 4) age,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and 5) marital status. Demographic data was recorded at the beginning of each interview guide (see Appendix A).

Since salient parameters of ethical decision making among CCU nurses cannot be identified until several informants' stories are heard and analysis begins, active guidance or control early in the investigation would have been counterproductive (Morse, 1989). Thus, early interviews looked more like "guided conversations" (Schatzman & Strauss, 1973), and may be appropriately called interactive interviews.

However, as the study progressed, interviews became more focused and I used previous findings in prior interviews to guide me in looking for areas of commonality and difference in respondents' stories (Morse, 1989). Therefore, later in the study, interviews were semi-structured or focused. Additionally, I moved back and forth in the same interview from a very unstructured approach to direct questions which tested working hypotheses. I tried to achieve balance between flexibility and consistency in order to achieve the goal of assuring that as many informants as possible were asked questions that appeared to be important.

Ethical Considerations

In accordance with the guidelines established by the Committee on the Protection of Human Subjects, University of San Diego, the proposal for this study was submitted for and received full committee approval (see Appendix B).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

There was minimal or no risk to the subjects. It was anticipated that talking about unpleasant experiences with ethical decision making might cause temporary emotional distress. In the event that such emotional distress did occur, I planned to stop the interview and attend to the feelings of the participant. Time would have been spent in helping the CCU nurse explore these feelings and reach some resolution of the distress. If this approach did not aid the nurse, then arrangements would be made with a counselor to assist the CCU nurse with emotional distress (see Appendix D). Furthermore, at the beginning of the interview, the participants were advised that the interview could be terminated at any time the participant requested it, or if I felt it was in the best interest of the participant.

Participants received a consent form (see Appendix C) at the initial meeting. After the participant signed the consent, a copy of the signed consent was given to each informant. Information about the study was given before the actual interview took place and any questions were addressed before the consent form was signed. Questions were addressed as they arose during the study.

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

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Participants were made aware, through the initial phone call requesting participation in the study, that all interviews would be audiotaped and the tapes would be transcribed by a paid transcriptionist. However, no one other than myself 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 myself. All names, phone numbers of participants, and the audiotapes were destroyed at the end of the research study.

Data Management

Recording and Storage of Field Notes

Notes of observations and interviews were recorded on audiotapes. As soon as possible after the interview, I audiotaped observations bearing upon events experienced principally through watching and listening during the interview. Additionally, I recorded observations of myself and the methodological process. These audio tapes were then transcribed on my personal computer.

Transcribed notes for each interview were kept in a notebook separated by dividers and identified by code numbers. Data disks were kept at my home in a locked file. Subjects were identified in the notebook and computer printouts by code numbers. All research materials were kept in my possession at all times.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Validation of Data

Lincoln and Guba (1985) have argued that reliability and validity, terms used to refer to quantitative instrumentation, do not fit well when discussing rigor in qualitative research. However, data collected in the naturalistic paradigm should meet criteria for trustworthiness (Lincoln & Guba, 1985). In accordance, I took appropriate steps to insure the credibility, transferability, dependability, and confirmability of the data.

Morse (1989) states that qualitative researchers test reliability in the same way reliability is tested in a quantitative study where the variables change over time. Quantitative researchers have criticized the reliability of unstructured or open-ended interview, because it is hard to test reliability of that which changes over time. However, another method of testing reliability is equivalence, wherein two persons will listen and verify the information simultaneously. Equivalence in qualitative research may be achieved in some of the following ways.

Morse (1989) states that when key informants are interviewed over time, their responses to the same questions on the same topic should be answered with essentially the same information. This provides stability in the data. To test the reliability and validity of the recorded data, I tested the reliability of an informant by using alternate form questions with the interview itself, which provides a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

form of equivalency. Tape recording the interview instead of relying on my memory was another form of equivalence that I used.

Since the researcher is the research instrument in field work (Lincoln & Guba, 1985), methods for establishing reliability of the investigator must be used. Since I was alone and was not able to use equivalence with another investigator, equivalence was developed by working with the informants. Any conclusions or inferences drawn were verified with the informant.

Peer debriefing as described by Lincoln and Guba (1985) was utilized to strengthen the trustworthiness of the study. Lincoln and Guba (1985) describe this 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 by seeking a peer who was doctorally prepared and experienced in qualitative methodology, but neutral in terms of the population and topic under study. The peers reviewed all data to validate that the significant statements were reflective of the categories established by the researcher.

Credibility and dependability was established by ongoing discussions with committee members who are well versed in the grounded theory method and who offered critiques at all stages of the research study. These critiques aided me in enhancing interview techniques which best elicited responses to the research questions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Furthermore, I critiqued my interview technique with an eye towards assuring that my assumptions would not be imposed in some way.

Data Analysis Strategies

Data analysis was accomplished by using the constant comparative method described by Glaser and Strauss (1967). Data analysis occurs simultaneously with the data collection. I analyzed the data as I went along both to adjust the observational strategies, and thereby shift some emphasis towards those experiences which bear upon the development of understanding the phenomenon. Additionally, this exercised control over the emerging ideas by simultaneous "checking" or "testing" of these ideas (Schatzman & Strauss, 1973). Furthermore, as recommended in grounded theory (Glaser & Strauss, 1967), informants were interviewed and categories were filled until no further categories appeared and the material became redundant. At this point, I stopped sampling because saturation was reached (Morse, 1989).

Theory was generated through the process of coding, memoing, theoretical sampling, and sorting as described by Glaser (1978). Field notes were designed so that the left hand margin was left free for words or phrases that would denote categories or classes of events recorded. Each transcript of the interview was dated and copied, with each copy kept geographically separate to ensure precaution against mishaps (Schatzman & Strauss, 1973).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Field notes included observational notes (ON), methodological notes (MN), and theoretical notes (TN). Observational notes were statements bearing upon events experienced principally through watching and listening (Schatzman & Strauss, 1973). Theoretical notes represent self-conscious, controlled attempts to derive meaning from any one or several observation notes (Schatzman & Strauss, 1973). I interpreted, inferred, or hypothesized in theoretical notes. Theoretical notes were a preliminary analysis. The methodological notes were statements that reflected an operational act completed or planned, such as an instruction to the researcher, a reminder, or a critique of one's own tactics (Schatzman & Strauss, 1973).

I also prepared analytic memos by tying together several inferences in a more abstract statement (Schatzman & Strauss, 1973). These analytic memos were typed on paper of a different color in order to aid in quick retrieval. The analytic memos became the heart of my final set of ideas. The analytic memos developed and put closure to ideas or concepts (Schatzman & Strauss, 1973).

The first level of coding began with open coding, which is the process of breaking down, examining, comparing, conceptualizing, and categorizing data. I transferred these code words onto 3 1/2 by 5 inch note cards for ease in sorting. Two analytic procedures were basic to this coding process. These procedures were: 1) the making of comparisons, and 2) the asking of questions (Strauss &

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Corbin, 1990). These procedures gave the concepts in grounded theory their precision and specificity.

I approached open coding by analyzing each sentence or paragraph, and asking myself "what seems to be going on here?" Initially the names for the concepts were written on my field notes, then were transferred to the note cards for later sorting. Open coding involved labeling of phenomenon, discovering categories, and naming categories. An important source of names were the words and phrases used by the informants themselves. These terms are called "in vivo" codes (Glaser, 1978). Furthermore, categories were developed in terms of their properties and dimensions.

The next level of coding entailed axial coding. Axial coding began to fit the pieces of the puzzle together. During axial coding I suggested and verified relationships between categories and their subcategories in terms of the paradigm being examined (Strauss & Corbin, 1990). I attempted to link together and find connections between categories. The focus was on specifying a category in terms of the conditions that gave rise to it; the context in which it was embedded; the action/interactional strategies by which it was handled; and the consequences of those strategies (Strauss & Corbin, 1990).

Selective coding was the third step in the data analysis. I integrated concepts around a core category and filled in categories that needed further development and refinement (Strauss & Corbin, 1990). During this process, I

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

validated the relationships between categories. By reviewing memos and diagrams I discovered the evolving theory. At this point in data analysis it was helpful to ask the following questions: 1) What phenomenon are reflected over and over again in the data?, 2) What do I consider important about this area and why?

Finally, I developed diagrams in order to give visual representation of the relationships between concepts. By sorting and looking back over memos and diagrams and grouping them, I could tell what I wanted to know about ethical decision making and where further clarification was needed (Strauss & Corbin, 1990). These diagrams served as a model depicting the theory and were an aid in writing (Strauss & Corbin, 1990).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 4

The Process Model

The outcome of the grounded theory method is to generate a theory to explain and predict the process through which people experience a particular aspect of life. The focus of this study was to determine the process of ethical decision making among critical care nurses. The data collection and analysis methods prescribed by Glaser and Strauss (1967) and Glaser (1978) resulted in the identification of five major core categories, and a basic social process was identified. This chapter describes the evolution of categories and the basic social process as they evolved from the data.

This chapter will begin by describing the context of the ethical dilemmas faced by the critical care nurses in this study. The context of the ethical dilemmas evolved due to patient vulnerability that hindered autonomous decision making. Consequently, CCU nurses saw themselves as advocating for patients in situations where patients could not always make their own decisions or control their treatment plans.

The second part of the chapter will relate the intervening conditions which bear upon the action/

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interactional strategies used in the ethical decision making process. Intervening conditions may constrain or facilitate the strategies of the CCU nurse taken within the context of ethical decision making.

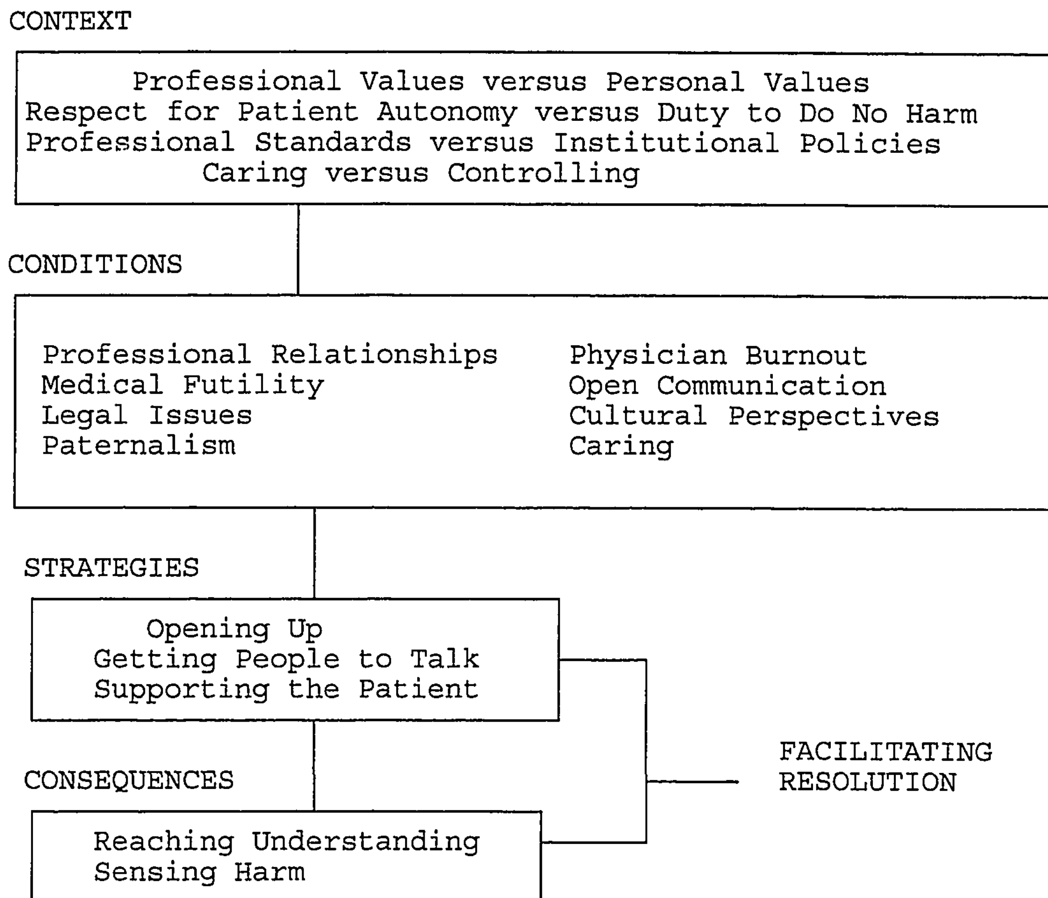
The third section of this chapter outlines the strategies taken by these CCU nurses in response to these ethical dilemmas, and the consequences of these strategies. Finally, the last part of this chapter will detail the basic social process, "facilitating resolution."

The Context of Ethical Dilemmas

Strauss and Corbin (1990) state that a context represents the specific set of properties that pertain to a phenomenon. The context consists of "particular sets of conditions within which the action/interaction strategies are taken to manage, handle, carry out, and respond to the specific phenomenon" (Strauss & Corbin, 1990, p.101). The context of the basic social process of "facilitating resolution" of ethical conflict among CCU nurses is outlined in Figure 1. The context of the ethical conflicts experienced by these CCU nurses can be categorized as: professional values versus personal values, respect for patient autonomy versus duty to do no harm, professional standards versus institutional policies, and caring versus controlling.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure 1. Facilitating Resolution of Ethical Conflict Among CCU Nurses.



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Professional Values versus Personal Values

An ethical dilemma involves a forced choice between two equally desirable or undesirable alternatives for these CCU nurses in their everyday practice in critical care settings. The CCU nurses in this study used situations which they defined as ethical dilemmas, but which did not always meet the above definition. All of the subjects mentioned conditions or factors about the context that were present for each patient while the EDMP was occurring.

SC experienced an ethical dilemma which she described in the following manner: "the CCU nurses had not been able to make the lady comfortable." SC was caring for a 46 year-old female in the CCU that had a diagnosis of terminal cancer and cardiomyopathy. The patient was dying of bone cancer and had developed cardiomyopathy from the chemotherapy she had been receiving.

The cardiologist on her case was going to insert a Swan-Ganz catheter, which is why she was in the CCU. The conflict developed around the issue of pain control.

> The cardiologist was giving the patient about "one third of her regular morphine, and the lady was screaming in pain. The man [the husband of the patient] was really upset by that time because her pain wasn't being controlled."

The husband asked SC to give his wife some additional morphine [in addition to the patient controlled analgesia pump administration of morphine]..."and I went ahead and gave her 5 milligrams of intravenous morphine."

The cardiologist came in 15 to 20 minutes later and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "found her unresponsive and apneic, so he started resuscitating her. We [CCU nurses] are standing around...you know, we didn't want to resuscitate this poor thing. Finally he [the physician] asked the husband 'do you want everything done?' and her husband said, 'No. We discussed this last night, and we did not want any extraordinary measures.' The doctor lambasted us for over-medicating her; in fact, he even used the word euthanasia."

SC saw another aspect of the conflict as being between the physician and the husband. SC told the physician, "You can't imagine how horrible it is to watch your loved one die from something like cancer." The physician told SC, "That's why it's not a family decision. It should be a medical decision because the family gets too emotional at a time like this." SC told the physician, "I strongly disagree with that."

SC's ethical dilemma contains several ethical conflicts: 1) lack of the CCU nurses' ability to control pain due to the physician not allowing more pain medication to be given, 2) conflict between the physician and husband over continuation of life support, and 3) the physician's perception that pain control in terminal illness was a medical decision and not a patient/family decision.

SC's lack of autonomy in her nursing practice to administer pain medication interfered with what SC deemed necessary to provide comfort for this patient. This part of the ethical conflict would fall under the heading of Personal Values versus Professional Values. SC's personal values about what constitutes pain control and her ability

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

to provide this were in contradiction to the professional values and standards that do not allow her the autonomy to freely administer pain medication.

In HK's ethical dilemma, a young male patient had Guillian Barre syndrome and was paralyzed. The patient became very depressed due to his paralysis and was suicidal; the patient did not want to live. The dilemma for HK in this situation was conflict between the patient's choice to live or not live and her own feelings of continuing life through a sense of God's wishes for the patient. As a professional nurse, HK would not act on the patient's wish to not live. However, the ethical conflict for HK arose out of her personal values versus her professional values.

HK's ethical dilemma involved a choice between her duty to help clarify the patient's own values and assist the patient to make a decision to live based on his own values, versus HK's convincing the client to follow her personal values. HK's statement to this patient demonstrates the involvement of her own values in the process of assisting this patient in making a decision to live. HK's personal values have entered the relationship and may alter the patient's choice. The ethical conflict stems from the value of promotion of life based on the nurse's values versus the ending of life based on the patient's values.

> "Look, you know what? Your life does not belong to you. It was given to you, and that is a gift. And the gift comes from the Lord. It comes from a very special...and you have to take care of it. It is up to Him to decide...If He saved you...It

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> is for a reason. You have a mission. You got your purpose in life."

The patient's having "a purpose in life" is a part of the context of EDMP that influences the CCU nurses' process of decision making.

Respect for Patient Autonomy versus Duty To Do No Harm

The ethical dilemma identified by LM was described as: "the dilemma was that the care that we were delivering was not put in the realm of what we, critical care nurses, considered caring for someone...providing her with comfort and care." A 99 year-old female was admitted to the CCU after having had a total hip replacement. This patient developed an infection that was resistant to treatment by antibiotics and progressed into pneumonia. The patient had an advance directive stating that she did not want to be kept alive in a vegetative state on life support systems. She also had a power of attorney (POA) for health care who had decision making authority for medical treatment. The problem was that the POA was blocking treatment of pain because he did not believe in narcotics for the relief of pain.

LM's difficulty did not derive from the advance directive nor from the designation of a durable power of attorney for health care, but rather from the inability to carry out comfort measures which she perceived as harmful to the patient. IN LM's interview she stated the following:

> "She had an advance directive...but the conflict for me wasn't so much between that advance directive,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> because my feeling is that people should be allowed to live until they die, and that doesn't mean that I should hurry them to die, but that I should try to do as much as I can to make whatever time they have as comfortable as I can."

Conversely, in AP's ethical dilemma the advance directive was present and led up to the ethical dilemma. In this ethical dilemma, a 78 year-old female had a cardiac arrest while driving her car. Unable to speak, as she was unconscious, she was resuscitated by paramedics and brought into the hospital unresponsive. The patient was intubated and put on a ventilator immediately, and never regained consciousness due to a stroke. Initially, the family wanted some treatment for their mother.

Within hours of admission to the CCU, it was discovered that this particular patient had a very detailed advance health care directive. The directive stated that she did not want resuscitative measures or life support measures, and it became a part of the chart within a few hours. Within a few days it became apparent that there would be no recovery for this patient and she continued to be non-responsive.

The actual ethical dilemma for this CCU nurse was that nobody paid any attention to the patient's wishes established in the advance directive from the beginning. This occurred despite her family's early objection to further life support measures. The family and her general practitioner knew she would not want this done to her. Yet the physician specialists wanted to and did continue

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

treatment despite these objections and knowledge. In this case, the following conditions precipitated this ethical dilemma for AP: having an advance directive which was ignored, "there was no hope of any kind of meaningful recovery", and the fact that "the woman could not speak for herself." AP stated:

> "In essence, no one paid any attention to this patient's wishes as spelled out in her Advance Directive and as insisted upon by her daughter who was the Durable Power of Attorney for Health Care and was physically present and asking the physicians to stop treatment...He [the neurologist] was making these judgments about the family and whatever, you know,...I know they [physicians] come from a different...but I think they need to be a little more sensitive to...when there's an Advance Directive."

Both LM's and AP's ethical dilemmas dealt with a conflict between respect for the patient's autonomy and right to self-determination and the medical and nursing profession's duty to do no harm. The Code of Ethics for the nursing profession and the medical profession is based on the ethical principle of protecting the patient from harm. This principle also spills over into the area of preventing harm and promoting good for the patient.

The POA for health care for LM's client interpreted "doing no harm" as not medicating the client with narcotics and keeping her alive, despite her wishes to not be kept alive in a vegetative state. The POA for health care in AP's ethical dilemma recognized that keeping her mother alive on life support was being disrespectful of her mother's right to self-determination. However, the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

physician interpreted his duty to do no harm as a duty to keep her alive on life support despite the fact there was no hope for a meaningful recovery.

In both instances, respecting the patient's right to self-determination through the expression in an advance directive was compromised, since the professional's duty and the POA's moral duty to do no harm conflicted with the values and wishes of the clients.

MI's ethical dilemma was similar to AP's in that the patient was intubated and put on a ventilator against her will. MI's elderly female patient was intubated and kept on life support against her will and was "tied up" to prevent her from extubating herself. The intubation "was done at a time when she was powerless over what was happening to her...and she got free one time and extubated herself immediately. The doctor came and reintubated her. But she didn't want it." MI stated the following about the ethical dilemma encountered:

> "I would say first and foremost, I guess, that the doctor is like the director. I think that if the doctor knows the patient well, then it will be a patient-directed thing. Some doctors just get the patient in the emergency room [and do not know the patient]. But some, it's been their patient for a long time and they know them. They are used to them and their families, and they know what they want."

Patients are sometimes subjected to a prolonged dying trajectory because of medical indications that they can be kept alive.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

DT described an ethical dilemma between a patient and her physician. The elderly Hispanic female was dependent on a respiratory ventilator for life support. However, if the patient was extubated, or removed from life support the "doctor felt that she would not live very long." The patient did not want to remain on life support, and was already designated a "no code" patient. A "no code" status meant that in the instance of cardio-pulmonary arrest she would not be resuscitated.

The ethical conflict evolved out of the physician's desire to continue life support systems even though the patient did not want it. The patient wanted to talk with her family and put closure to her life and relationships. This communication was impossible while she remained on life support due to her inability to verbally communicate. DT describes the actions taken after resolution of the ethical dilemma:

> "She was a 'no code' and had a big family... A Mexican family, and she wanted to be able to say something to her children. So the doctors felt that to wean her and extubate her...she would not live very long. So they [the family] gathered around the bed...the whole room was probably full of 25 people. So we pulled the tube out, and she took on one at a time, and told them what she expected of them, what she wanted them to do in life, now this is grandchildren, great grandchildren. All the way up to the older children. It was about four or five hours after that that she died. That was real neat to get involved with the doctors [in the EDMP]."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The conditions that led up to this ethical dilemma of "pulling the tube out," or removal of life support systems were: a) conflict between the physician's desire to prolong life and the patient's desire to be removed from life support, b) "probably would not live very long" after extubation, c) the patient wanted "to be able to say something to her children", and d) the CCU nurses' ability "to get involved with the doctors." Often the CCU patient has been unable to speak due to medical interventions for life support, but is conscious and communicating in a non-verbal fashion just prior to the EDMP.

In another ethical dilemma, BG describes a CCU patient that was chronically ill and in a skilled nursing home. This patient had an advance directive wherein the decision was made by this patient to "not be maintained on life support." However, in the emergency room, in the event of acute respiratory distress, the patient got "air hungry," and "panicked and decided that she wanted life support for breathing."

The emergency room physician "felt very uncomfortable and felt like she was asking for help and he needed to provide it, so she got intubated. Finally, after she realized she was not getting any better in getting off the machine, she wrote down on paper that she wanted to be taken off the breathing machine and that she wanted to be able to die in peace."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Similar to the ethical dilemmas described by SC, MI, DT, AP, and LM, BG's CCU patient had an advance directive, and was unable to speak in the face of being on life support systems. Five of the six CCU patients were unable to speak due to being intubated, and two out of the six patients were unconscious and were dependent on durable power of attorneys for health care to make decisions for them.

BG's ethical dilemma is unique from the other five CCU patients in that the patient changed her decision twice while being hospitalized about being on life support systems. This is only possible if the patient is conscious and able to communicate in some fashion to the CCU nurse. Several of the interviewees described the condition of respect for the patients decision in the advance directives executed by these patents.

During the interview BG stated: "Actually the physician asked me to find out what the patient wanted and to have her write it. He asked me to do that for him. He said 'we need to have a conference'."

BG related to the interviewer that she "explained to the physician what the patient had done and that she had written me this note. At this point the son was going to come in and talk with the physician personally, along with his mother, about what she really wanted and they were going to make the final decision and then...they took her off the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

breathing machine and she thrived and she was able to move out of the CCU that day."

One other participant, CG, talked about asking a son about life support systems for his parent and she stated the following:

> "I mean he was very upset because it's a very difficult issue for him to deal with. But it was something I had to bring up. 'Well, if something happened, would you want us to do CPR or how far do you want...what would you like us to do?'"

CG reacted to this by stating that this was a "hard topic for people to deal with because it's like playing God." CG stated that this is a particularly hard topic to deal with in the context of relationships. Underlying the context of culture, religion, and health beliefs is the foundation of respecting the patient's autonomy and right to self-determination.

DLT experienced an ethical conflict when obtaining an informed consent for thrombolytic therapy. The client did not want to receive the thrombolytic treatment. However, the paternalistic environment within which the treatment choice took place was a strong condition that influenced this CCU EDMP. In this ethical dilemma, the physician was encouraging the patient to have the thrombolytic treatment instead of surgical treatment which the patient preferred. The physician may have unduly influenced the patient's choice.

DLT did not act to protect the patient, by interfering with the informed consent process, before the treatment was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

administered. The consequence of the treatment was a cerebral vascular hemorrhage for the patient, and within two months, death occurred. This was the most devastating factor for DLT. However, she recognized competing principles within this ethical dilemma as demonstrated by the following statement:

> "I think it is the duty to do no harm. There are competing principles involved. Probably several. One of them being his autonomy. Of course, that is debatable, if we are autonomous at all. But if he was able to make his own choices freely, and the other thing...and the preventing harm, and the trying to do good for him."

After the outcome or consequences of this ethical dilemma, DLT could recognize that there were several competing ethical principles involved in the context of this event.

Professional Standards of Practice versus Institutional Policies

MI also mentioned the properties of autonomy of practice and legal threats as conditions that influenced the EDMP just as LM and AP did. MI compared her autonomy in nursing practice in Scotland, before she emigrated to the United States, to that in nursing practice in the United States:

> "I think in the past that that, [fear of reprisal as a reason why nurses have not played more of a role in participating in EDMP] would have maybe been more like the doctor to talk to them about it...from my point of view, it's a kind of thing that as nurses, many years ago, in Scotland we did. We were much more... the nurse did...we made many more independent decisions, and I really noticed when I came to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> America that it was this legal threat looming over you continuously that makes people very ...even like, retreat rather than...instead of being confrontive or being assertive, it's like, well, you just never know."

Furthermore, MI went on to describe conditions of decision making in Scotland as compared to America.

> "We used to give pain medication [when the patient needed it]. A lot of times we made decisions like that. Not like here...we didn't have written orders that said you couldn't do that, so a lot of stuff we did...just like if people were at home. You had a headache, you take Tylenol. We could do that kind of thing. And plus the fact that being a nurse was noble and much admired profession. People really did look up to you."

MI went on to describe a fear of reprisal for nursing interventions in the United States that might lead to ethical conflict.

> "And the feeling that the superiors would not support you and I think that a lot of nurses really kept quiet when they could have been a lot more verbal, but were mute because they had...were in kind of a limbo a lot of times."

Hospitals, as employers, have an obligation to facilitate professional practice standards and to allow for discretionary professional judgments. However, the hospital also has the authority to administer policies and maintain adherence to these policies. If the CCU nurse perceives a conflict between her professional standards of practice and the policies of the institution, this may lead to an ethical dilemma. According to MI, she feels that her "autonomy of practice" is limited and that "legal threats loom over her continuously." Consequently, CCU nurses "were mute...

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

because they were in a kind of limbo a lot of times" due to institutional policies.

The nurse-employer relationship predicates that the nurse has an obligation to her employer which may supersede the nurse's professional responsibility to the patient. Institutional financial constraints sometimes hinder CCU nurses from giving the excellent care they have a professional responsibility for. The historical domination of nursing by repressive institutional policies often leaves the CCU nurse conflicted between the obligation to the employer and the obligation to the patient.

Institutional policies regarding overtime was a condition that led up to this ethical dilemma for HK. HK described this ethical dilemma which involves her role as an employee. In this dilemma it is the interest of the nurse/employee versus the interests of the employer/hospital. This dilemma evolved out of a lack of time to complete all care needed for HK's patients. HK states:

> "Guess who is always getting off late? Me. Because I have a tendency to be more close to the patient and observe. Even though they say, 'Oh, you don't have to go and assess the patient completely...just assess the problem'...My license is in jeopardy. But sometimes when they say you have to leave...you have to go. And then they tell you...'you are slow'."

In a second similar ethical dilemma, which revolves around staffing and assessment issues, HK is torn between

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

caring for a patient in crisis and the care of her other patients.

> "All of a sudden she [the patient] was complaining of pain...[after medicating the patient] I could not arouse her. So I started assessing her...then her blood pressure started dropping down...and in the middle of all this, I have my other patients, and watching this one too."

Conversely, in this situation the supervising nurse supported HK after the events described above. HK said the following occurred:

> "The charge nurse was very impressed, by my way of handling this situation. She told the supervisor that I was going to be late because of this problem. She was supporting me a lot. She said 'Don't worry about staying late, I will sign your card for over time,' and I thought, gosh, that's nice of her. Because she knew I was working. But others, they don't care. They don't care. That is what I really resent...At least tell me and I will choose."

HK's perception of what the source of this second dilemma was described by her as:

> "Yes, the system pushing the nurses to not be nurses, just doing mechanical work without feelings. Without being a little bit human. That is not a nurse to me. Just a simple person that just gives shots...gives pills. But in the frame of time that you have, you don't have time to come back to see if the patients are worse...you are missing something."

In this ethical dilemma for HK, wherein the "system is pushing nurses to not be nurses," HK feels an ethical conflict between professional standards of practice and the duty to the employer. The context of the nurse-employer relationship, wherein "the system pushes nurses to not be

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

nurses" precipitated this ethical dilemma of choosing between the duty to patients or the duty to the employer.

The ethical dilemma described by MBW was: "nurses going ahead and taking care of the [medical] orders for seizures without calling the physician throughout the night shift. "Because he [the doctor] did not really want to do it. It was obvious he did not want to do anything more for the patient. This was made clear through the physicians statement of, 'Don't call me again tonight'."

The crux of the ethical dilemma here for MBW "was the nurse's liberty to write orders, not to wake the physician up in the middle of the night on things that probably didn't make any difference." MBW said, "I think we [CCU nurses] can make those kind of judgments." The dilemma was not the nurse's actions, but writing orders for physicians in order not to wake them up in the middle of the night. The nurse's professional judgment and patient care were put in conflict with the institutional policy, and the legal status of the nurse practice act.

Caring versus Controlling

LM put the terms of her ethical dilemma into her own words:

> "the dilemma was that the care that we were delivering was not put in the realm of what we CCU nurses considered caring for someone ...providing her with comfort and care. We could not provide the kind of caring that we wanted to for several reasons: the physician and the power of attorney were kind of controlling the game, and they wanted things followed their way. But they were not

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> there watching daily and seeing the reactions and the responses that we [CCU nurses] saw."

Who is "controlling the game" had a lot to do with what LM considered "the kind of caring that we want to" give to patients.

The second ethical dilemma described by MBW involved an incident where MBW made an assessment in a critical event on a post operative trauma patient and she ordered her own hemoglobin and hematocrit to ascertain the current hemoglobin and hematocrit of the patient. MBW was angered that the physician did not think to make this medical order and she had to order it for the patient. MBW stated, "I guess the problem was I don't know why they are practicing medicine if they don't care about the patient." MBW went on to say:

> "If they are not going to follow through, then they should not be practicing. And...the anesthesiologist was very nonchalant, like he could have cared less. He couldn't wait to get out of there. She had needed the 1500cc..."

The ethical dilemma for MBW was the lack of care to follow through on a patient that needed a medical judgment. MBW was forced to choose between using her nursing judgment to obtain data that required a medical order and following the medical orders which omitted these data. Caring enough to follow through for the patient versus control of the medical care for this client was the ethical issue for MBW. MBW had to choose between subservience to the medical plan of care versus caring enough to use independent nursing judgment.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CG's comments about the caring part of the ethical dilemma deals with an affective response of "caring." In CG's ethical dilemma, the physician became angry with CG because she used her nursing judgment to obtain laboratory tests to determine a patient's respiratory status in an emergency situation. The physician was angry and refused to respond to the abnormal data. He did not act on the information. Within two days the patient expired. Furthermore, CG went on to state the following about the physician's attitude:

> "I think he [the physician] is burned out. I think they just get burned out and they just don't care anymore and they don't want to deal with it and they don't want to know any bad results, because if they do, then they will be angry that they will have to deal with it."

Critical care nurses' EDMP can only be understood in the context of these ethical dilemmas described above. The context of these ethical conflicts contain conditions that either facilitate or constrain the strategies of these CCU nurses to resolve them.

Intervening Conditions

Strauss and Corbin (1990) state that intervening conditions may be thought of as the broader structural context pertaining to a phenomenon, such as EDMP. These intervening conditions may act to either constrain or facilitate the action/interactional strategies taken by CCU nurses within the context of EDMP. The intervening conditions described by these interviewees will be presented

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

as constraining and facilitating conditions in the ethical decision-making process.

Constraining Conditions

Constraining conditions act to inhibit action/ interactions that CCU nurses would take to resolve ethical dilemmas through the EDMP. The constraining intervening conditions related to me by the CCU nurses were: a) Professional Relationships, b) Medical Futility, c) Legal Issues, d) Paternalism, and e) Physician Burnout.

Professional relationships. Conflict between physicians and nurses often arose in the data. In CCU psychodynamics most doctors are male and most nurses are female. The traditional nurse-physician relationship has historically been pictured as the nurse being passive and subservient to the physician. The conflicts described by MBW between these health care practitioners often relate to gender stereotypes.

MBW made a statement in reference to sexism and culture she encountered during an ethical dilemma. The dilemma involved calling a physician to order some electrolytes on a patient who had an electrolyte imbalance and was 4000 cc behind in his intake and output. The physician was angry that he was called.

> "I just wonder if it's because he's [physician] not sure of himself, or he doesn't like being reminded by a nurse that he did not do something? His culture is different from the nurse's culture and he has difficulty, I think, relating to Americanized women. It's a male-female thing and he is not used to women or nurses being

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> assertive, or willing to pick up on their suggestions. And I still think there's a lot of sexism, whether people want to admit that or not...[sexism between the decision makers]."

The low value accorded to the nurse's opinion on patient care decisions and her knowledge base have been shaped throughout nursing history by the male dominated medical culture. The medical model has set values determined from their own perspectives of knowledge and truth.

MBW states her perspective on knowing what should be done: "I think the dilemma is that we [CCU nurses] know what should be done and we go ahead and do it just to cover for them [physicians], because we know that if we don't, something is going to happen to the patient. What if we didn't get the laboratory work that was needed?" MBW stated that she felt "frustrated" because:

> "They [physicians] are the ones that should be writing the orders and not the nurse and they are shirking their duties, physician's duties."

MBW inures that lack of respect between nurses and physicians may be an operant condition in reference to the ethical dilemmas she encountered:

> "If we hadn't have done anything, we would legally have been neglectful, because we knew better. Yet physicians don't respect our knowledge".

This "lack of respect" from physicians for the CCU nurse's "knowing" somehow seems to have contributed to MBW's frustrations. Also the "covering up for them" [physicians] also seems to be linked to the frustration that MBW feels.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The conflict was also brought up by MBW in the statement, "I think caring should be part of a physician's job as well as a nurse. I care about how I take care of my patient."

This lack of respect between disciplines is also intra-professional as described within AP's ethical dilemma. "The hierarchy" is a term that describes an intervening condition that leads up to this ethical dilemma. The general practitioner was ready to withdraw life support and the neurologist was not. AP revealed this during the end of the interview:

> "That Tuesday he [general practitioner] wrote that progress note. That as far as he was concerned...they should withdraw [life support]. But, you know, how the hierarchy goes [medical hierarchy], once you call the specialist in, you have to...[subvert to them]."

The intervening condition of "the hierarchy" suggests that there is a pecking order within the medical profession that may promote ethical conflict even between physicians. In this ethical dilemma, a conflict between a generalist and a specialist develops over continuing life support. Although essential for coordination of care, as well as for the sake of efficiency, the hierarchy of authority even within the medical arena produces, among the less specialized physicians, feelings of inequality and apathy towards achieving the goals this patient had outlined for herself in the advance directive. This intervening condition could be labeled a constraining condition. In other words, it does not facilitate EDM.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In MI's ethical dilemma, the patient was intubated and put on a ventilator against her will. MI's elderly female patient was intubated and kept on life support against her will and was "tied up" to prevent her from extubating herself. The intubation "was done at a time when she was powerless over what was happening to her...and she got free one time and extubated herself immediately. The doctor came and reintubated her. But she did not want it."

MI went on to describe a fear of reprisal for nursing interventions, that is like a silencing of the nurse's voice in an ethical dilemma such as the one described above:

> "And the feeling that the superiors would not support you and I think that a lot of nurses really kept quiet when they could have been a lot more verbal, but were mute because they had...were in a kind of a limbo a lot of times."

Medical futility. CG talks of the reasons physicians find it so difficult to "quit when there is no hope":

> "Death is...discussing death is for anybody... [hesitation on CG's part occurs and then CG changes the focus to]...we are all trained to save lives, and are educated to do our best, and maybe if you did not give it forever, you would think you weren't doing your best and you wouldn't feel good about yourself. Maybe that's part of it."

The manner in which health care workers are educated impacts the decision making according to CG. Training "to save lives" and "to do our best" created a constraining condition in these situations in which continued treatment was no longer indicated.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

A reference to a religious or philosophical belief about life in the context of these types of ethical dilemmas was made by CG. Despite what CG experienced in the above ethical dilemma, CG reflects on the opposite ethical dilemma wherein the physician continues to provide life support in futile care situations.

> "A life is...depending on your view of life... that it's still a life. And we are not animals. So I see them wanting to do everything. I know they base it on prognosis and I can see them trying... at least giving it their best shot for a certain period of time, you know...but what's that certain period of time?"

MBW relates a conversation between a physician and herself regarding a CCU patient's care:

> "The physician said, 'well he's going to die anyway.' [MBW responded with:] 'Well why did you do the surgery? Why not just keep this man comfortable? If people are not going to make it, then we need to offer them other interventions instead of torturing...and I think we do that a lot'."

Aggressive medical treatment in futile care cases, such as the one MBW described above, brings about the condition of "torturing." According to MBW the context of "torturing" surrounds the interactions or actions that constrain the EDMP. When the investment of resources appears disproportionate given the marginal benefits likely to be obtained in these cases, MBW feels that nursing and medicine should offer other or alternative interventions, such as comfort measures.

In this case scenario, the physician admits that "he's going to die anyway." The futility in the nursing and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

medical care of these patients creates an environment or condition of a lack of comfort called "torturing" by MBW.

Legal issues. AP gave further elucidation to a constraining condition that was interfering with a more expeditious decision in this case. AP stated the following:

> "The neurologist stated that he thought it was hopeless and why he wanted to give her another 48 hours, I don't know. Just to make him feel better about...believing the family that this is...or maybe to protect himself against... maybe that's a self-protective thing. Maybe their lawyers have told them that the family can change their mind at any time."

The legal system has contributed as much to the decision making made by medical practitioners as the medical education system. In this case, AP voiced concern that perhaps the neurologist was basing his medical decision to continue to treat, even in the face of no meaningful recovery for this patient, upon legal constraints to his/her practice.

BG talked about the "legal aspects" of this ethical dilemma for the CCU nurse and physician:

> "I think the reason this one [ethical dilemma] might have been a little bit different, was because of the fact that this had already been established once before in a power of attorney situation. The fact that the patient sort of went against what she had already committed herself to, the whole situation needed to be rewritten again for legal aspects."

AP also talked about the legal aspects of the EDMP in the narration of her ethical dilemma. The difference between BG's dilemma and AP's dilemma is that the medical doctors were ignoring the patient's wishes in her advance

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

directive. In AP’s dilemma the patient was unconscious. BG’s patient was conscious and still able to communicate in a fashion about her wishes. BG also compares these conditions in an account of her previous experiences:

> "So legalities of the whole situation might have been a little bit unique...but I’ve been in situations before where making a decision on a ‘no code’ and withdrawing support was made purely on the decision of the family in a patient care conference and the physicians...health care workers in general."

Paternalism. Paternalism was described as a constraining intervening condition that led up to the ethical dilemma that DLT encountered. A middle-aged male patient in the CCU had a coronary artery bypass graft (CABG) several years prior to the chest pain that he was now having. The cardiologist caring for the patient wanted to try thrombolytic therapy to open the occluding coronary vessel. However, the patient wanted to have open heart surgery to correct the problem of chest pain.

In order to start the thrombolytic therapy, a consent for the procedure had to be signed. DLT was the nurse caring for this patient and had to obtain the consent for the procedure. The patient was hesitant and reluctant to sign the consent for this treatment. Reluctantly, he signed it and then had a terrible outcome from the thrombolytic therapy, wherein he suffered a cerebral vascular accident (CVA) and died one and a half months later.

DLT said she felt like the patient was being coerced into agreeing with the thrombolytic therapy. DLT "felt like

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

he really didn't want it to begin with and we just kind of convinced him." DLT stated, "It's just always bothered me. Because I think I was part of the convincing. We are supposed to be doing good for patients and we were actually harming him."

The conditions and events that preceded this ethical dilemma described by DLT were as follows: 1) "he was hesitant and reluctant" to sign the consent, 2) "he was educated enough to know what all of it was about, or at least what the CABG was about," 3) the "patients history of having gone through the CABG before," and 4) "this particular cardiologist is very involved with companies that are producing thrombolytic therapies," i.e., a conflict of interest.

Paternalism was described best by DLT in the following statement:

> "I just wondered if things had been presented to him differently, maybe more objectively, where this option...this option, and this option [were explained to the patient]...this one has these good and bad [points], rather than someone saying ...because he knew what some of those options were and not that they were not presented to him, ...but they were presented [to the patient by the doctor] in such a way as this is what I think is best [for you]."

DLT goes on to say that she believes that part of the ethical dilemma is that certain cardiologists are involved with pharmaceutical companies in research studies, or are trying certain treatments under the influence of drug companies.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Physician burnout. CG's ethical dilemma also concerned the issue of calling a physician at night for orders to treat a patient's abnormal arterial blood gases. The physician was "irate" that the CCU nurse had used "her own decision making processes" to get a blood gas despite the fact that the patient was in distress. The physician was angry because he had to deal with the data. He chose not to deal with the data and hung up the telephone on this CCU nurse. CG felt as if the physician "did a real disservice to this lady. The lady ended up coding and dying in the next day or two."

It really "bothered her that they did not do all they could for her." CG said she saw the ethical conflict as being "if there was no hope for this lady, then they should be up front and give the family and the patient the options and decide what to do from there. Let the family decide to go all out or to try for...but to not give the lady her best shot from the very beginning, I think is wrong."

The summation of this ethical dilemma for CG was the omission of treatment, and not giving the patient/family the choice of not treating. Furthermore, CG was angry at the doctor for putting the nurse in a conflict position between the physician and the patient.

In CG's ethical dilemma outlined above, CG questions:

> "How can they [physicians] turn off the caring? I mean, how can they just turn it off and on? I think he's [physician] burned out. I think they just get burned out and they don't care any more and they don't want to deal with it and they

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> don't want to know any bad results, because if they do, they'll be angry that they'll have to deal with it. I know they're [physicians] pulled in a thousand different directions, I know they have a lot of responsibilities, but to me, they build up a wall so big that they only let so much in, so that they can deal with it and they can cope personally with it."

CG went on to explain the difference between caring and burnout:

> "[if you are caring]...you might be faster to jump on abnormal labs. Or abnormal changes. I think we all think of ourselves as caring. ...Because I see a difference in how aggressive interventions are and...[how much sooner a decision was made]. 'cause that [burnout] goes along with caring. 'Cause if you're burned out, you don't care. You don't act on things as quickly. And you don't intervene maybe when you should."

CG continued to relate how she thinks these two conditions, caring and burnout, impact EDMP:

> "And maybe burnout sometimes can mean... can even go the other way and maybe not cut something [life] short when it should be cut short because you don't want to have to deal with it, so you just let it prolong day after day after day, and you don't come to decisions, 'cause you don't have the emotional energy to deal with the family and the decisions that have to be made. So I think it goes both ways."

Facilitating Conditions

Facilitating conditions are events or conditions that make the EDMP less difficult and promotes resolution. The facilitating conditions that the interviewees described are: a) open communication, b) cultural perspectives, c) caring, and d) respect for religious values.

Open communication. CG relates the importance of open communication between the physician and the CCU nurse:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "If I know what the physician's thoughts are behind these interventions [or lack of interventions], then I have a better...I know what things are important for that physician to know...and I know what things are important to do for that patient and or the family of that patient and I know how to best support that. If you only knew what their goal..."

CG stresses the importance of "knowing the thoughts/goals of the physician" and "supporting" the physician and family. Assessing another's perception's and feelings requires openness to others' knowledge which promotes creative problem solving.

In AP's ethical dilemma an elderly woman was driving her car and had a cardiac arrest. She was resuscitated on the scene and brought to the hospital. She suffered a stroke and became unconscious and uncommunicative. The patient's advance directive stated that she did not want to be maintained on life support, which occurred. Going against the patient's directions became an ethical dilemma for AP. AP stated:

> "Knowing the patient is important to prevent this type of ethical dilemma from occurring. The family was angry at the neurologist, in particular...Her general practitioner knew her wishes and he wrote in his progress notes that he knew the patient and he knew that her wishes would be that she would not want to have a feeding tube, she would not want to live in this state."

CCU nurses often know what should be done in their ethical dilemmas. MBW spoke of CCU nurses knowing what should be done:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "I think the dilemma is that we [CCU nurses] know what should be done and we go ahead and do it to cover for them [physicians] because we know that if we don't, something is going to happen to the patient."

In MBW's ethical dilemma, a physician omitted ordering a laboratory test for a patient after her surgery, when it was clear that the patient needed to have this laboratory test done to determine if fluid replacement should occur. MBW obtained the laboratory test on her own recognizance and administered the fluid the patient needed until the doctor could be notified of the low hemoglobin and hematocrit and blood could be ordered for this patient.

CG thinks communication between the physician and nurse, and physician and physician, before talking to the family would be good. CG states that she knows the following:

> "At [some institutions] they have patient care conferences every day...to at least be in agreement before you go in there and talk to the patient's family and/or the patient, because they get conflicting views."

"Being in agreement" is a necessary part of the relationship between health care workers and participants in the EDMP. "Being in agreement" evolves from a certain quality of communication between participants involved in the ethical dilemma. "Being in agreement" also connotes inter-subjectivity. More than one person is involved during this part of the process of making ethical decisions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Clarification of resuscitation status. The facilitating condition in this ethical dilemma for DT was described in these words:

> "She was a no code, and had a big family...A Mexican family and she wanted to be able to say something to her children. So the doctors felt that to wean her and extubate her...she would not live very long. So they [the family] gathered around the bed...the whole room was probably full of 25 people. So we pulled the tube out, and she took on one at a time, and told them what she expected of them, what she wanted them to do in life, now this is grandchildren, and great grandchildren. All the way up to the older children. It was about four or five hours after that that she died. That was real neat to get involved with the doctors [in the EDMP]."

This dilemma required DT to convince the physicians to remove the endotracheal tube, the life support system, and medical treatments that were keeping the patient alive. The patient was a 'no code' status, which meant that no resuscitative efforts would occur if the patient went into a cardiac arrest while on the ventilator. However, 'no code' status does not mean that life support systems already in place would be removed.

Since this patient wanted to speak to her loved ones, in order to communicate parting words before her death, this could only be accomplished by removing the endotracheal tube. Additionally, this patient could not be weaned from the respiratory life support system. Through communicating to the physicians the wishes and desires of the patient, DT was able to resolve the dilemma of inability to speak and communicate for this patient in the last hours of her life.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The presence of the 'no code status' made the resolution of this ethical dilemma easier for the physicians and DT. A decision had been made earlier to not resuscitate the patient in the event of cardiac arrest or respiratory arrest. In other words, a preliminary decision making process made this final decision easier for the parties involved to follow the wishes of the patient.

Patient care conferences. HK also talked about a patient care conference when she talked about the ethical dilemma concerning the young male Guillian Barre patient that wanted to die. HK, the other nurses, the physician, and the mother and brother had a patient care conference about this client because he "was a very difficult patient." HK stated:

> "Well actually we requested a team conference because he was getting on our nerves. It was getting to the point where everybody was refusing to take care of him. Even myself, I got my doubts, many times. I am a human."

The recurrent message from HK, CG, BG and DT was that the patient care conference was the setting and condition that surrounds and facilitates the EDMP. Patient care conferences improved communication and decision making by providing prognostic information, elicited patient and family preferences, and increased the understanding of disease prognosis and treatment.

Cultural perspectives. BG believed that practicing in the location that she does, and dealing with different cultures of clients, "we health care workers need to find

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

out a little bit more information about how to make the situation a positive experience for everyone." BG went on at length about an ethical dilemma that occurred with a client of an Asian culture.

> "In one case that we had where they had decided that they didn't want their loved one to be on the breathing machine, we needed to make sure that they clearly understood that when the machine was stopped and the tubes were taken out, there was a possibility that the person could die... immediately. The question was asked several times in different situations. Where it was asked by the nurse, it might be asked by the physician. But then also again, it was asked in a group setting, in a conference setting. They understood that."

In respect to taking the tubes out and the finality of the situation, BG describes the Asian family:

> "The family was in the room when we were taking the tubes out because they knew that he could die quickly. They wanted to be there. We couldn't get the tubes out fast enough. One of the family members had taken the foley catheter out with the balloon inflated. That catheter bothered them. I think it was because it was stuck through the penis...like it was a desecration. As if that...the body is a temple. I am not really sure. I don't know that much about [their nationality]. They were either Laotian or Vietnamese. No sooner than I...Oh! they were pulling those tubes out. That was one of the first times anything like that had ever happened to me. They were all in the room and I had to shut the door...and they were very ceremonial. They all wanted to be right there, the ones that were able to deal with it, wanted to be there...We had to close the door, because they get very vocal".

This cultural experience with the end of life ethical decision making that occurred around the removal of life support systems impacted BG to the point that she said the following:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "I think nurses and physicians need education and understanding about the cultures and how they feel about death and how do they feel about life support. I kind of get the feeling in the Hispanic situation, maybe they feel like nature has to take its course. Even though the machine is there or not there...I think because of our geographic location, we need to do some work on the Asian and the Hispanic situations because that's the future of California."

A client's socio-cultural orientation is a condition that can influence the basic social process of ethical decision making in the health care setting. Careful assessment of this condition before the EDMP occurs appears to be a critical factor for BG in her CCU practice. DT and MBW also discussed culture as a condition that existed in their ethical dilemmas also.

While it is good for human beings to be healthy, medicine's role is limited. Medicine can not solve or even cope with cultural problems dealing with health beliefs. The definition of health and health beliefs are different for everyone. For instance, BG feels that practicing nursing in the geographic location one does should demand understanding the culture of that location:

> "We [CCU nurses] need to find out a little bit more information about how to make the situation a positive experience for everyone."

BG demonstrated an appreciation for the existence of a cultural/spiritual force that the patient/family experiences during the ethical decision making process. BG takes into consideration that each person has their own frame of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

reference for this subjective experience of "God" and how "culture" influences this experience.

BG described an ethical dilemma that involved a Hispanic lady. One of the woman's daughters was totally ready to let her mother go and the others in the family could not make that decision. BG stated the following:

> "I think there's a lot of spiritual pressure. I'm not sure what the Church is advocating, the Catholic Church...Hispanic people are... the majority follow the Catholic religion. You have the families that can not make decisions... possibly they just don't want to have the burden of the decision. The fear of making the wrong decision. The fear of playing that God figure possibly."

The family's "fear of playing that God figure" is explained by this informant as being connected to their religious values and may contribute to the inability to arrive at a decision. Some persons may interpret their religious values in one way and others have another perception.

Respect for religious values. In DT's ethical dilemma the condition of religion was also present. DT stated:

> "And some of it is religious...you know they bring up the religious part of it. We [CCU nurses] say if you believe in God...even as we decide to make a 'no code'...God is making that decision whether he is going to live or die because if the heart stops and he wants him live, he is going to live no matter what we do...there is the religious part that you can bring up to help them feel a little better about making the decision [to make their loved one a 'no code' or remove life support systems]."

BG brought up the condition of the patient's religion and the topic of God in her dialogue in reference to the end of life decisions related to her ethical dilemma:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "Depending on the circumstances, we are not God. I mean, we can only say that from our experience this is what we have seen... but there are times when you never know. You could be that one percent that turns around. So if you have given...if there is a glimmer of hope, if you are looking at this patient to be that one percent that survives, the situation can be prolonged."

In this context BG speaks about how a CCU nurse must be truthful with the families of patients and to not give false hope about survival and recovery. The gravity of not being God is spoken about in terms that mean only a spiritual force outside of themselves can effect the outcome for their loved one.

Caring. MBW also discussed caring in reference to a physicians actions or lack of actions. MBW stated the following:

> "And then he decided that maybe he should give her some blood. But to me, I guess the problem was...I don't know why they are practicing medicine if they [physicians] don't care about the patient...I think caring should be a part of a physician's job as well as a nurse. I think nurses do [care], well, I don't know, I care about how I take care of my patients. I care about what reflects on me...I feel that if you are doing your job, you should do a good job or don't do it at all. I think that it's also that you really care about the outcome of the patient."

MBW was referring to the ethical dilemma where she had to order laboratory work on a post-operative patient without the physician's order. The hemoglobin and hematocrit result was low and the patient needed blood. The dilemma was a result of the physician's omission of ordering the laboratory work, necessitating MBW to act for the physician

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and initiate a medical order in the middle of the night. After receiving the abnormal laboratory results, MBW had to call the physician and ask him to order blood for the patient. This example of caring implies that the CCU nurses cared because they wanted to improve the outcome for the patient. This "caring about the outcome of the patient" was the facilitating intervening condition in the context of this ethical dilemma for MBW.

In summary, the purpose of this section has been to identify and describe the broader structural context of the EDMP by outlining the facilitating and constraining intervening conditions. These intervening conditions are broad and general conditions which bear upon the action/interactions of these CCU nurses (Strauss & Corbin, 1990). However, grounded theory is a transactional system, wherein I examined the interactive nature of events occurring within the EDMP of these subjects. Central to the transactional system, and located within the range of conditions listed above, are the actions/interactions of these CCU nurses.

Strategies for Ethical Decision Making

The next section will identify and describe the actions/interactions which took place in a related sequence, and are thus processual in nature. The actions/interactions were carried out by the CCU nurses in order to manage, respond to, or resolve the ethical dilemmas described above. This process is outlined in the next section under the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

categories of: a) strategies used by the CCU nurses, and b) the consequences of these strategies.

The first category of strategies labeled as "opening up" is best described through the perceptions of the CCU nurses: a) "getting cues," b) "hearing the patient talk," c) "empathizing with the patient/family," and d) "respecting the patient's view."

The second category of strategies labeled as "getting people to talk" was described in the following terms by CCU nurses: a) "building relationships," b) "negotiating between," and c) "re-evaluating." A third category of strategies used by these CCU nurses was described as "supporting the patient" and includes: a) "praying for him," and b) "alleviating pain." "Protecting the patient" was a strategy used by one CCU nurse, which resulted in an unfavorable outcome for the patient.

Finally, the consequences of these strategies used by these CCU nurses will be discussed. The categories of consequences were: a) "reaching understanding", and b) "sensing harm."

The first part of the EDMP begins when the CCU nurse perceives that either the CCU nurse or the patient has been frustrated over an ethical concern. The CCU nurse decides to choose a method to manage or resolve the ethical dilemma. These methods are called strategies. The management process includes selection of an action/interaction which will bring out into the open the positions of all parties involved in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the ethical conflict. The consequences of the actions/ interactions that CCU nurses strategize determines their success in reaching resolution of the ethical conflict.

Opening Up

During the first part of the process of ethical decision making the ethical conflict was perceived and discomfort was felt by the CCU nurses. The felt conflict was often described by the subjects as feelings of anger, fear, and frustration. However, it was possible for the subjects to perceive ethical conflict and not express an emotional response; the ethical dilemma was only viewed as a problem to be solved.

In Greek mythology, Pandora was the first woman, who brought with her from heaven a box containing all human ills and blessings. Upon the box being opened by her husband, Epimetheus, all escaped except hope. Similarly, the CCU nurses opened up their patients' "Pandora's box" through: "talking about what the patient really wanted" for themselves in the end of life, "getting the family to start thinking" about the options they had in the EDMP, and "getting cues from the family."

"Opening up" describes the stage wherein the nurse perceived an ethical conflict and attempted to determine what the patient wanted or would have wanted in such a situation. BG related the following about her perceptions during the EDMP:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"It's like opening up a Pandora's box. I'll talk to the [patient's] significant other and say, by the way, have you discussed with your loved one, or has it ever been mentioned amongst yourselves, what they really want? What their thoughts of life support are? It's amazing how soon they'll respond and say...Oh, Henry said he never, ever, wanted to be maintained on life supports. Not on these machines. No way."

BG's technique of responding to the ethical dilemma involved an attempt to discover more information and to uncover other facets of the issue.

Getting cues. In addition to using the above affective interaction during the EDMP, BG states she often "gets cues from the family."

"I think what ends up happening is the health care worker sort of gets cues from the family. A lot of times the cues come as a result from all the information coming back and the physician telling the family about the actual state of affairs and what the prognosis is and his recommendations."

Likewise, BG described another perception of "opening up a Pandora's box":

"Actually the physician asked me to find out what the patient wanted and to have her write it. He asked me to do that for him. He said we need to have a conference. At this point the son was going to come in and talk with the physician personally, along with his mother, about what she really wanted, and they were going to make the final decision and then...they took her off the breathing machine and she thrived and she was able to move out of the CCU that day."

BG responded to the ethical dilemma by "talking about what the patient really wanted."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CG also discussed patient care conferences as a trigger to get patients and their families to start thinking about making a decision:

> "Depending on the nurse...and how well the nurse knows the patient and the family, that will influence how much input the nurse has or what kinds of questions she asks the doctor...what kind of comments or what kind of questions she asks the family to get them to start thinking [about the ethical decision], or to get a response out of them that maybe the doctor has not thought out."

CG was responding to the ethical dilemma for this patient by trying to "get the family/patient to start thinking."

Hearing the patient talk. Similarly, DT, a male CCU nurse, shared a technique he uses in the EDMP:

> "I hear the patient talk. I know that this has happened to all of us...When the patient knows he is not here by himself with the doctor and that he can come back and say, 'well what did the doctor say a while ago?...what was he talking about?' You are there to explain what the doctor said."

This is a technique similar to BG's "getting cues from the family." Both are listening techniques that they use to let the patient open up to them during EDMP.

Empathizing with the patient/family. During the "Opening Up" process, the CCU nurses reacted to the experience of the ethical dilemmas by: "empathizing with the family" and "identifying" with their patients. Empathizing with their clients is also a process of "opening up." They "open up" themselves by appreciating feelings outside of themselves. SC stated:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> "You don't want them to die, but you don't want them to live with pain like that, and I was so empathetic with the husband, it was very emotional, very emotional for me."

SC gave another example of "empathizing with the family":

> "Well, like I said, I really related to this whole thing. I saw my brother-in-law all over again. I was emotional because I went through this similar thing. Well not a similar thing, but my brother-in-law died of cancer. It's horrible for a family member to sit and watch someone die of cancer. You don't want them to die, but you don't want them to live with pain like that. I was so empathetic with the husband. It was very emotional, very emotional for me."

Being able to relate to the patient's and family's pain or dying experience affected the EDMP for SC. The ability to transfer her own experience with pain and dying of cancer impacted her response to this ethical dilemma, wherein SC gave extra pain medication.

DLT described her "opening up" process of the EDMP as "identifying with" the patient, which is similar to "empathizing":

> "I had identified with this guy, because everywhere he liked to travel were places that my husband and I have been. He was an artist and I...he was just a neat guy. So, it made it more difficult. Sometimes, it seems that if there is anonymity, it is easier to handle."

DLT was taking a part of this clients' personality and identifying with it. This term of "identifying with" is a term of feelings for DLT. Consequently, this in vivo code of "identifying with" falls into an affective interaction that is a preliminary response to the ethical dilemma.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Respecting the patient's view. CG discussed the idea of respecting the patient's view about life support systems. CG stated that the patient will change their mind at the last minute and say:

> "'Give me the tubes.' I think you have to respect the patient's view and go along with that until...it's difficult...[stated as if conflicted] not all situations are alike and of course there is a lot of different factors that play into it. I think it just depends on what the chances are for recovery and I think it depends on the patient's prior wishes if they are written down."

"Respecting the patient's view" also allows the CCU nurse to open themselves up to another person's values. In the "Opening Up" process of EDM, the CCU nurse opens up oneself to a viewpoint outside of their own self. "Respecting the patient's view" allows the CCU nurse to assist the client and others to arrive at the best decisions dictated by the circumstances.

Getting People to Talk

The second category of strategies, "Getting People to Talk," describes actions/interactions of the CCU nurse that brings the issues out into the open to make an effort to better understand the positions of all parties involved in the EDMP. According to Strauss and Corbin (1990), interaction means people doing things together with respect to one another in regards to a phenomenon. This includes the actions, talk, and thought processes that accompany the doing of those things (Strauss & Corbin, 1990, p.164).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Many strategies are used by the CCU nurses in this category to prevent or resolve conflict and facilitate achieving the patient's goals. The nurses' descriptions repeatedly confirm the CCU nurses' attempts to negotiate and advocate for resolution of the ethical conflicts. Strategies used to improve communication and ethical decision making can be grouped into these three themes: "building relationships", "negotiating between", and "reaching closure."

Building relationships. Improving communication by "getting people to talk" involved these strategies used by these CCU nurses: "being like a member of the family," "requesting a team conference," and "going to the physician."

DT speaks about building relationships with doctors, patients, and families as an important precursor and part of ethical decision making. DT talks of the "relationship with the family" in terms of: "I think sometimes you almost have to be like a member of the family." DT thinks that his "ability to get people to talk" promotes "a deeper understanding of where they are coming from, too." A helping trusting relationship evolves from a certain quality of communication. DT states the following about his interactions during the EDMP:

> "I have always been able to get people to talk ...and you start to get them to loosen up about where they are from and what they used to do. And I ask every patient where they are from... even after five minutes when they are first admitted

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> ...while I am checking them out...You know you get them talking about things and you have a deeper understanding of where they are coming from, too. It does not take but five or ten minutes and you really have the person relaxed."

DT stated that after he has established a rapport with the client, and "understands where they are coming from, too", he is able to use "timing" and the relationship he has built with the patient and family to explain ethical decisions they may have to make.

DT uses the strategic interaction of "being like a member of the family" and "getting people to talk" to bring the individuals in conflict together. These strategies may also be used to prevent or ameliorate conflict situations and to help the patient and family negotiate the health care system during the ethical conflict.

One method HK used to bring the individuals in conflict together was "requesting a team conference."

> "Well actually we requested for a team conference because...he was getting on our nerves. It was getting to the point where everybody was refusing to take care of him. Even myself, I got my doubts, many times. I am a human."

HK was acknowledging her own humanity and feelings about the issues revolving around the care of this patient. HK used this sensitivity, and affective response to the dilemma during the EDMP. The code words, "requested for a team conference" were used to describe or identify the actions she took in response to feelings experienced. HK's admonition of only "being human" suggests that this patient

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

was "getting on her nerves" and that she has or owns the same qualities of any human in a similar situation.

LM stated that the CCU nurses "went to the physician" to improve communication during the EDMP:

> "Initially, we went just to the physician and said, 'you know, we really feel like we are not accomplishing what we [CCU nurses] need to do...that we really need to medicate her,' and what we found was that he [physician] was more or less writing his orders to follow whatever the power of attorney (POA) wanted...and his [POA] feeling was that narcotics or sedation of any kind would be detrimental to her."

This statement represents the first phase of the EDMP for LM, which is perception of the problem. LM was frustrated enough to voice her feelings, that she did not feel as if she was able to accomplish what she needed to in the care of this patient. "Going to the physician" was the action she took in response to her perception of "feeling like we are not accomplishing what we need to do."

Negotiating between. Negotiating actions and interactions are the main theme of "getting people to talk" among the individuals involved in the EDMP. Interactions and actions taken by these CCU nurses were aimed at achieving the patient's and family's goals, understanding the physician's goals, and making these parties feel satisfied with the outcomes of the negotiation process. Some of the strategies used by these CCU nurses are described as: "facilitating between," "initiating it," "being a little confrontive," "disagreeing with the physician," and "relaying what we were seeing."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CG talked of a recent patient care conference she participated in as a family member. CG was analogizing her own personal experience of an ethical decision making process to the process she uses in her own work in the CCU.

> "The particular one that a family member of my husband's was involved in was,... What do we do?...or Where do we go?... What kind of help does the patient need? and How do we facilitate that between....the social worker and then the internist and the psychologist and her husband and then me and my husband were there. We brought up concerns and things we knew we wanted for her and things we felt like were important and...had them assist us in doing the best for her. But most of the other ones that I have seen...It is usually because we were to the point where what do we do? Do we make this person a code or do you want full life support? How far do we go? It is usually decisions. How far do you want us to go with your loved one?"

This process that CG described as "facilitating between" all members of the team and the patient and family involved is part of the negotiating process. The questioning, whether it be self-questioning on the family side, or if it is questioning on the part of the CCU nurse, is another way of "facilitating between" persons to get to the consequence phase of the EDMP.

"Being a little confrontive" and "initiating it [EDMP]" are examples of the theme of "negotiating between" individuals in the EDMP. CG made the following statement in reference to the communication process between the CCU nurse and the physician in her ethical dilemma:

> "I'll just ask them [physicians] up front if I see them...Well what are we doing? [Part of the decision making in this type of ethical dilemma] is to initiate it. A lot

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> of times they have things going on in their own mind and they know what they are doing. ...I think they are oblivious unless somebody comes up and asks them, Well, okay, you know... They don't always spell it out in their progress notes."

This part of the EDMP that CG spoke of, entailed confronting the physician, and initiating the first contact or communication regarding the plan to resolve the ethical dilemma. The physician was often not communicating clearly, or not communicating at all, to other health care team members or the patient and family. In order to clarify the medical plan of care the CCU nurse often initiated the process or confronted the physician with resolving the dilemma.

MI used similar tactics in resolving ethical conflict:

> "Being a little confrontive...like is this something you discussed? It is okay for CCU nurses to ask these kind of questions, even though the nurse is afraid to ask them. That is what I found out. A lot of people expect the nurse to bring things [ethical dilemmas] up."

MI also talked about confronting the physician or family member about thinking processes or prior communications regarding the ethical dilemma. The confronting part of the EDMP usually occurred after the CCU nurse had experienced frustration or an emotion such as fear in the "Opening Up" part of the EDMP. MI stated the following: "...even though the nurse is afraid to ask them [physicians, patients, family members about ethical decisions]." This statement alludes to the frustration or

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

fear that the CCU nurse first experiences in an ethical dilemma in the "opening up" and "getting people to talk" part of the process.

The second category of the process of resolving these dilemmas occurred when the CCU nurse chose to communicate, negotiate, compromise, or avoid resolution with other health care team members/patient/family, of the ethical conflict. MI's statement about ethical decision making reflects this second category: "Being a little confrontive...it is okay for the CCU nurse to ask these kind of questions."

Resolution of the ethical conflict occurred when appropriate communication skills were used. An example of such an interaction is MI's statement: "Being a little confrontive...it is okay for CCU nurses to ask these kind of questions. A lot of people expect the CCU nurse to bring these things up." An honest discussion to bring all issues out into the open and to make an effort to understand the position of the health care team members, patients, and families is the crux of the second category of the EDMP.

All three CCU nurses, MI, AP, and CG, talked about communication skills that allowed them to get to the honest discussion phase of the EDMP through the following interactions: (a) "confronting," (b) "initiating it [discussion of ethical dilemma]," and c) "facilitating between." These three types of interactions comprise a negotiating behavior that is a part of the basic social process of ethical decision making among CCU nurses.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The interventional strategy of "disagreeing with the physician" is an example of a negotiating behavior used by SC:

> "So the doctor quit but then walked out, and lambasted us for over medicating her. In fact, he even used the word euthanasia. Of course, we were very emotional." [SC told the physician], 'You can not imagine how horrible it is to watch your loved one die from something like cancer.' [The physician responded with], 'That's why it is not a family decision. It should be a medical decision, because the family gets too emotional at a time like this.' [SC responded with], 'I strongly disagree with that'."

Disagreeing with the physician was an intervention on SC's part to mediate this ethical conflict. At that point, the ethical conflict had escalated from inadequate pain control for the patient to whether it is a medical decision or patient/family decision about adequate pain control.

"Relaying what she was seeing" was a strategy used by LM, which succinctly described the behaviors and interventions she used to negotiate the issue of adequate pain control. LM provided relevant information in order to bring the individuals involved in the EDMP to an understanding and ensure that all parties heard one another effectively.

> "Actually what we tried to do was relay what we were visually seeing to people who were not seeing it [physician and power of attorney] and trying to give them an understanding of why we felt she needed pain medication."

Relaying information and observations was LM's way of intervening on behalf of the patient in order to obtain the physician's order for pain medication. Actually, LM was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

protecting the patient. LM and the other CCU nurses had failed, in their estimation, to provide the comfort and care they needed to as CCU nurses. When the CCU nurses were unable to provide this comfort and care, they tried alternative methods such as music, hot packs, bringing in different kinds of beds. LM stated that these alternative methods provided minimal relief of pain upon movement.

Reaching closure. These final strategies for "getting people to talk" were examples of the theme of reaching closure and following up on the negotiation process. They were: a) "re-evaluating," b) "following through," and c) "meeting the criteria the doctor set up." Restating the agreements made between the individuals, so that it is clear to everyone what has been agreed upon is meaningful to the EDMP. LM stated:

> "We had absolutely no power in the process until the end, and then the end was meeting criteria that the physician set and then just making sure it was followed through on, but we really didn't have any power in terms of determining change in the patient's care."

LM obviously was frustrated by her feelings of powerlessness. Patient care conferences between the CCU nurses, physicians, and the power of attorney were done to provide closure and re-evaluate agreements made between the individuals involved in the EDMP. LM stated the following:

> "We had three conferences...two with the power of attorney, and one without the POA. We CCU nurses and the physician set up guidelines that initiated this masseuse thing...and then we CCU nurses would re-evaluate the patient and see if she had

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

significantly improved. If so we would continue with the massages."

This was an example of unresolved conflict, and the attempts by the CCU nurse to "re-evaluate" or attempt different strategies to assist the client.

Supporting the Patient/Family

The third category of strategies used by these CCU nurses to resolve ethical conflicts was labeled as "supporting the patient." "Supporting the patient" also includes the strategies of "alleviating the pain","praying for him," and protecting the patient.

AP used a mediating response of "supporting the family" in the ethical dilemma as described by AP:

> "The family was upset about this. And I supported the family. I agreed with the family and we did... They did discuss and I called the doctor and they talked with him on the phone. The cardiologist, and he [other specialist physician] agreed to withdraw life support".

AP mediated the conflict through the following interventions: (a) "supporting the family," (b) "agreeing with the family," and (c) "calling the doctor" to explain the family's wishes and desires. As AP stated: "No one paid any attention to this patient's wishes as spelled out in her advance directive and as insisted upon by her daughter who was the durable power of attorney for health care."

CG also talked about "supporting" the patient/family, and physicians. In CG's ethical dilemma, "better communication" between physicians and nurses would have decreased the conflict between these two roles. CG stated

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the following regarding "better communication" between physicians and CCU nurses:

> "If I know what the physician's thoughts are behind these interventions, then I have a better ...I know what things are important for that physician to know...and I know what things are important to do for that patient and or the family and how to best support that. If you only knew what their goal [was for the patient]."

Looking at both AP's and CG's statements in reference to the ethical decision making process, the CCU nurse is actively "supporting" the patient, the family, and/or the physician. By supporting the physician, the CCU nurse indirectly may or may not support the patient's wishes. However, CG emphasized that having knowledge of the physician's goals for the patient would make it easier to support the physician's interventions.

Alleviating pain. Alleviating the patient's pain could also be categorized as a method of mediating for the patient and supporting the patient. In one case, the patient was intubated and could not speak. Consequently, the CCU nurses mediated the dispute over alleviating pain for this client. Also included in this theme of "alleviating pain" were: "taking the sensory load away" and "not causing more pain."

> "We tried some music and we tried some hot packs, and we tried anything we could to take the sensory load away and...We got different types of beds in hope of relieving stress points for her because she was still obviously experiencing pain in the initial injury site."

LM's client had an advance directive which afforded durable power of attorney (POA) for health care to a certain

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

individual. The POA and physician were "controlling the game," as LM put it in her interview. The POA and physician would not provide adequate pain control for the client. The ethical conflict for LM was: "the dilemma was that the care that we were delivering was not put in the realm of what we CCU nurses considered caring for someone...providing her with comfort and care."

LM took all the alternative actions that she could in order to relieve some of the discomfort that the patient felt, because she was being denied pain medication. LM stated the following:

> "My perception of what I do is certainly that I don't cause more pain than someone already has, and I try to alleviate as much pain as I can... most of the time we do that with narcotics... with medications. In this case we were not allowed to do that, so we tried other things."

Promoting comfort during the EDMP in this case was paramount for this CCU nurse. This CCU nurse was in conflict, because she had been denied the use of traditional medical treatments. Consequently, she diverted to the next best thing she could think of in order to promote comfort for the client.

Praying for him. HK demonstrated transcending interactions which exceeded the limits of nursing interventions by seeking divine intervention for the benefit of the patient. HK demonstrated these transcending actions/interactions by "praying" with this patient and "bringing him the Bible" and other religious icons.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

HK stated that she took the following actions in trying to resolve the ethical dilemma concerning this young male patient:

> "I brought him the Bible and I brought him a Jesus heart, a little stamp, and I put it by his side, so he can look at it with his family there, with his mom. His mom happens to be religious too."

HK was nurturing faith and hope in this person because "when they come in this kind of depression and they feel that life is not worth it...but also he was young." HK was encouraging the patient's beliefs and values in order to promote and maintain health within this patient. HK attempted to normalize the patient's depression. HK told the patient the following statements:

> "You have a reason to be depressed. If it had happened to me, I would be the same way. So don't worry about it. This is very normal. But you have to be strong! Come on, get those shoulders up! So let's get it."

These statements are an attempt by HK to normalize the patient's depressed response to his illness.

Protecting the patient. Protecting the patient and keeping the patient safe and empowered was discussed in DLT's interview. DLT's feelings and reactions to her participation and non-action in the EDMP were described as "inflicting harm":

> "I felt kind of guilty. I thought, Oh, my God...[an expression of alarm as the patient suddenly started spurting blood and at the same time complaining that his neck and head hurt]. I just keep thinking back it was all something that he did not want. I felt like I was inflicting harm...it just stands out in my mind."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Some of the protecting behaviors that DLT did employ after the event were as follows: (a) stopping the thrombolytic therapy immediately when the patient complained of head and neck pain, (b) notifying management and the physician, (c) making an incident report, and (d) calling in some form of peer review for the physician and the treatment approach for this patient. Actions taken to protect the patient were apparent in a number of the CCU nurses' interviews.

Consequences

Both short- and long-term effects of the ethical dilemmas were determined by the extent to which all parties involved in the dilemma achieved their goals. An additional variable to consider was whether all parties' -- the patient, the physician, and the CCU nurses -- goals were alike or congruent. If the CCU nurse and the patient's goals were congruent with the physician's goals, then resolution of the ethical dilemma occurred.

Conflicts or barriers to resolution were removed, or there was continued breakdown in the resolution of the ethical dilemma. If the conflict was not resolved, the CCU nurse attempted to come to a resolution by reverting to the "opening up" phase, by continuing further assessment, or attempted different "getting people to talk" strategies to resolve the ethical dilemma.

Outlined below are some examples of the interviewees' consequences to the interactions/actions taken in the "opening up" and "getting people to talk" strategies of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

EDMP. Those consequences that contained a resolution to the ethical dilemma will be discussed. Additionally, the consequences that did not contain a resolution of the conflict will be discussed. "Reaching understanding" is the first category of consequences described. "Sensing harm" is the second category of consequences discussed.

Reaching understanding. The theme of this consequence focuses on understanding the viewpoint of the other party. It is likely that what one individual perceives differs from the perception of another. These CCU nurses concentrated on understanding, and not only on agreement.

DT explained that he has always had the "ability to get people to talk." This action/interaction had the consequence of "a deeper understanding" between himself and the patient about what the patient's goals were for care.

> "You know you get them talking about things and you have a deeper understanding of where they are coming from too...It doesn't take but five or ten minutes and you really have the person relaxed."

The consequence of the negotiating strategy of "relaying what we were seeing" demonstrated an attempt by LM to revert to a second strategy when she had previously been unsuccessful in negotiating pain relief:

> "Actually what we tried to do was relay what we were seeing to people who were not seeing it [physicians and the power of attorney] and trying to give them an understanding of why we felt she needed pain medication."

Through the patient care conferences that LM had with the physician and power of attorney, she was able to give

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the physician an understanding of why she felt the patient needed the pain medicine. However, she was unsuccessful on three attempts to achieve getting the medical order for the pain medicine. Eventually, by persevering through three attempts at negotiating and three patient care conferences she was able to obtain an order for the pain medication she was seeking, and resolved her ethical dilemma.

This demonstrated closure to the negotiation process wherein the CCU nurse kept an open mind and concentrated on reaching understanding and not only on agreement. Ethical conflict can be resolved by focusing on the issues, such as pain control, and through joint compromise.

In BG's ethical dilemma, removal of life support systems were about to occur with her client. This consequence was an extension of an action/interaction strategy of "requesting a team conference" and "getting people to talk." In this part of the EDMP, the nurse was performing a nursing action such as removal of life support systems. BG went on at length about the consequence of this ethical dilemma:

> "In one case that we had where they had decided that they didn't want their loved one to be on the breathing machine, we needed to make sure that they clearly understood that when the machine was stopped and the tubes were taken out, there was a possibility that the person could die...immediately. The question was asked several times in different situations. Where it was asked by the nurse, it might be asked by the physician. But, then again, it was asked in a group setting, in a conference setting. They understood that."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The theme of this consequence category, again, is "reaching understanding." BG was able to bring closure to the EDMP by concentrating on "reaching an understanding" and not just focusing on agreement on removal of life support systems.

The optimal goal in conflict resolution is lessening the perceptual differences that exist between parties involved in the EDMP. There may be perceptual differences between the patient/family, physician, and CCU nurse about the desired or preferred treatments for patients. Often the CCU nurse begins "facilitating between" parties and "being confrontive" in order to lessen the perceptual differences between all parties involved to resolve ethical dilemmas. The consequence of these strategies was "reaching understanding" for the patients and their families.

> "Oh, I see what you mean. You mean like... No, No, No,...Henry would not want to be kept alive on machines."

By "being confrontive", the CCU nurse was able to resolve or prevent an ethical dilemma by ascertaining relevant information and eliciting patient or family preferences to be on life support.

Sensing harm. When a disproportion in power occurred in the relationship between a patient and other individuals in the EDMP, harm occurred. The theme of harm is more likely to prevail when the perceived interests of the patient and other parties are different or diverge. The imbalance of power between patients and health care

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

professionals may be small or large, thus influencing consequences proportionately. In non-emergency situations, patients may be able to clarify and express their preferences and desires, and thus avoid harm. Coercing into agreement can lead to the consequence of "sensing harm" to the client. Enhancing a patient's ability to make a voluntary, uncoerced decision and lessening the perceptual differences between parties should be encouraged. Coercion can be exercised, as in DLT's ethical dilemma, with benevolent motives. DLT's statement that summed up the consequence of her ethical dilemma was:

> "I guess that the part of it that bothers me the most is that we are supposed to do good for patients and we were actually harming him."

In this ethical dilemma three actions/interactions occurred after the "opening up" strategy. In the "opening up" strategy of the EDMP, DLT had an emotional response to the ethical dilemma. The actions/interactions that DLT took were described as: a) "coercing into agreement," and b) "inflicting harm." DLT still felt guilty about her actions at the time of the interview, after this ethical dilemma that had occurred two years prior. DLT stated during the interview: "It's just always bothered me, because I was part of the convincing."

The consequences that represented "reaching understanding" among the parties in the EDMP demonstrated a lessening of the perceptual differences between individuals. Behavioral outcomes exemplifying "reaching understanding"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

are "the person is relaxed" and is "not being kept alive on machines." "Getting people to talk" in the EDMP allowed "reaching understanding" to occur and the goals of all parties were met.

If there was a lack of conflict resolution, and the perceptual differences between parties persisted, "sensing harm" resulted. In the unresolved conflicts, the goals of only one party or neither party in the EDMP were met. The viewpoints of one of the participating parties was neither understood nor respected.

Facilitating Resolution

The discovery of a core category or a basic social process (BSP) is the desired outcome of grounded theory methodology (Glaser, 1978). A core category was defined by Glaser (1978) as the main theme that gives credibility to other categories and serves to tie the theory together. A basic social process also provides a main theme, but, as the name implies, is a process in nature. The emergence of the main theme for this study is described in this section.

Grounded theory continuously and concurrently collects and analyzes data for the purpose of generating theory grounded in empirical data. The main purpose of this method in this study was to examine the core categories or process that explain the behaviors of the CCU nurses.

The properties and dimensions of the basic categories eventually were linked to the core categories of:
(a) "opening up," (b) "getting people to talk,"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

c) "supporting the patient," d) "reaching understanding," and d) "sensing harm." A core category explains most of the variation in the data and links the major categories and their properties and dimension to form a descriptive whole (Glaser, 1978).

As stated above, the basic social process (BSP) is a core category that is processual, having two or more clear stages (Glaser, 1978). Additionally, the BSP describes the process of ethical decision making among critical care nurses over time.

As the core categories developed from the data, it became necessary to explain what was going on in the EDMP. Furthermore, the categories had to be linked together. Consideration was given to what prompted each interviewee to describe the interventions employed in the EDMP. Within the first five interviews it became clear that the basic social process and actions taken were "facilitating resolution" of the ethical conflicts between the patient/family, the professional disciplines of nursing and medicine, and the hierarchal structures in place in the organization.

"Facilitating resolution" of the ethical conflicts between the patient and professionals came out in such phrases as: (a) "opening up a Pandora's box," (b) "hearing the patient talk," (c) "cues from the family," (d) "respecting the patient's view," and (e) "empathizing and identifying with." These are clearly skills that the CCU nurse uses in the "opening up" process while she/he is

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

making a perception/assessment of the ethical conflict. At this point in the EDMP, the CCU nurses tried to be unbiased observers of the ethical dilemma. The CCU nurses often asked questions that would promote discussion rather than single word responses. Elicitation of a variety of appropriate solutions allowed the CCU nurse to become the enabler or facilitator of resolution of the ethical conflict.

The ongoing events over time entailed perceiving, reevaluating the outcomes of their strategies, and implementing new strategies. This sequence of "facilitating resolution" of the ethical conflict leads to the idea that the CCU nurses were framing and reframing the problem continuously. In essence the EDMP of these CCU nurses was dynamic and ongoing. It could be described as open, and an exchange of information across the boundaries of each category of the BSP occurred. The parties involved in the EDMP were in constant interaction with a changing context or environment. As changes occurred in the context of the ethical dilemmas, or the intervening conditions, changes would also occur in the strategies and consequences of the EDMP.

Perceptual errors of these CCU nurses were frequently at the heart of the breakdowns in resolution of the ethical dilemmas. Projection, biases, and past experiences led to assumptions about the patients/families/doctors. These assumptions may have set a competitive/defensive stance

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

between the parties involved in resolving the ethical dilemma. This seemed particularly evident when "facilitating resolution" of ethical conflict between physicians and patients/families occurred over ethical dilemmas. This was evident in many of the interviewees' descriptions of "facilitating resolutions."

Strauss and Corbin (1990) state that the interactional level of a basic social process entails people doing things together or with respect to one another in regards to a phenomenon. Interactional processes and actions are carried out to respond to or manage a phenomenon. These actions combine with interactional processes to complete the picture of the EDMP of these CCU nurses. These actions/interactions are strategies used by CCU nurses to resolve the ethical dilemmas they described.

Examples of "facilitating resolution" of ethical conflicts by these CCU nurses are: a) "getting people to talk," b) "requesting a team conference," c) "relaying what we were seeing," d) "supporting the family," e) "supporting the patient/family," f) "facilitating between," g) "following through," h) "meeting the criteria the doctor set," i) "alleviating pain," j) "not causing more pain," k) "being like a member of the family," l) "going to the physician," m) "initiating it," n) "setting up guidelines" for decision making, o) "re-evaluating the patient," and p) "having three conferences." Most of these actions/ interactions were done with or "between" the nurse and the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

physicians, POA, and family. These were supportive behaviors which intervened with group process issues.

"Bringing the Bible" and "praying for him" are two examples of supporting and transcending actions and interactional processes of the EDMP done directly with the patient. These actions were done to help the patient participate in the EDMP. These also are examples of "facilitating resolution."

"Being a little confrontive" and "disagreeing with the physician," are also examples of "facilitating resolution" of ethical conflict. If both or all of the parties desire a change in the ethical dilemma, there is greater probability of resolving the ethical conflict. For example, in LM's and SC's ethical dilemmas, the physicians and the power of attorney were not dissatisfied with the properties and dimensions of the ethical dilemmas and did not desire a change. They were "controlling the game" as put by LM.

The CCU nurses could have very easily, and perhaps unconsciously, directed the physicians and families/patients toward a particular solution, or to consider other solutions that might have been inappropriate for the patient/family. However, most of these CCU nurses demonstrated flexibility and objectivity and were willing to relinquish some control. This enabled the key players in the EDMP to not depend on the CCU nurse or the physician, or any one person in the hierarchal structure, to make the ethical decision. "Facilitating Resolution" allows the group players to pass

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

beyond dependence upon the hierarchal players to solve problems. In most of the ethical dilemmas described above, the CCU nurse, through "facilitating resolution" skills, enabled the stakeholders in the ethical dilemma to resolve the conflict.

With the emergence of words like "supporting," "facilitating," "disagreeing," "relaying," "following through," "setting up guidelines," "re-evaluating," and "meeting the criteria set," it became apparent that what guided informants' thinking and responses in ethical conflict situations was the need to "facilitate resolution" of ethical conflict to enable the stakeholders/patients to achieve their end objective. This end objective was often clearly outlined in an advance directive.

A gerund was selected from the in vivo codes that best described these enabling behaviors. "Facilitating" refers to making something easier or less difficult; to help forward an action or a process (Webster's Dictionary, 1984). This definition of facilitating explains the actions of the CCU nurses involved in the ethical conflict. The CCU nurses were trying to help move the ethical decision making process forward.

"Facilitating resolution" describes the linking of action/interactional strategies. I looked for signs in the data that indicated a change in the intervening conditions and then traced out what corresponding changes in action/interaction occurred. For example, when the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

intervening condition of "silencing of nurse's voice" was eliminated as a constraining intervening condition, this allowed "facilitating between" parties and "supporting the patient/family" to occur. The consequences of these strategies resulted in either resolution or non-resolution of the ethical conflict. "Facilitating resolution" is the central phenomenon or basic social process that is occurring in these CCU nurses' ethical decision making processes in this study.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 5

Discussion

Grounded theory generates theory about previously unexplored areas (Glaser & Strauss, 1967). A substantive theory will emerge from the data and thus will be grounded in the data. The purpose of this study was to enter the world of critical care nurses and undersand their view of ethical decision making in their environment, the critical care unit. Through constant comparative analysis, ethical decision making patterns were identified, categories were developed, and theoretical linkages appeared between the categories.

Glaser and Strauss (1967) proposed that this substantive theory could represent an integrated set of hypotheses that should be related to the existing literature. However, Glaser and Strauss (1967) were ambivalent about literature reviews. Prior knowledge of the literature may narrow the vision of the researcher. These reviewed literature sources were necessarily bracketed (Morse, 1989) or put aside for later use in discussion of the study results. Consequently, I put aside previous literature until the thoughts of other authors could be

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

integrated without detracting from the data that emerged from this study.

This chapter includes research and theoretical perspectives relevant to the basic social process of "facilitating resolution" of ethical conflict in critical care units. The strategies and the consequences of the EDMP serve as the organizational theme for the discussion of "facilitating resolution."

Strategies

The experience of perceiving ethical conflict and ethical dilemmas for these CCU nurses was comprised of the strategies and consequences of the basic social process of "facilitating resolution." Ethical conflict is perceived by the CCU nurse and is recognized in a variety of manners. Some of the CCU nurses recognized the ethical conflict logically and impersonally. Perceived conflict was not emotionalized by the CCU nurses who used this type of reasoning; the perceived conflict was intellectualized and viewed simply as a problem to be solved. In other words, they internalized the conflict and used strategies to resolve the ethical conflict from a logical reasoning base and an internal locus of control. Individuals who have an internal locus of control believe that the outcomes they obtain are largely a result of their own ability and effort.

Rotter (1967) defines locus of control as the extent to which people perceive that events are under their own control. Those who attribute the cause of events to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

external reasons, reasons out of their control, are considered to have a high external locus of control. Individuals who attribute the cause of events to internal reasons, such as ability and effort, are considered to have a high internal locus of control.

Opening Up

"Opening up" is a process of perception and is a complex physical and psychological process. "Opening up" is a sense-making process. Individuals interpret their environment so they can make appropriate responses to it. The sensing task soon becomes unmanageable, so perception becomes selective. Once one recognizes stimuli in the "opening up" strategy, they make appropriate responses to them.

Some of these CCU nurses externalized the perceived conflict. The perceived conflict was emotionalized and caused feelings to arise within the CCU nurses. Fear, anger, resentment, and frustration were some of the emotions experienced in the "opening up" stage. One of the respondents described herself as feeling "very emotional... very emotional." She stated that even recalling the events of the interactions between herself and the physician and patient made her feel emotional one year after the event. This subject had an external locus of control in that external factors, such as the doctor "lambasting us," were influencing her perceptions. She described the "opening up" strategy she used to cope with this perception as

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"empathizing with the family." The affective response to this ethical dilemma was due to a lack of control over events occurring in the ethical dilemma. This response was due to interactions with other individuals in the ethical conflict, such as the physician.

"Empathizing with the patient/family" is similar to nursing models of empathy described by Morse, Anderson, Bottorff, Yonge, O'Brien, Solberg, and McIlveen (1992). Natural empathy and clinical empathy are similar in that both "assess and perceive the inner world of another and facilitate an interpersonal relationship that will enhance the well being of another" (Morse et al., 1992, p. 277).

Natural empathy and clinical empathy differ in that a detachment or dissociation phase is needed to remove the nurse from risk of personal involvement. When detachment in the relationship between the nurse and client occurs, the relationship is transformed from a personal relationship to a professional one.

The informants in this study that described "empathizing" with the patients in their ethical dilemmas may have lost the detachment that is required in clinical empathy. Two female informants who clearly described this strategy may have been less objective. This strategy of "empathizing" resulted in consequences of unresolved ethical conflict.

According to Kolb and Coolidge (1991), women are more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

likely to see negotiation as behavior that occurs within relationships without large divisions marking when it begins and ends. Women tend not to draw strict boundaries between negotiating and other aspects of their relationships with other people. Women see negotiations as flowing more naturally from the relationship and may not recognize boundaries between personal and professional unless they are clearly limited by the background against which they occur.

According to Mellody (1989), people with permeable boundaries can at times set limits and at other times with other people they are powerless to set boundaries. For example, a person may be able to set boundaries with everyone but authority figures, or his or her child or spouse. With certain individuals in certain circumstances they step into someone else's life and try to control or manipulate it. An intact internal boundary protects our thinking, feelings, and behavior and keeps them functional. Intact internal boundaries allow us to take responsibility for our thinking, feelings, and behavior and keep them separate from that of others.

An example of permeable boundaries was SC's statement:

> "I was emotional because I went through this similar thing when my brother-in-law died of cancer. It is horrible for a family member to sit and watch someone die of cancer. You don't want them to die, but you don't want them to live with pain like that, and I was so empathetic with the husband, it was very emotional,...[distressed tone] very emotional for me. I really related to
>
> this whole thing. I saw my brother-in-law all over again."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

SC was putting herself in the position of the husband, and was transferring her own personal experience of pain and dying of cancer onto this professional experience. SC may have difficulty with keeping her internal boundaries intact when she has to interact with authority figures in her environment, such as the physician who was being verbally abusive and "lambasted her" and accused her of "euthanizing" his patient. Consequently, this CCU nurse may have had difficulty developing the detachment necessary in this situation.

Three examples of intact internal boundaries were: "hearing the patient talk," "respecting the patient's view," and "opening up a Pandora's box." These gerunds "hearing," "respecting," and "opening up" describe viewing the ethical dilemma from an objective point of view. These are assessment techniques that these CCU nurses are using to gather data about the ethical dilemma. These CCU nurses are learning how the other parties perceive the situation.

Abilities and efforts gained over many years of experience are used to solve a problem. In one sense, they are using techniques that indicate that participants may have an internal locus of control. Most of the participants that used these techniques felt they had some control over the events and possible outcomes at this point of the basic social process.

Central to the "opening up" strategy of the BSP is the awareness of the study participants of the relationship

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

among the parties who are resolving these ethical dilemmas, and the context of the ethical conflict. Solving the problem is not the only focus of the participants. Learning how the other party perceives the ethical dilemma is central to the BSP of CCU nurses' EDMP. Examples of learning how the other party perceives the ethical dilemma are: "opening up a Pandora's box," "hearing the patient talk," and "respecting the patient's view." According to Kolb and Coolidge's (1991) evaluation of research on gender and negotiation, "expressions of emotion and feeling and learning how the other experiences the situation are as important, if not more important, than the substance of the discourse" to women (p. 264).

"Hearing the patient talk" and "respecting the patient's view" are similar to findings in Omery's (1986) study of CCU nurses in an adult critical care unit. Omery found that in CCU nurses who were identified as sovereign reasoners, the themes of advocacy, respect for persons and fairness appeared in their narratives. Advocacy and respect for persons were also typical themes heard in the interviews of this study. Gilligan (1982) further described women's response to moral dilemmas as non-judgmental and reluctant to judge others.

"Opening up" strategies are affective responses to ethical conflict which emanate from either an internal locus of control or an external locus of control in the CCU nurses. Strategies which are emotionalized, such as

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"empathizing with the patient/family," have traditionally been discouraged by contemporary nursing models. Detachment or dissociation has traditionally been encouraged in order to keep the relationship between the nurse and patient in the realm of clinical or therapeutic empathy (Morse et al., 1992).

However, this model of therapeutic empathy is the basis of psychological counseling and not professional nursing. Morse et al. (1992) question the appropriateness of the use of psychological counseling model of therapeutic empathy for nursing. The fact that the use of "empathizing" precipitated strategies that resulted in consequences that resulted in unresolved conflict does not mean that this type of empathy can be totally devalued. The time allowed for therapeutic empathy encounters in a critical care setting may be unrealistic. In fact, patients in critical illness situations may not be able to experience the beneficial effects of therapeutic empathy because they are focusing on coping with the illness.

Nonetheless, in this study, "opening up" strategies which evolved out of an internal locus of control appear to be a rational and intellectual view of the clients involved in the ethical dilemmas. Internalized perceptions of the ethical conflict evolved into strategies that produced outcomes ending in resolved ethical dilemmas.

This may suggest that strategies which obtain consequences that result in "reaching understanding" and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

resolution of ethical conflict largely result from the CCU nurse's own ability, skill, and effort where events are perceived as under their control. Events which were not under the CCU nurse's control usually involved physician decision making or institutional policies.

Getting People to Talk

Kolb and Coolidge (1991) state that women are more likely to seek empowerment where there is "interaction among all parties in the relations to build connection and enhance everyone's power" (p. 265). The CCU nurses' strategies of "getting people to talk" may be typical of "women seeking to engage the other in a joint exploration of ideas whereby understanding is progressively clarified through interaction" (Kolb & Coolidge, 1991, p. 266). These CCU nurses alternate listening and contributing, and this results in what Kolb and Coolidge (1991) call "the weaving of collective narratives that reflect newly emerging understanding" (p. 266).

"Getting people to talk" is an in vivo code stated by these CCU nurses as an example of how they "facilitated resolution" of ethical conflict among all the parties involved in the EDMP. This in vivo code is an example of exploring ideas with other persons and gaining clarification through interactions. By listening to the patient or "hearing the patient talk," as in the "opening up" strategy, the CCU nurse then proceeds with the strategy of "getting people to talk" or "supporting the patient/family" in order

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

to clarify their positions or views on the ethical conflict. These perceptions and strategies resulted in the consequence of "reaching understanding," another in vivo code used to describe the EDMP.

"Getting people to talk" through patient care conferences with the goal of engaging others in exploring ideas to assist in "reaching understanding" is also validated through Gilligan's research on moral decision making among female subjects. Similarly, Gilligan (1982) found that women consider relationships and connectedness important in ethical behavior. Ethical decision making from the feminist perspective requires careful consideration of the meanings of relationship, experience, and environment when considering EDMP among CCU nurses. Gilligan's view of moral reasoning gives an alternative to the justice based hierarchial theories. Noddings (1984) also gives support to the idea that receptivity, relatedness, and responsiveness is part of nursing ethics. These are recurrent themes when women and nurses describe the ethical decision making process.

The subjects in this study described intervening conditions which encouraged the strategies of "getting people to talk" and "supporting the patient/family." Patient care conferences, open communication, and caring were vehicles for implementation of these strategies. According to Taylor (1995), one of the functions of patient care conferences is to enable the care team to present the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

family with a unified position and rationale for treatment.

Additionally, the care team may want "to rethink the goal of treatment, which may change from restoration and cure to preparation for a dignified death" (Taylor, 1995, p. 305). Taylor uses the patient care conference as a tool to assist the exploration process the caregivers and families of critically ill patients go through, in a similar manner described by the CCU nurses in this study as "getting people to talk."

"Negotiating between" parties is a means of getting people to talk. The subjects in this study used the patient care conference to "negotiate between" the physician, psychologist, social worker, and family of the patient in order to "do what was best for her [the patient]." Taylor (1995) describes the advantages of a "shared decision making" process in ethical conflicts over medical futility, whereby the care team members "facilitate the trust between professionals and patient/surrogate" and "facilitates better allocation of resources" (p. 303).

"Negotiating between" parties in the EDMP can also prevent conflict. Taylor (1995) describes succinctly how "negotiating between" parties increases trust between family/patient and caregivers. If periodic meetings between caregivers and family members occur, misunderstandings might be clarified, treatment goals can be explored, and treatment priorities can be reassessed. If this type of facilitation occurs, bad news will not be so shocking to the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patient/family/surrogate. The family will be less distrustful when a recommendation to withdraw or withhold further aggressive treatment is made by the care team. Additionally, Taylor (1995) recommends "focusing on securing the patient's good" (p. 304), just as the above described participant did in her EDMP. The study participants confirm these findings by their statements throughout the interviews.

"Re-evaluating" was another strategy used by the participants of this study that reflected the recommendations given by Taylor in her writings on medical futility. "Re-evaluating" was a process of setting up periodic meetings between the nurses, the physician and the POA, allowing the nurses in this study to diminish a distrustful relationship that had developed. Additionally, it helped the nurses in "setting up guidelines" for care, "relaying what they were seeing" to the POA/surrogate, and "meeting the criteria set by the doctor." "Re-evaluating" was a constant, consistent process on their part to increase trust among all parties and to decrease misunderstandings. The study participant's strategies paralleled the recommendations and findings of Taylor's writings on "medical futility and nursing" (1995).

<u>Supporting the Patient/Family</u>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"Praying for him" was a transcending interactional strategy used to support the patient/family in one of the ethical dilemmas described. Transcending behaviors may exceed the limits of nursing interventions by seeking divine intervention for the patient. One CCU nurse perceived the patient as having a need that she could not meet within her traditional nursing practice. Transcending behaviors such as prayer and talking about a spiritual force may help the client find meaning in life and progress them to a higher level of consciousness or give them inner strength to make hard decisions.

Hutchinson and Bahr (1991) found prayer to be a universal way of caring among residents in a long-term health care facility. Hutchinson and Bahr defined the transcending property of caring as "seeking divine intervention for the benefit of others who are perceived as having needs that the person cannot supply due to his or her human limitations or human nature" (p. 87). Although the participants in Hutchinson and Bahr's study were not nurses, their theme of prayer is similar to the transcending behavior of "praying for him" noted in this study of CCU nurses. Praying for patients may be a strategy used in the EDMP when all else fails in the repertoire of strategies that a CCU nurse uses to resolve ethical dilemmas.

"Protecting the patient" is a strategy used by one CCU nurse as a technique to keep the patient safe. This strategy evolved out of a perception of an ethical conflict

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that was emotionalized and the CCU nurse felt as if she were "inflicting harm." Similar to other emotionalized perceptions, this strategy led to an unfavorable consequence, "sensing harm."

Callahan (1988) states that the role of emotions in ethical decision making has been largely ignored in the past. However, there have been other reports of health care providers who persuade vulnerable patients to remain in a research study from which they had asked to withdraw, as the research protocol had promised (Carpenter, 1994). The ethical dilemma experienced by DLT was similar to that described by Carpenter in the literature.

Wilkenson (1987) discussed the process of "coercing the patient into agreement" and the emotions this provoked within the CCU nurse. Wilkenson (1987) states that during any ethical decision making process, nurses' emotions undergo change. If the change is toward exerting power and domination over the patient, outcomes may be the lessening of personal integrity in the nurse. Another possibility is that these nurses continue to practice but fail in their professional responsibility to advocate for the patient. Carpenter (1994) states that representing patients who are powerless, and being the voice of the voiceless, is the true intent of the professional nurse.

However, playing advocate sometimes puts the nurse in opposition with the physician, as it did in DLT's case. Furthermore, identifying the lack of morality in the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

physician who insisted that the patient receive thrombolytic therapy instead of the surgery that he requested may be a mechanism to reduce her own anxiety. Examining her own unethical behavior created anxiety and emotions. These emotions were externalized into the perception of "empathizing with" and "identifying with" the client. Externalizing unethical behaviors and emotion resulted in the consequence of "sensing harm," since the CCU nurse did not advocate for the patient.

Consequences

The consequence phase of the basic social process of "facilitating resolution" for these CCU nurses involves the categories of "reaching understanding" and "sensing harm." Both short term and long term effects of "facilitating resolution" of ethical conflict are determined by the extent to which the parties achieve their goals in the EDMP. The consequences of the CCU nurses' strategies were broken down into resolution of the conflict and lack of resolution.

Consequences which resulted in resolution of the ethical dilemmas was "reaching understanding." The resolution of the ethical dilemmas evolved out of a shared decision making process which included affirming mutual understanding of each of the parties' thoughts, feelings, and desires. An outcome described by the CCU nurses that was typical was "a deeper understanding." The CCU nurse might ask for a restatement of the other parties' positions until there is clear understanding, such as the "re-

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

evaluating" strategy. In the same way, Gilligan's (1982) informants resolved conflicts not by invoking a logical hierarchy of abstract principles, but through trying to understand the conflict in the context of each person's perspectives, needs, and goals.

Ultimately, the short- or long-term goal for the patient/family was obtained. In the cases described by study participants, the patients were "relaxed" and were "not being kept alive on machines" when they did not want to be. These patients' rights to refusal, options, and dignity in death were respected. Similarly, Belenky et al. (1986) described women who possessed constructed knowing, when faced with moral choices, as "insisting on a respectful consideration of particulars of everyone's needs and frailties," and did not want "an illusory search for some kind of end all, be all, cure all" (p. 149).

The CCU nurses that had resolution of ethical conflicts for their patients did not experience their perceptions through an emotionalized or externalized viewpoint. They perceived their ethical dilemmas simply as problems to be solved. Most of these CCU nurses drew from an inner locus of control that allowed them to "facilitate resolution" from an inner area of self-confidence, experience, skill, knowledge, and sometimes religious strength.

Some ethical conflicts resulted in "sensing harm" and unfavorable outcomes for the patients involved in uncontrolled pain or who had an outcome of death. In one

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

case, the CCU nurse perceived that she had failed to actively advocate for refusal to sign an informed consent. Perhaps she became an unwilling though silent participant of a repeated and routine activity of obtaining informed consent.

Some female CCU nurses perceived their ethical dilemmas from a highly emotionalized base. Two CCU nurses stated that they were very "emotional" before, during, and after the interactions with the physicians/families/patients. This style of perceiving the ethical dilemma or sense-making of the dilemma led to unilateral decision making. In one case the CCU nurse and physician argued, and in the other case the CCU nurse became submissive and went along to get along with the physician. Both decision making processes had overtones of environmental dissonance.

Perceptions which become externalized instead of internalized by the CCU nurses can lead to interactions which do not promulgate "facilitating resolution" of ethical conflict in a shared or equalized process. Both of the externalized perceptions emanated from a natural empathy base rather than a clinical empathy base of emotion. In this study these perceptions led to interactions of disagreements and apathy described through the following words: "strongly disagreeing with the physician" and "inflicting harm."

Consequently, I believe that the "opening up" phase of "facilitating resolution" of ethical conflict may be a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

critical stage for CCU nurses involved in ethical dilemmas. Primarily this is the stage wherein the CCU nurse tries to make sense of what is going on in the environment. A closer look at the way these CCU nurses draw boundaries between interacting in the ethical dilemma in a professional sense and other relationships with other people may be needed. This may lead to clues as to why some nurses use a more internalized locus of control in the perceptions stage versus an external locus of control.

Facilitating Resolution

How much power the CCU nurse has in comparison to the physician in these ethical dilemmas influenced many of the "facilitating resolution" behaviors. Crott, Kayser, and Lamm (1980) report that negotiators with more power bluffed more often and communicated less with their counterpart than those with less power. These results support the intoxication theories of power, which hold that power corrupts the thinking of the powerful. Perhaps a balance of power between the physician and CCU nurse would lead to more stable, ethical conduct than an imbalance. Conceptually, the same theory would hold true for the patient. Traditionally, the physician has been the power-holder in the physician-patient relationship, and in the nurse-physician relationship.

Another possibility that may account for the CCU nurse not advocating vociferously for the patient is her agency to the patient. CCU nurses find themselves representing the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patient's viewpoint, as in DLT's ethical dilemma. The CCU nurse is acting as an agent for the patient and is not always representing her own personal viewpoints. Perhaps this CCU nurse's actions were influenced more by her personal standard of ethics than her professional standard of ethics. A number of authors (Bowie & Freeman, 1992) have suggested that when acting as an agent for someone else, the agent may be more willing to violate his own personal ethical standards.

If a shared decision making process would occur consistently in critical care units in ethical conflict, then nursing could be seen in a more expansive light. Perhaps CCU nurses need to care not only for the individual but also the environment. Unresolved conflict seems to evolve out of environmental dissonance, where parties involved in the ethical conflict suffer an imbalance of power.

It seems that only in extreme dramatic events did CCU nurses recognize the patient's right to refuse treatment, the right to knowledge, and the right to dignity in death. Removal of life support and advance directives strongly influenced the interactions of these CCU nurses. However, habitual performance of certain activities, such as obtaining informed consent and pain control, may fall prey to being considered repeated and routine activities which fall outside the realm of ethics. The routine environment may lull the CCU nurse into conforming, which will lead

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

eventually to subservience, powerlessness, and lack of respect. By taking an assertive role in a shared decision making process by "facilitating resolution" of ethical conflict, CCU nurses may escape a performance/task oriented environment.

Women perceive and use power differently than men. The power bases of the parties interacting in the ethical decision making process also seems to be important. In both instances of unresolved conflict the CCU nurse disagreed with the physician in situations where his power base was dominant. As stated above, Kolb and Coolidge (1991) describe women as more likely to seek empowerment where there is "interaction among all parties in the relationship to build connection and enhance everyone's power." This also reinforces Gilligans (1982) study of gender-related differences in moral perspectives in the area of identity development. The responsibility orientation is more central to those whose conceptions of self are based on a sense of connection and relatedness to others. This sharply contrasts to the justice orientation of Kohlberg's (1971, 1976) study on boys and men who define themselves in terms of separation and autonomy.

As a primarily female group, CCU nurses come to their profession with an identity already developed through a female socialization process. The powerful templates that men have laid down in the literature, arts, and society have handed down truths, be they right or wrong, about women.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The intellectual and emotional development of women has not been fully explored. In the past, researchers have traditionally sought male research subjects. Exploring women's experiences and problems in perceiving self and relationships may provide further insight into how CCU nurses perceive, strategize, and resolve ethical dilemmas.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 6

Conclusions and Recommendations

This study describes the process used by CCU nurses in the ethical decision making process (EDMP) and provides a basis for further theory development related to how nurses make ethical decisions. In addition, the results of this study indicated that the "opening up" strategies used in the EDMP were critical to the direction of the basic social process of "facilitating resolution" of ethical conflict. This chapter identifies conclusions reached, strengths and limitations of the study, and recommendations for nursing education, practice, and research.

Strengths and Limitations of the Study

Concerns or limitations of qualitative research revolve around the issues of generalizability and representativeness of the sample. Probability sampling techniques are a prerequisite to external validity or generalizability common in quantitative research designs (Morse, 1989).

However, qualitative methods were used to describe and explain the phenomena of ethical decision making among CCU nurses, and the findings are not generalizable. Qualitative research methods are context bound, and therefore not typical of the general population of nurses. Furthermore,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the issue of representativeness of the sample is explained through deliberate selection of a sample of CCU nurses who theoretically represent patterns of ethical decision making in critical care units.

The limitations of this study include the small number of participants, the limited number of male and ethnically diverse participants, and bias in insider research. The number of participants in this study is small by some standards; however, I interviewed until no new themes appeared and saturation was reached. The categorical model of "facilitating resolution" of ethical conflict will require further validation in other settings.

The sample primarily consisted of only women. One male CCU nurse was included in the sample. The dominance of female subjects in this study may not reflect the male CCU nurses' ethical decision making processes. However, the one male CCU nurse included in this study did show similarity with female nurses in the types of perceptions, strategies and consequences of the positive outcomes of ethical conflicts.

The ethnicity of the participants was mainly caucasian. One Hispanic female was included. Perhaps few of the participants included in this study have experienced the economic hardships or racial and ethnic exclusion of minority and ethnically diverse CCU nurses. The experiences of subjects with ethnic diversity might make them more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

insistent on the importance of respect for equal worth of persons.

Furthermore, diversity in participants' religious values may also produce different results. One participant used transcending behavioral strategies to resolve ethical conflict. The perceptual viewpoint of CCU nurses in ethical conflict may be shaped not alone by their relationship to self and others, but through their religious value system.

The context or environment of the EDMP may have also influenced these CCU nurses' EDMP. The power imbalance between the physician and the CCU nurse may have filtered the CCU nurse's moral voice through their agency to the patient and their power relationship to the physician. Without the convention of the power imbalance, the CCU nurse may have used different strategies and achieved different outcomes. This may be particularly true of the two CCU nurses that experienced unfavorable consequences with certain strategies. Nurses in different settings, who experience more autonomy in practice, may have reacted differently to the perceptions of ethical dilemmas.

Finally, one of the major purposes of field research is to sensitize the researcher to the nature of the community, including language (Field, 1989). If I went into the setting "believing that the culture is already familiar, problems may have arisen, as important pieces of data may have been overlooked" (Field, 1989, p.80). This was a risk

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

for myself as a CCU nurse researcher doing field research in one's own community of CCU nurses.

However, Field does note that even when doing research in one's own society, the linguistic variables that carry social information are network specific. I attempted to counter insider bias by sampling CCU nurses from a variety of institutional settings. Furthermore, Field goes on to say that because society is formed of many sub-groups and different geographical locations, no researcher is likely to be a complete insider. In different and new institutional settings, and different geographical locations, I did not fit the description of an insider.

The strengths of this study were that all of the clinical environments had similar characteristics and that the CCU nurses working in these critical care units described their interactions and relationships with all the parties involved in the EDMP in a similar fashion. Reliability was enhanced by the process of theoretical sampling, wherein the researcher deliberately selected a sample of individuals who were theoretically representative on the basis of concepts that were relevant to the evolving theory. Deliberately selecting informants according to the theoretical needs by probing and clarifying ambiguity in the data as it emerged allowed the individuals to be representative of CCU nurses' culture and role. Interviews over time were used to corroborate recurrent or changing data, and categories were saturated, ensuring adequacy.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Conclusions

The purpose of this study was to discover the ethical decision making process through which CCU nurses resolve ethical conflict. "Facilitating resolution" of ethical conflicts explains the basis for the strategies used by these CCU nurses and the consequences seen in the EDMP.

Since the theory that has evolved from this study is based on a primarily female sample of CCU nurses, it provides insight into the way professional women approach ethical conflict. The theories proposed by others is partially supported by the data from this study.

A significant finding that is suggestive of Gilligan's (1982) and Omery's (1986) research is the influence of the environment and relationships on the ethical dilemmas and the EDMP. These CCU nurses, like the subjects in Gilligan's and Omery's research, considered relationships and connectedness important to ethical behavior. Patient care conferences, open communication, and caring were all facilitating intervening conditions for the EDMP of these CCU nurses.

Silencing of nurses' voice, sexism, lack of respect toward nurses, and paternalism were all constraining intervening conditions within the context of the ethical dilemmas. These are all examples of factors that create a lack of connectedness and separation.

The CCU nurses who had positive outcomes to their ethical dilemmas felt empowerment through the facilitation

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of interaction among all the parties involved in the ethical dilemmas, including themselves. "Facilitating resolution" of ethical conflict among all parties seemed to enhance the power of everyone involved in the ethical dilemma. Consequently, this engagement of others aimed toward "reaching understanding" was clarified, and occurred through interaction and "getting people to talk."

Other themes similar to Omery's research on adult intensive care unit nurses who were sovereign reasoners are advocacy and respect for persons. "Respecting the patient's view" was a perception or sense making of the ethical conflict employed by these CCU nurses. This was a technique they used to learn more about the client as a whole in order to see or perceive their belief system. "Respecting the patient's view" also humanized the patient.

The CCU nurses' perceptions of the conflict were often expressed as "empathizing with the patient" or "identifying with the patient." In the two participants who used this perception there was an attempt to humanize the client. The relationship between the CCU nurse and the patient was important and might be referred to by Watson (1989) as: "inter-subjectivity 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 our own" (p. 233).

However, according to the data from this study, "identifying with" others may not bring about positive

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

outcomes in ethical dilemmas. There is always the possibility of using natural empathy, such as sympathy, condolence, or pity versus clinical empathy in the process of "facilitating resolution" of ethical conflict.

Transferring emotions from personal relationships onto professional relationships may indicate a lack of internal boundaries that would allow them to keep their personal feelings separate and take responsibility for their own feelings, behaviors and thoughts. Again, this may be due to environmental factors, such as the imbalance of power between physicians and nurses, and between institutional policies and nursing practice.

Therapeutic empathy as used in the psychological counseling arena may not apply to professional nursing practice. Morse et al. (1992) outline assumptions that underlie the psychological counseling model of therapeutic empathy that may be unrealistic for critical care nursing practice. Morse points out that it may be impossible to create an empathetic relationship between the nurse and patient, similar to the counseling relationship, due to the nature of the nurse's work load in the acute care setting. The CCU nurse's lack of time, privacy, and ability to interact in the CCU setting may not be adequate to establish the necessary rapport and disclosure associated with therapeutic empathy.

Equally important are the data from this study which support a shared decision making process by CCU nurses

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

"facilitating resolution" of ethical conflict in the CCU setting. "Facilitating resolution" increases the trust between professionals and patients/families; prevents, and in some cases resolves, ethical conflict between the patient/family and professionals. Patient care conferences were often the vehicle for this shared decision making.

Recommendations for Nursing Education

It is evident from the results of this research study that nursing educational programs need to extend their focus on nursing ethics by integrating relationship enhancement methods, conflict resolution theory, and theoretical approaches to understanding male and female ethical decision making styles.

Since nursing is primarily a female profession, nurse educators need to be aware that women are very aware of the relationships among the parties in the EDMP. Education should focus on learning how the other parties perceive the ethical conflict, expressions of emotion, learning how to draw boundaries between personal relationships and resolving ethical conflict in a professional relationship, and increasing skill in problem solving through dialogue.

Women use a style of alternately listening and contributing that allows for the emergence of new understanding. Nursing education should also include skill enhancement in the areas of active listening and openness in communication. Furthermore, the theory of "facilitating resolution" demonstrated positive outcomes of ethical

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

conflict with CCU nurses' techniques of "opening up," "hearing the patient," and "respecting the patient's view." A style of learning that enhances openness, connectedness, and relationship building will raise the level of learning in nursing ethics.

Morse et al. (1992) state that nursing educational programs designed to teach nurses how to be empathetic have not influenced nursing practice or patient outcomes as dramatically as expected. However, there is an assumption that empathy is central to nursing and other helping relationships. The focus on empathy as a therapeutic strategy in nursing practice may be relevant to enhancement of the nurse-patient relationship, but what part it plays in the EDMP is not clear from this study. Inclusion of therapeutic empathy in educational programs on nursing ethics needs to be the subject of further nursing research before including it as an effective strategy.

"Respecting the patient's view" was a theme in this research that has also been brought out in Omery's (1986) research on intensive care unit nurses. Additionally, it is a relationship enhancement method that would increase the success of female CCU nurses in "facilitating resolution" of ethical conflict. Respect for the patient's view and being non-judgmental in the nurse-patient relationship should be emphasized in education on nursing education.

Inclusion of theoretical approaches to moral development that provide views of moral reasoning that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

support the importance of caring, relatedness, and responsiveness would provide an alternative to the justice focused hierarchical theories. Since women consider relationships, caring, and connectedness as important in ethical behavior, Gilligan's theory of moral reasoning should be discussed in nursing seminars on ethical decision making process. Nurses should be aware of both the justice-rights focused theories and the alternative view of caring-relationship based theories of moral reasoning.

Implications and Recommendations for Nursing Practice

This model of "facilitating resolution" of ethical conflict can be used by CCU nurses to increase understanding of the experience of ethical decision making among CCU nurses. The findings of this research imply that shared decision making implemented through "facilitating resolution" in ethical conflict will result in positive outcomes for patients in ethical dilemmas. Representing patients who can not represent themselves and sharing one's knowledge through open communication forums such as patient care conferences will achieve demonstrated positive patient outcomes. Furthermore, prevention of ethical conflict and enhanced understanding may be achieved through proactive planning to "get people to talk," "facilitating between parties," "re-evaluating" care and communication, "supporting patient/family," and "praying for" clients. The use of relationship enhancement methods will also encourage resolution of ethical dilemmas.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Patient care conferences were demonstrated through this research to assist patients, nurses, physicians, and families to explore what the care needs are, and to increase trust levels of the care team. In modern professional nursing, an important component of managed care is coordination of care. One of the nurse's main responsibilities is "getting people to talk" about the plan of care and the goals of care. This coordination of care necessarily entails "facilitating resolution" through patient care conferences. Patient care conferences were a facilitating intervening condition, and encouraged shared decision making between all parties. In the future, patient care conferences will become routine in every critical care unit.

Relationship enhancement methods should be used by nurses to increase the perceptual abilities in the EDMP. Openness, respecting the patient's view, and active listening were a few of the techniques used in resolving ethical dilemmas. Group process skills that can successfully facilitate decision making are invaluable. Knowing the patients and their families enhances the nurse-patient relationship which is at the heart of the interdisciplinary team process of "facilitating resolution" of ethical conflict.

In the future the use of therapeutic empathy in the clinical setting needs to be clarified. The critically ill patient and his family may be totally focused on coping with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

a critical or life-threatening illness. The time needed to establish a therapeutic empathetic relationship with a client or his family may not be possible. Lack of time, privacy, and inability to communicate with the patient may interfere with the empathic process and not culminate in positive patient outcomes as demonstrated in this research. Nurses may project their own feelings into patient situations and as a consequence limit their range of responses to the ethical dilemma rather than enhance the EDMP. Further nursing research into the use of therapeutic empathy in acute care settings is recommended.

Implications for Nursing Research

This study provides direction for further research in the area of nurses' ethical decision making process. The scope of this research is limited to ten CCU nurses, and can not be generalized beyond this group. However, the "facilitating resolution" theory does provide a basis for the development of formal theory.

Future studies should expand the study of ethical decision making among CCU nurses to all male or mixed group studies. One male CCU nurse in this study was not adequate to describe differences between male and female CCU nurses' responses, perceptions, and strategies used in the EDMP. Furthermore, male subjects may have different responses to ethical dilemmas and use different strategies to resolve the ethical dilemmas. The one male subject in this study responded similarly to the female subjects in perceptions of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ethical conflict and strategies to resolving ethical conflict. However, this is not conclusive that all male CCU nurses would respond similarly to these female CCU nurses.

Further research on male subjects may also elucidate how they perceive and use power in interactions among all parties in the EDMP. Do male CCU nurses need connection and relationship building in order to "facilitate resolution" of ethical conflict in critical care units? How do male nurses use their agency to the patient, employer, and other health care providers in the environment of the CCU setting? Further research on EDMP with more male subjects is needed to clarify these issues.

Questions were raised regarding the use of therapeutic empathy in the "opening up" phase of "facilitating resolution" versus the use of natural empathy. The use of therapeutic empathy has been borrowed from the field of psychological counseling and may be inappropriate for use in an acute care setting such as critical care. The use of therapeutic empathy within the context and conditions of such a setting needs further exploration.

Further research on the part that subjects' internal and external boundaries play in the perceptions stage of the EDMP is also indicated. The lack of or permeability of internal boundaries in nurses may promote transference and projection of the nurses' own feelings and emotions into the patient situation.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Additionally, inquiry into the relationship of power between parties, such as the nurse-physician relationship, may give further clarity to EDMP. Women see the EDMP flowing from the relationship between parties. Non-parity in relationships and interactions between parties that provoke emotions have an impact on EDMP.

Finally, this inquiry has contributed to the profession of nursing by elucidating the EDMP of a group of nurses involved in ethical dilemmas on a daily basis. Therefore, any study that clarifies this process adds to the body of knowledge and thus the understanding of this important aspect of critical care nursing. Further research into the area of ethical decision making can assist other disciplines as well as nursing to gain valuable insight into women's ethical decision making processes.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

REFERENCES

Aikens, C. (1925). Studies in ethics for nurses. Philadelphia: W.B. Saunders.

Allen, J.D., & Hall, B.A. (1988). Challenging the focus on technology: A critique of the medical model in a changing health care system. Advances in Nursing Science, 10(3), 22-34.

American Nurses Association. (1926). Committee on ethical standards: A suggested code. American Journal of Nursing, 26, 600.

American Nurses Association. (1940). Committee on ethical standards: A tentative code. American Journal of Nursing, 40, 978.

American Nurses Association. (1950). Committee on ethical standards: A code for nurses. American Journal of Nursing, 50, 196.

American Nurses Association. (1953). Committee on ethical standards: What's in our code? American Journal of Nursing, 53, 1009.

American Nurses Association. (1976). Code for nurses with interpretive statements. Kansas City, MO: American Nurses Association.

American Nurses Association. (1980). Nursing: A social policy statement. Kansas City, MO: American Nurses Association.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

American Nurses Association. (1985). Code for nurses with interpretive statements. Kansas City, MO: The Association.

Ashley, J. (1976). Hospitals, paternalism, and the role of the nurse. New York, NY: Teachers' College Press.

Baggs, J.G., & Schmitt, M.H. (1995). Intensive care decisions about level of aggressiveness of care. Research in Nursing & Health, 18, 345-355.

Beauchamp, T.L., & Walters, L. (1989). Contemporary issues in bioethics. Belmont, CA: Wadsworth Publishing Co.

Beck, L.W. (1959). Foundations of metaphysics of morals. Indianapolis, IN: Bobbs-Merril.

Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1986). Women's way of knowing. New York: Basic Books.

Bentham, J. (1967). An introduction to the principles of morals and legislation. In A.I. Melden (Ed.), Ethical theories: A book of readings (pp. 367-390). Englewood Cliffs, NJ: Prentice-Hall.

Bishop, A.H., & Scudder, J.R. (1987). Nursing ethics in an age of controversy. Advances in Nursing Science, 9(3), 34-43.

Bode, J., & Page, R. (1978). Comparisons of measures of moral development. Psychology Reports, 43, 307-312.

Bowie, N., & Freeman, R.E. (1992). Ethics and agency theory. New York, NY: Oxford University Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Bussey, K., & Maughan, B. (1982). Gender differences in moral reasoning. Journal of Personality and Social Psychology, 42, 701-706.

Callahan, D. (1987). Setting limits. New York, NY: Simon & Schuster.

Callahan, S. (1988). The role of emotion in ethical decision making. Hastings Center Report, 18(3), 9-14.

Caplan, A. (1981). Kidneys, ethics, and politics: Policy lessons of the ESRD experience. Journal of Health, and Political Policy Law, 6, 488-503.

Carpenter, M.A. (1994). Tutor or tyrant? In J. McCloskey, & H. Grace (Eds.), Current issues in nursing (pp. 758-762). St. Louis, MO: Mosby.

Cassidy, V.R. (1991). Ethical responsibilities in nursing: Research findings and issues. Journal of Professional Nursing, 7(2), 112-118.

Cassidy, V.R., & Oddi, L.F. (1988). Professional autonomy and ethical decision making among graduate and undergraduate nursing majors. Journal of Nursing Education, 27, 405-410.

Cassidy, V.R., & Oddi, L.F. (1991). Professional autonomy and ethical decision-making among graduate and undergraduate nursing majors: A replication. Journal of Nursing Education, 30(4), 149-151.

Chinn, P.L., & Jacobs, M.K. (1983). Theory and nursing: A systematic approach. St. Louis, MO: Mosby.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Chrisham, P. (1981). Measuring moral judgment in nursing dilemmas. Nursing Research, 30(2), 104-110.

Cooper, M.C. (1989). Gilligan's different voice: A perspective for nursing. Journal of Professional Nursing, 5(1), 10-16.

Corley, M.C., & Selig, P.M. (1992). Nurse moral reasoning using the nursing dilemma test. Western Journal of Nursing Research, 14(3), 380-388.

Corley, M.C., Selig, P., & Ferguson, C. (1993). Critical care nurse participation in ethical and work decisions. Critical Care Nurse, 13(3), 120-128.

Crott, H., Kayser, E., & Lamm, H. (1980). The effects of information exchange and communication in an asymmetrical negotiation situation. European Journal of Social Psychology, 10, 149-163.

Cunningham, N., & Hutchinson, S. (1990). Myths in health care ethics. Image: Journal of Nursing Scholarship, 22(4), 235-238.

Curtin, L. (1980). Ethical issues in nursing and nursing education. New York: NLN.

Curtin, L. (1986). Nursing in the year 2000: Learning from the future. Nursing Management, 17(6), 7-8.

Curtin, L. (1990). The committment of nursing. In T. Pence, & J. Cantrall (Eds.), Ethics in nursing: An anthology (pp. 283-286). New York: National League for Nursing.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Davidson, D., & Robbins, S. (1978). The reliability and validity of objective indices of moral development. Applied Psychology Measurement, 2, 389-401.

Davis, A.J., & Aroskar, M.O. (1983). Ethical dilemmas and nursing practice (2nd ed.). Norwalk, CN: Appleton-Century-Crofts.

Dewey, J. (1934). Art as an experience. New York, NY: Minton, Balach, & Co.

Dewey, J. (1937). Logic: The theory of inquiry. New York, NY: Wiley.

Dewey, J. (1965). Reflective morality and ethical theory. In R. Ekamm (Ed.), The nature of moral theory. New York, NY: Charles Scribner's & Sons.

Dock, L. (1966). Nurses should be obedient. In B. Bullough, & V. Bullough (Eds.), Issues in nursing (pp. 96-97). New York, NY: Springer.

Edelstein, L. (1967). The Hippocratic Oath: Text, translation, and interpretation. In O. Tempkin, & C.L. Tempkin (Eds.), Ancient medicine: Selected papers of Ludwig Edelstein (pp. 3-64). Baltimore, MD: The John Hopkins Press.

Edwards, C.P. (1978). Social experience and moral judgment in East African young adults. Journal of Genetic Psychology, 133, 19-29.

Emra, K.L. (1988). Does the nursing shortage change the rules? RN, 5(10), 30-35.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Erlen, J.A., & Frost, B. (1991). Nurses' perceptions of powerlessness in influencing ethical decisions. Western Journal of Nursing Research, 13(3), 397-407.

Felton, G., & Parsons, M. (1987). The impact of nursing education on ethical-moral decision making. Journal of Nursing Education, 26(1), 7-11.

Field, P.A. (1989). Doing fieldwork in your own culture. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 79-94). Rockville, MD: Aspen.

Field, P.A., & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Rockville, MD: Aspen.

Ford, M.R., & Lowery, C.R. (1986). Gender differences in moral reasoning: A comparison of the use of justice and care orientation. Journal of Personality and Social Psychology, 50(4), 777-783.

Frisch, N. (1987). Value analysis: A method for teaching nursing ethics and promoting the moral development of students. Journal of Nursing Education, 26(8), 328-332.

Fry, S. (1989). Toward a theory of nursing ethics. Advances in Nursing Science, 11(4), 9-22.

Gadow, S. (1980). Philosophical foundations of nursing. In S. Spicker, & S. Gadow (Eds.), Nursing: Images and ideals (pp. 79-101). New York: Springer.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gadow, S. (1987). Nurse and patient: The caring relationship. In A.H. Bishop, & J.R. Scudder (Eds.), Caring, curing, coping: Nurse, physician, patient relationships (pp. 31-43). Birmingham, AL: University of Alabama Press.

Garwood, S.G., Levine, D.W., & Ewing, L. (1980). Effect of protagonists sex on assessment of gender differences in moral reasoning. Developmental Psychology, 16, 677-678.

Gilligan, C. (1977). In a different voice: Women's conception of the self and morality. Harvard Educational Review, 47(4), 481-517.

Gilligan, C. (1982). In a different voice. Cambridge, MA: Harvard University Press.

Gilligan, C. (1986). Remapping the moral domain: New images of the self in relationship. In T.C. Heller, M. Sosna, & D. Wellberry (Eds.), Reconstructing individualism: Autonomy, individuality and the self in western thought. Stanford, CA: Stanford University.

Gilligan, C. (1987). Moral orientation and moral development. In E.F. Kittay, & D.T. Meyers (Eds.), Women and moral theory. Totowa, NJ: Rowan & Littlefield.

Gilligan, C., Langdale, S., Lyons, N., & Murphy, M. (1982a). The contribution of women's thought to developmental theory: The elimination of sex bias in moral development research and education. Final report: National Institute of Education.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gilligan, C., & Wiggins, G. (1987). The origins of morality in early childhood relationships. In J. Kagan, & S. Lamb (Eds.), The emergence of morality in young children (pp. 277-305). Chicago, IL: University of Chicago Press.

Glaser, B. (1978). Theoretical sensitivity. Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1965). Awareness of dying. Chicago, IL: Aldine Publishing Co.

Glaser, B., & Strauss, A. (1968). Time for dying. Chicago, IL: Aldine Publishing Co.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York, NY: Aldine DeGruyter.

Grennan, E.M. (1930). The ultimate problems of ethics: A brief review of the Somera case. American Journal of Nursing, 30, 733-734.

Heidegger, M. (1962). Being and time. J. Macquarrie, & E. Robinson (Trans.). New York, NY: Harper & Row.

Heider, F. (1958). The psychology of interpersonal relationships. New York, NY: John Wiley & Sons.

Hilbert, G. (1988). Moral development and unethical behavior among nursing students. Journal of Professional Nursing, 4(3), 163-167.

Holstein, C.B. (1976). Irreversible, stepwise sequence in the development of moral judgment: A longitudinal study of males and females. Child development, 47, 51-61.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Hudack, C.M., Gallo, B.M., & Lohr, T. (1986). Critical care nursing: A holistic approach. Philadelphia: Lippincott.

Hutchinson, C.P., & Bahr, R.T. (1991). Types and meanings of caring behaviors among elderly nursing home residents. Image: Journal of Nursing Scholarship, 23(2), 85-88.

Ketefian, S. (1981a). Moral reasoning and moral behavior among selected groups of practicing nurses. Nursing Research, 30(3), 171-176.

Ketefian, S. (1981b). Critical thinking, educational preparation, and development of moral judgment among selected groups of practicing nurses. Nursing Research, 30(3), 98-103.

Kolb, D., & Coolidge, G.G. (1991). Her place at the table: A consideration of gender issues in negotiation. In J.Z. Rubin, & J.W. Breslin (Eds.), Negotiation theory and practice (pp.261-277). Cambridge, MA: Harvard Program on Negotiation.

Kohlberg, L. (1971). From is to ought. How to commit the naturalistic fallacy and get away with it in the study of moral development. In P. Boaltes, & K. Schaie (Eds.), Cognitive development and epistemology (pp. 151-235). New York, NY: Academic Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Kohlberg, L. (1976). Moral stages and moralization: The cognitive developmental approach. In T. Lickona (Ed.), Moral development and behavior, theory, research, and social issues (pp.31-53). New York, NY: Holt, Rhinehart, & Winston.

Kurtines, W., & Grief, E.B. (1974). The development of moral thought: Review and explanation of Kohlberg's approach. Psychological Bulletin, 81, 453-470.

Larkin, H. (1988). Will the public support health care rationing? Hospitals, 9, 79.

Lincoln, Y.S., & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lyons, N.P. (1988). Two perspectives: On self, relationships and morality. In C. Gilligan, J.M. Ward, & B. Bardige (Eds.), Mapping the moral domain (pp.21-48). Cambridge, MA: Harvard University Press.

Mellody, P. (1989). Facing codependence. San Francisco, CA: Harper & Row.

Miller, J. (1976). Toward a new psychology of women. Boston, MA: Beacon Press.

Millette, B.E. (1994). Using Gilligan's framework to analyze nurses' stories of moral choices. Western Journal of Nursing Research, 16(6), 660-674.

Moody-Adams, M.M. (1991). Gender and the complexity of moral voices. In C. Card (Ed.), Feminist ethics (pp. 195-212). Lawrence, KS: University Press of Kansas.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Morse, J.M. (1989). Qualitative nursing research: A contemporary dialogue. Rockville, MD: Aspen.

Morse, J.M., Anderson, G., Bottorff, J.L., Yonge, O., O'Brien, B., Solberg, S.M., & McIlveen, K.H. (1992). Exploring empathy: A conceptual fit for nursing practice? Image: Journal of Nursing Scholarship, 24(4), 273-279.

Munhall, P. (1980). Moral reasoning levels of nursing students and faculty in a baccalaureate nursing program. Image: Journal of Nursing Scholarship, 21(3), 172-175.

Muyskens, J.L. (1982). The nurse as an employee. In Moral problems in nursing: A philosophical investigation. Savage, MD: Rowman & Littlefield.

Nails, D. (1983). Social scientific sexism: Gilligan's measure of man. Social Research, 50(3), 643-666.

Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Berkeley: University of California Press.

Nokes, K. (1989). Rethinking moral reasoning theory. Image: Journal of Nursing Scholarship, 21(3), 172-175.

Omery, A. (1986). Moral reasoning of nurses who work in adult critical care settings. Heart & Lung, 15, 313.

Omery, A. (1989). Values, moral reasoning, and ethics. Nursing Clinics of North America, 24(2), 499-508.

Orchowsky, S.J. & Jenkins, L.R. (1979). Sex biases in the measurement of moral judgment. Psychological Reports, 44, 1040.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Packard, J.S., & Ferrara, M. (1988). In search of the moral foundation of nursing. Advances in Nursing Science, 10(4), 60-71.

Peters, R.G. (1971). Moral development: A plea for pluralism. In T. Mischel (Ed.), Cognitive development and epistemology. New York, NY: Academic Press.

Piaget, J. (1932). The moral judgment of the child. New York, NY: The Free Press.

Piaget, J. (1965). The moral judgment of the child. New York: The Free Press.

Pinch, W.J. (1985). Allocation of scarce resources: Critical care nursing dilemma. Dimensions of Critical Care Nursing, 4, 164-173.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Summing Up. (1982). Washington D.C.: U.S. Government Printing Office.

Priest, A. (1983). The moral reasoning process of critical care nurses. Unpublished master's thesis, University of Virginia, Charlottesville.

Priest, O. (1957). Utilitarianism. New York: Bobbs-Merrill.

Ray, M.A. (1987). Technological Caring: A new model in critical care. Dimensions in Critical Care Nursing, 6(3), 166-172.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reigle, J. (1992). Preserving patient self-determination through advance directives. Heart and Lung, 21(2), 196-198.

Rest, J.R. (1974). Manual for the defining issues test. Minneapolis, MN: University of Minnesota.

Rest, J.R. (1975). Recent research in an objective test of moral judgment: How the important issues of a moral dilemma are defined. In D.J. Depalma, & J.M. Foley (Eds.), Moral development: Current theory and research (pp. 75-93). New York: John Wiley & Sons.

Reverby, S. (1987). A caring dilemma: Womanhood and nursing in historical perspective. Nursing Research, 36(1), 5-11.

Rotter, J.B. (1967). A new scale for the measurement of interpersonal trust. Journal of Personality, 35, 651-665.

Sample, R. (1978). Psychology, thought, and morality: Some limitations of Piaget and Kohlberg. In P. Scharf (Ed.), Readings in moral education (pp.220-229). Minneapolis, MN: Winston Press.

Schatzman, L., & Strauss, A. (1973). Field research. Englewood Cliffs, NJ: Prentice-Hall.

Searle, L. (1988). The extent of the nursing shortage in critical care. Heart and Lung, 17, 25A-28A.

Simpson, E.L. (1974). Moral development research, a case of scientific cultural bias. Human Development, 17, 81-106.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Smerke, J.M. (1990). Ethical components of caring. Critical Care Nursing Clinics of North America, 2(3), 509-513.

Strauss, A.L. (1990). Qualitative analysis for social scientists. New York: Cambridge University Press.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Strosberg, M.A., & Fein, I.A. (1987). Policy and management issues in rationing care for the critically ill. Hospital Administration Currents, 31, 1-6.

Swanson, J.M. (1986). The formal qualitative interview for grounded theory. In W.C. Chenitz, & J.M. Swanson (Eds.), From practice to grounded theory: Qualitative research in nursing (pp.133-145). Menlo Park, CA: Addison-Wesley.

Swanson, J.M., & Chenitz, W.C. (1986). Surfacing nursing process: A method of generating nursing theory from practice. In W.C. Chenitz, & J.M. Swanson (Eds.), From practice to grounded theory (pp.24-380). Menlo Park, CA: Addison-Wesley.

Tate, B.L. (1977). The nurse's dilemma: Ethical considerations in nursing practice. Geneva: International Council of Nurses.

Taylor, C. (1995). Medical futility and nursing. Image: Journal of Nursing Scholarship, 27(4), 301-306.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Thelan, L.A., Dave, J.K., & Urden, L.D. (1990). Critical care nursing. St. Louis, MO: C.V. Mosby.

Thompson, J.E., & Thompson, H.O. (1985). Bioethical decision making for nurses. Norwalk, CT: Appleton-Century-Crofts.

Veatch, R.M., & Fry, S.T. (1987). Case studies in nursing ethics. Philadelphia: J.B. Lippincott.

Watson, J. (1985). Nursing human science and human care. Norwalk, CT: Appleton-Century-Crofts.

Watson, J. (1989). Watson's philosophy and theory of human caring in nursing. In J. Riehl-Sisca (Ed.), Conceptual models for nursing practice (3rd ed.) (pp.219-236). Norwalk, CT: Appleton & Lange.

Webster's new collegiate dictionary. (1976). Springfield, MA: Merriam-Webster.

Webster's new world dictionary. (1984). New York, NY: Warner Books.

White, G.B. (1983). Philosophical ethics and nursing: A word of caution. In P.L. Chinn (Ed.), Advances in nursing theory and development. Rockville, MD: Aspen.

Wilkenson, L. (1987). Moral distress in nursing practice: Experience and effect. Nursing Forum, 23(1), 16-29.

Wilson, H.S. (1977). Limiting intrusion-social control of outsiders in a healing community. Nursing Research, 26(2), 103-111.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Winland-Brown, J. (1983). A comparison of student nurses, nurses and non-nurses with regard to their moral judgments on nursing dilemmas. (Doctoral dissertation, Florida Atlantic University). Dissertation abstracts international, 44, 336B.

Wlody, G. (1990). Ethical issues in critical care: A nursing model. Dimensions of Critical Care, 9(4), 224-230.

Yarling, R., & McElmurry, B. (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.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Appendix A

Interview Guide

CODE #0

Time in Position: Years;

Years in Nursing: Years;

Level of Education:

Description of Work Setting:

Age:

Ethnicity:

Sex:

GUIDE QUESTIONS FOR INTERVIEW

Tell me about the last time you made an ethical decision.

What did you view the ethical dilemma to be?

What led you to this conclusion?

What types of situations seem to cause ethical dilemmas in your work setting?

How did you react to the last situation that you considered to be an ethical dilemma while it was going on? ...after it was over? Was this typical of how you respond to ethical dilemmas in your work setting? If not, how did it differ? What made this situation different?

Were there any conditions/factors that affected your decision making process in this dilemma?

How did the other health care team members respond to it at the time? ...after it was over? Was this a typical response for the health care team? If not, how did it differ? What made this situation different for them?

How did the nurse managers respond to it at the time? ...after it was over? Was this response typical of the nurse managers?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

If not, how did it differ? What made this situation different?

How did the patient's family respond to it at the time? ...after it was over? Was this response typical of family members? If not, how did it differ? What made this situation different?

What was the outcome of this situation? If needed probe with: on people? working relationships? the work setting in general?

Is there anything further that you would like to tell me about your ethical decisions made in your work setting?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

UNIVERSITY OF SAN DIEGO

CONSENT TO ACT AS A RESEARCH SUBJECT

Mary E. Bowen, doctoral candidate, is conducting a research study that involves interviewing critical care unit staff nurses. Since I have been selected to participate in this study, I understand that I will be interviewed about ethical decision making in my work setting. I further understand that I may be asked for a follow up or second interview by the researcher.

I understand this data collection will take about an hour each time that I am interviewed. Furthermore, I understand that the interview will be tape recorded. Participation in the study should not involve any added risks or discomforts to me except for the possible minor fatigue or emotional discomfort as I relive my experiences with ethical decision making.

My participation is entirely voluntary. I understand I may refuse to participate or withdraw at any time.

I understand that my research records will be kept completely confidential. My identity will not be disclosed without consent required by law. I further understand that my name will not be used in any publication of the results of this study.

Mary E. Bowen has explained this study to me and answered my questions. If I have other questions or research-related problems, I can reach Mary E. Bowen at 619-788-1590.

There are no other agreements, written or verbal, related to this study beyond that expressed on this consent form. I have received a copy of this consent document.

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

Location

Signature of Researcher　　　　　　　　　　Date

Signature of Witness　　　　　　　　　　Date

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Ellen Hyslop Reardon • [illegible] San Diego, CA 92108 • 619/563-5160

March 10, 1993

Human Subjects Committee
USD School of Nursing
Alcala Park
San Diego, CA 92110

Dear Human Subjects Committee and
Mary Bowen:

I appreciate the opportunity to participate as back up counsel for Mary Bowen in her research study. I will be available as a clinical nurse specialist to provide counseling as needed to the nurses she includes in her study regarding ethical decisions made among critical care nurses.

I have been in private practice in the Mission Valley area as a clinical nurse specialist. I work primarily with adults and specialize in women's issues, depression and group therapy. I have extensive background working in the medical arena as a nurse in the medical-surgical setting and then more recently as a consultant with a specialty in psychiatric issues.

Thank you very much for this opportunity.

Sincerely,

Ellen Hyslop Reardon MSN RNCS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.