

ETHICAL ISSUES IN CRITICAL CARE: A PERCEPTUAL STUDY
OF NURSES' ATTITUDES, BELIEFS AND ABILITY TO COPE

by

Margret T. Fenton

A thesis submitted to the University of Manitoba
in partial fulfillment of the requirements
for the degree

Master of Education

Winnipeg, Manitoba

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ABSTRACT

Critical care nurses are frequently involved in traumatic life and death events. The nurse's perception of and response to the ethical dimension of these kinds of situations are not clearly understood. The purpose of this investigation was to explore and describe the perceptions and beliefs that critical care nursing students and their instructors have in relation to the ethical issues which occur in their clinical practice. Semi-structured interviews were conducted with 5 instructors and 5 recent graduates of an Intensive Care Nursing program situated in an 1250 bed acute care hospital. A phenomenological approach to the analysis of the interview transcripts focused on: 1) the participants' perceptions of the ethical issues which occur in critical care, 2) their attitudes, feelings and beliefs in relation to these issues and 3) the manner in which they responded to and coped with these situations. Results indicate that nurses are most distressed by situations involving excessive therapy and discontinuation of therapy. Participants described feelings of emotional distress which sometimes required a significant period of resolution. This study adds to the understanding of critical care nursing practice and the findings have implications for nursing education and administration.

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Somewhere along the path of development we must discover what we really are, for the influence we exert is through our own life and what we become ourselves.

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To be a nurse requires the willing assumption of ethical responsibility in every dimension of practice. The nurse enters a partnership of human experience where sharing moments in time - some trivial, some dramatic - leaves its mark forever on each participant. The willingness to enter with a patient that predicament which he cannot face alone is an expression of moral responsibility, the quality of the moral commitment is a measure of the nurse's excellence.

(Levine, 1977, p.845.)

Chapter One

Nursing is a profession which involves an intimate and caring relationship between human beings. It demands expert knowledge and skill, but also a genuine human response to the whole individual (Watson, 1979). Nursing may be described as a problem-solving process, guided by scientific principles. However, it cannot be detached from human emotions nor can it be completely neutral with respect to human values. As the nurse shares in the life events of another human being, personal values, beliefs and attitudes may play an important role in determining the nature of that relationship.

Caring for a patient in a life-threatening crisis is challenging and demanding. Critical care requires that the nurse has advanced knowledge and expert psychomotor skills in order to function safely and effectively in an environment where unexpected emergencies are a common occurrence. The life crises that the nurse shares with a critically ill patient often involve situations which challenge one's personal moral beliefs and values.

Quality of life, the right to die and the right to receive or reject treatment are issues that occur frequently in the critical care unit. The nurse is challenged not only by the major bioethical dilemmas which concern matters of life and death, but also by the seemingly more insignificant

problems of confidentiality, interdisciplinary communication and bureaucratic policy. Ethical issues can therefore be a persistent problem in critical care and the nurse's ability to come to terms with these issues can greatly affect the quality of care that the patient receives.

Care of the critically ill patient involves an interdisciplinary approach to problem-solving. Decisions are made by a team of health care professionals which may include the physician, the nurse, the pharmacist, the dietary consultant, and a group of medical specialists. Although the nurse may participate in the problem-solving process, the physician assumes the responsibility for the final decision. When this decision concerns an ethical issue, the nurse may face a serious moral conflict in which the medical orders are contrary to one's personal beliefs. Conflicting responsibility to the patient, the physician, the profession, the institution and to one's personal integrity are factors which may create a significant personal dilemma for the nurse.

The nurse is guided by a professional code of ethics, but this serves only as a guide and does not offer solutions to complicated ethical problems (Levine, 1977). Bureaucratic policy also serves as a guide for the interdisciplinary team in the problem solving process, but the unique variables involved in each patient situation may create a considerable

element of 'grayness' in choosing alternatives. Although there may be policy and procedure guidelines for the team to utilize in the decision-making process, the unique circumstances of individual patient care situations may require a significant degree of interpretation in order to apply this protocol to an ethical dilemma.

Skill in manipulating scientific data cannot be equated with the ethical problem of examining values and making value judgments. Although clinical judgments involve reasoned analysis, Aroskar (1980) states that clinical expertise cannot be generalized to the moral and ethical dimensions of a patient care situation. A reasoned and critical approach to problems of an ethical nature requires knowledge of ethical theory and an ability to apply ethical principles to a unique situation in order to choose a morally justifiable action (Thompson and Thompson, 1985). The effective resolution of an ethical issue may therefore be a significant challenge for the health team.

Although an ethical issue may be extremely complicated for the health team, the ineffective personal resolution of such a problem may be a significant source of stress for the nurse who is so intimately exposed to the family in crisis. Because of the continuous contact that the nurse has with the patient and family, Youngner, Jackson and Allen (1979), State that there is also a more intimate contact with physical and

psychological pain and suffering. Emotional depletion and spiritual exhaustion may be a consequence of such stress over an extended period of time. The nurse who is emotionally depleted from the stress of a prolonged or unresolved ethical issue may be unable to render quality care to the patient. The long term effects of this type of situation may be not only personally devastating for the nurse, but require a lengthy period of resolution.

In summary, response to an ethical issue in critical care involves one's personal values and beliefs. Moral conflict and emotional distress results when personal values and beliefs are challenged by the ethical dimension of a patient situation and particularly when the decision of the health team is contrary to one's personal values or beliefs. Conflicting loyalties to the patient, the health team, the nursing profession, the institution and to self may create a multi-dimensional problem for the nurse who must personally come to terms with such situations.

How the critical care nurse perceives morally distressing situations and personally comes to terms with the ethical issues involved is not clearly understood. This study describes the critical care nurse's perceptions of ethical issues and the factors which may be associated with the personal resolution of these issues.

Purpose of the Study

This is an exploratory/descriptive study which focuses on two different groups of critical care nurses. In order to provide a rich description of the phenomenon of ethical issues in critical care, the personal experience of a group of neophyte and a group of more experienced critical care nurses will be explored.

The purpose of this study is to explore and describe the perceptions and beliefs that critical care nursing students and their instructors have in relation to the ethical dilemmas that occur in clinical practice.

The study focuses on the following research questions:

1. What are the ethical dilemmas that critical care nursing students and their instructors perceive in clinical practice?
2. What are the feelings, attitudes and beliefs that critical care nursing students and their instructors have in relation to these ethical dilemmas?

3. How do critical care nursing students and their instructors come to terms with these ethical dilemmas?

Definition of Terms

For the purpose of this study, the following definitions are applied to the terms used in this thesis:

Ethics may be defined as a systematic reflection on human behaviour (Walleck, 1983), ou comme la science du bien et du mal (Blondeau, 1986). Both ethics and morals are used in the English language in reference to right and wrong behaviour and attitude. For the purpose of this investigation, morals is used in application to the practical consideration, whereas ethics is used to distinguish the theoretical aspects of approval or disapproval of a given conduct (Thompson and Thompson, 1985).

Issue refers to a point in question, a matter not yet finally settled or a problem and is used interchangeably with the term problem in this thesis (Gove, 1966).

Dilemma refers to a difficult problem which seems incapable of a satisfactory solution. It involves a choice between equally unsatisfactory alternatives (Aroskar, 1980).

Ethical Dilemma is a situation which arises from conflicting moral obligations, rights and claims (Walleck,

1983). It creates such questions as "What ought I to do? What is the right thing to do? What harm or benefit will result from this decision or action?" (Davis and Aroskar, 1983, p.6). There are no right or wrong answers, only choices between equally unacceptable solutions. Curtin (1982) states that a dilemma may not be solvable, however it is resolvable and where there is a choice, even though it is between two equally unfavourable solutions, the choice of taking no action may be even worse. A true dilemma is rare.

Ethical Problem is a situation which is characterized, according to Curtin (1982) by the fact that: 1) it cannot be resolved through the application of scientific data, 2) it is inherently perplexing and 3) the answer which is achieved will have relevance for several areas of human concern. It raises two questions, the answers to which are related but distinct. These questions relate to the issue of finding an answer which will allow the individual peace within himself and peace with others.

Attitude is a disposition primarily grounded in affect and emotion and is expressive of an opinion rather than a belief (Gove, 1966).

Belief is a firm conviction as to the beneficial, genuine or good quality of something. It is a mental acceptance of or an assent to something offered as true with or without certainty (Gove, 1966).

Feeling is an emotional state of responsiveness, a frame of mind or an unreasoned opinion (Gove, 1966).

Response is a reaction, that is, the act or action, of responding to a stimulus (Gove, 1966).

To cope is to face or encounter in order to find the necessary expedients to overcome a problem or a difficulty (Gove, 1966).

Critical Care refers to the care of the critically ill patient in a specific and specially equipped location of an acute care facility. It involves the nurse in the care of the individual who is in crisis, whose life is threatened by the acute phase of a disease process, by the effects of surgical intervention or as the result of an accident. Critical care often involves the utilization of life support systems as well as aggressive and complex interventions.

Critical Care Nurse refers to the nurse who is employed in a critical care unit and who has normally completed a post

basic intensive care nursing program. This nurse is able to utilize advanced knowledge and the psychomotor skills necessary to provide safe and effective nursing care to the critically ill patient.

Intensive Care Nursing Program refers to the post basic program offered to nurses who are currently registered to practice and who have at least one year of experience in an acute care practice setting (for example a medical or a surgical ward). It incorporates 8 months of theoretical and practical opportunities for the nurse to gain knowledge and skill in the care of the critically ill patient.

Critical Care Nursing Instructor is the individual who has completed a post basic course in intensive care nursing, has had experience working in a critical care area and is employed as an instructor in the Intensive Care Nursing Program.

Critical Care Nursing Student is the individual who is enrolled as a student in the Intensive Care Nursing Program.

Limitations of the Study

This study has several limitations which may influence the significance of the results. Variations in the previous practical experience, educational preparation, cultural background, sex, age and religion of the sample population

may affect the nature of the results of this study. Attitudes, feelings and beliefs regarding matters of ethical concern are significantly determined by one's past life experiences. Cultural as well as religious background often determines the personal philosophy that is applied to such situations and these factors will be uniquely different for each nurse.

The unpredictable nature of the critical care setting creates novel experiences for each student who participates in the Intensive Care Nursing Program, and the individual's perception of the ethical issues will reflect this. In planning for the student's practical experience, it is impossible to predict what will occur during a scheduled shift. The patients who are cared for in the critical care unit are physiologically unstable, with the result that unanticipated emergencies are common. The students, therefore, each experience a unique reality in clinical practice and formulate their perceptions based on this.

As a means of coping with the stress of working in a crisis situation, critical care nurses may become hardened and insensitive to the suffering that they witness daily. Fromer (1981) states that the continual exposure to intense and massive doses of human suffering is one factor that may be responsible for the deteriorating sensitivity that is evident in nursing practice. Carper (1979) states that

technological advances and the trend towards specialization has resulted in a fragmentation of patient care which is essentially depersonalizing. Several factors may then perpetuate an attitude of indifference or insensitivity and this may be reflected in a decreased awareness of ethical issues as they occur in clinical practice.

The significance of this study may also be influenced by researcher bias. Because of this investigator's personal past experience as a critical care nurse, there is a degree of expectation as to the nature and the means of coping with the ethical issues which are common in the critical care setting.

The choice of an interview as a strategy to collect information may impose several limitations on this investigation. Investigator bias may have influenced the direction of the interview through the design of the interview questions. As well, the tone of the interview may be influenced by the investigator's verbal or nonverbal response and the choice of probing questions utilized during the process of the interview.

The selection of a research paradigm which is qualitative in nature is limited by several factors. Leininger (1985) would argue that limitations of a qualitative methodology could be considered as strengths and attributes which distinguish this approach from a more

traditional quantitative method. The factors which are subject to such criticism involve difficulty with replication, subjectiveness of the design, researcher bias, lack of procedural guidelines and the fact that the information collected is remembered experience dependent on the participant's memory and subject to interpretive reflection. These comments will be explored more completely in subsequent sections of this chapter and in the review of the literature.

Basic Assumptions

1. Critical care nursing involves the nurse in matters of ethical concern.
2. The critical care nurse utilizes personal attitudes and beliefs in responding to and in coming to terms with these concerns.

Significance of the Study

This study adds to the understanding of critical care nursing practice. By determining what nurses perceive as ethical dilemmas and exploring how they cope with these situations, the meaning inherent in the reality of such situations may then be captured. Understanding the

experience of ethical issues from the perspective of the neophyte and the experienced critical care nurse may have implications for educators and administrators concerned with this particular area of specialized care.

If coping with such issues is a source of significant stress for critical care nurses, then deliberate efforts to prepare and support the critical care nurse should be considered. An awareness of the reality of this kind of experience could assist with such an effort.

Methodology

Nursing is concerned with the human experience of dysfunction and the understanding of such lived experience is accessed through one's perceptions, beliefs, skills and expectations according to Benner (1985). A phenomenological approach was selected as a research paradigm for this study because, as Oiler (1982) states, this approach can most effectively meet the goal of understanding a lived experience.

The research strategy utilized in this investigation was that of hermeneutics. As a particular view within the paradigm of phenomenology, hermeneutics focuses on the study of a person within the context of the situation (Smith, 1983). A hermeneutical approach, states Smith, focuses on

"the attempt to achieve a sense of the meaning that the others give to their own situation through an interpretive understanding of their language, art, gestures and politics" (p. 12). It is a process which takes into account the fact that meaning is historically and socially bound and that individual reaction is based on past experience, cultural influences, expectations, rules and biases.

As a research paradigm, a phenomenological approach is an expression of a particular ontological and epistemological view. This is reflected in several basic assumptions which influenced the conception and the process of this investigative effort.

In a phenomenological or naturalistic sense, reality is mind dependent, that is, there "is no reality independent of the shaping or creating efforts of the mind" (Smith, 1983, p.8). Reality is subjective, meaning that the world becomes real through contact with it and also perspectival, meaning that knowledge and experience shape one's view of reality (Oiler, 1982). One essential assumption of the phenomenological paradigm is a belief in the individual as self-interpreting (Jorgenson and Crabtree, 1986). Interest in the individual then focuses on the significance of how objects appear and the meaning that is given to a phenomenon of study. Meaning is paramount and as Benner (1985) states, it is contained neither solely within the individual nor the

situation. Rather, it is a transaction between the two, so that "the individual both constitutes' and is constituted by the situation" (Benner, 1985, p. 7).

Truth then becomes "a composite of realities (where) the world is grasped in profiles dependent upon individual perspective" (Oiler, 1982, p. 179) and where multiple realities are inter-related to form a pattern of truth. "Phenomena do not converge into a single form, a single truth, but diverge into many factors, many truths" (Guba and Lincoln, 1981, p. 57). A pattern of truths then constitutes the subjective reality of an experience.

This investigation is designed to search out such a pattern in relation to the participant's subjective experience with an ethical issue. Thus the goal of this investigation is to attempt to understand the individual nurse's experience with the phenomenon of ethical issues in critical care through the exploration and description of the context bound experiences of the participants.

Sources of Information

The target population for this study were the students and the instructors in an Intensive Care Nursing Program located in a 1250 bed teaching hospital in mid-western Canada. These two groups were selected as being

representative of the neophyte and the experienced critical care nurse. Students entering the program do not normally have past experience in critical care nursing. From the data obtained on the information sheet, this assumption was found to be true of this particular group of students. The experiences of this student group are therefore assumed to be typical of the inexperienced critical care nurse. One of the selection criteria for instructors in this particular intensive care nursing program is that they have demonstrated expertise in the clinical practice of critical care nursing. Because of the criteria of demonstrated expertise in clinical practice, it is assumed that this group might be representative of the experienced critical care nurse.

One month prior to actually contacting the individual participants, the investigator met separately with each group of students and instructors. The purpose of this meeting was to inform the two groups about the general nature and purpose of the proposed investigation and to provide an opportunity for the group members to raise questions or concerns. Group members were also offered the opportunity to decline to have their telephone number made available to the investigator if they so desired.

The sample population of five students was randomly selected from an alphabetical list of the eleven class members who completed their program of study in October,

1986. The students names were numbered from one to eleven in alphabetical order and with a random start at the ninth name, every second name to a total of five names was selected as an individual to contact. As a result of their irregular working hours and the subsequent difficulty in contacting these individuals, the final sample selection became the first five individuals who answered the telephone over a ten day period. Participation in the study was voluntary. Each of the five instructors was contacted by telephone and asked if she would consider volunteering to participate in the study. All of them agreed.

Data collection technique

Within one month of agreeing to participate in this study, each participant was again contacted by telephone to arrange for a suitable time and location for the interview. The personal contact of these two telephone conversations also served to establish the beginning of a relationship which then carried over to the actual interview. After several 'no shows', at the beginning of this process, a telephone call on the day of or prior to the interview was made to re-confirm the time and availability of the participant.

Selecting a location for the interview depended on the

working hours of the participant and the geographical location of the participant's home. Locations were selected which were convenient for the participant, but which also ensured privacy during the interview. Such locations varied from the interviewer's dining room to the participant's living room to an empty classroom in the hospital at the end of a working day. The time of day for the interview also varied from morning to evening depending on the participant's working schedule.

The location sometimes served as a barrier to communication. Guba and Lincoln (1981) suggest that the interview take place in comfortable surroundings in a face to face arrangement so that both interviewer and participant can look each other in the eye. When the selected location was the participant's home, such an arrangement was often side by side on a couch and this sometimes seemed to be a deterrent to openness during the course of the interview.

At the beginning of the interview, each participant was asked to complete an information sheet (see Appendix A) which included biographical information in relation to age, sex, religion, marital status, educational background and work experience. The participants were also asked to sign an agreement with the investigator that confirmed their understanding that participation in the interview was voluntary, that the data were confidential and that reporting

of the findings of the investigation would be done in such a way as to maintain the anonymity of the participants (see Appendix B). This consent form also included permission to tape record the interview. Participants were unanimous in their consent to have the interview tape recorded.

The interview, states Patton (1980), provides a framework within which respondents are able to express their understanding of the world in their own terms. The focus of this investigation was a sensitive and potentially emotional topic, and Guba and Lincoln (1981) suggest that the interview is more likely to elicit accurate responses on sensitive topics. It also provides a more complete picture of a participant's world view than other forms of inquiry. This method provided an appropriate means of exploring the nature of ethical issues in critical care.

Participants were informed at the time of initial contact that the interview would take approximately one to one and a half hours. Generally, the interviews varied in length from less than one hour to two hours.

A semi-structured technique was selected as the format for the interview. Selltitz, Wrightsman and Cook (1976) state that the less structured interview is more commonly used for an intensive study of perceptions, attitudes and motivations, and that this approach is useful when the investigator wishes to determine how a respondent conceptualizes a topic. These

authors describe the main purpose of such an interview as that of focusing attention on a given experience and its effects or, as Bogdan and Biklen (1982) state, gaining an interpretive understanding of the meaning that an individual assigns to his or her beliefs or behaviour.

The semi-structured interview, states Leininger (1985), is designed to elicit both definitive and unexpected kinds of information from the participant. This type of interview, states Wilson (1985), begins with an outline of topics which the investigator intends to cover. However, the interviewer and the participant also have the freedom to deviate from such an agenda in order to explore thoughts and feelings as the interview evolves.

Several interview strategies were employed in planning the structure of the interview. Spradley (1979) describes these as broad enquiry, descriptive questions and the use of experience queries. These strategies were utilized to assist the investigator to maintain as neutral a role as possible during the interaction. A list of ten questions, based on these concepts, was designed and utilized as a framework during each interview (see Appendix C).

The interview process is also facilitated by a degree of flexibility states Babbi (1979). Flexibility helps to elicit the affective and value-laden aspects of a response and to determine the personal significance or meaning which these

aspects have for the participant. Babbi also states that the participant's answers should form the basis for subsequent questions. Neutral probes, which Babbi describes as nondirective questions designed to elicit an elaboration on an incomplete response to an open-ended question, are a means of getting answers in more depth without biasing the subsequent answers. Some examples of the neutral probes used during the interview can be found in Appendix D.

One of the disadvantages of reflection on past experiences is that, as Oiler (1982) states, what is uncovered is not pure experience but rather it is remembered experience. Such reflections are influenced by the subject's interpretation of that experience so that the experience becomes layered with facts and theories which the individual may have used to make sense out of it. Controlling the bias involved in such interpretive reflection is accomplished by a process of what Oiler calls bracketing, that is, a pulling away of those layers of interpretation. Thus the neutral probes described earlier were a mechanism which helped to bracket the experience, that is, to bring it into clearer focus. Questions such as "What do you mean by that?" or "What did you think about that?" are ways of identifying the way in which the recalled experience may have been influenced by interpretation.

Other interview strategies were also employed to

facilitate an atmosphere of trust and openness during the process of the interview. Attending behaviour such as eye contact, verbal tracking, body language and mirroring the participant's posture (Ivey, 1982), were nonverbal skills which were utilized to help the participant to feel at ease during the interview. Verbal skills including reflection of feeling words, phrases and statements, as well as summative statements were employed in order to clarify and understand the participant's views. Interviewer responses were aimed at reflecting a sensitive and accepting awareness of the emotional nature of the topic as well as the participant's personal views.

Taking notes during the interview is suggested by Patton (1980). Although this was occasionally a distraction for the participant, it was a helpful strategy for formulating new questions, tracking themes as they emerged and facilitating later analysis by locating significant quotations. Notes taken during the process of the interview consisted of major points made by the participant and key words or terms which captured the participants own language.

The goal of interpretive understanding, or verstehen, states Smith (1983), involves the need to recreate within oneself, the experience of others. "At its core, the essence of understanding is to put oneself in the place of the other - something which is possible if one possesses a degree of

empathy with the other or has the disposition to recreate the experience" (p.12).

Involvement in the interview is a characteristic of naturalistic enquiry and the investigator, states Goodwin and Goodwin (1984), is often viewed as the investigative instrument. Guba and Lincoln (1981) state that "only the human instrument can produce descriptions of situations and cultures that provide the audience with an empathetic and vicarious experience of what it must have been like to be 'on site'" (p. 148). Interactivity is a characteristic of such a process and is based on the inseparable nature of the relationship between the investigator and the phenomenon being investigated.

A phenomenological approach is concerned with the product of human minds and according to Smith (1983), is therefore connected inseparably to our minds inclusive of all attendant subjectivity, emotions and values. Oiler (1982) states that researcher involvement is exploited in such an investigation with the deliberate and purposeful employment of empathic and intuitive awareness.

The subjective nature of phenomenological enquiry necessitates an awareness of the potential for researcher bias. Guba and Lincoln (1981) state that the best cure for biases is to be acutely aware of how they interfere with our interpretation of the subject's reality. These authors

suggest that the investigator keep a record of personal reactions and changes as the study progresses. Reliability of research results may be enhanced by this process of self awareness and reflection on how personal biases may shape what is heard. This is also analogous to the concept of bracketing which was presented earlier.

In order to limit the possibility of such bias, a journal was kept by the investigator. This was a record of the investigator's subjective reactions, impressions, observations and thoughts in relation to the process of each interview and to the participants. It included such information as the biographical data and personal appearance of the participant in relation to behaviour during the interview (posture, voice tone or inflection and eye contact).

The journal entries were made immediately or as soon as possible after the conclusion of the interview. This information not only contributed to the descriptive data but also enabled the interviewer to examine personal reactions and thoughts in relation to the collected data. Bogdan and Biklen (1982) state that such a process of self conscious awareness may limit investigator bias and facilitate greater critical insight.

Investigator bias was also suggested previously as a result of this author's personal past experience as a

critical care nurse. However, this possibility was countered by the insight and understanding that was possible as a result of a common background between investigator and participant. Jorgenson and Crabtree (1986) state that critical care nurses speak a language which is uniquely oriented to their work environment and that dialogue between nursing and medical personnel is transposed into a hybrid language. The participants in this study made use of this language by using phrases such as "the chronic COPDer and the post MI in cardiogenic shock" and terms such as "the Swan Ganz or the sage pumps". As the interviews evolved, particularly when the participant described an intensely emotional situation, understanding this language was thought to be a distinct advantage in attempting to search for the meaning inherent in such situations.

Reality in a phenomenological sense is context bound and dependent on the subjective interpretation of a lived experience and this is communicated through language. Thus, states Smith (1983), the description of that reality cannot be expressed in neutral scientific terms, but rather that which is consituted as real can only be expressed with the language of everyday life, the language of the situation. Thus the goal of this investigation was to gather, in the participant's own language, a rich description of the participant's lived experience in relation to the ethical

issues which occur in critical care nursing.

Each interview was tape recorded and transcribed completely in order to capture all of the descriptive detail provided by the participants. To protect their anonymity, participants were identified by randomly selected initials in the transcribed text of the interview. The transcripts together with the journal entries constituted the body of information which was used in the analysis phase of this investigation.

Data Analysis

The interview is a means of providing a structured social framework from which meaning can be systematically discovered (Brenner, 1978) and "one must respect the meanings which actions have to their actors if one is to formulate worthwhile explanations of social phenomena" (Menzel, 1978, p.141). Only reasonable claims can be made as to the meaning of an event, and answers cannot be interpreted at their face value. It is essential to interpret statements and facts in terms of what they mean to the participant.

The initial step in this process occurred in the interview process itself, where the interviewer attempted to clarify and understand the participant's statements as thoroughly as possible. In transcribing the interviews, further

clarification resulted from adding observations about the participant's behaviour in relation to the topic of discussion. For example, when the discussion focused on a sensitive issue that the participant encountered, observation and post interview recording of the associated nonverbal behaviour enhanced the descriptive data.

The reflection and speculation which occurred with each interview was an initial step in the search for meaning in the data and also served to stimulate critical thinking about what was seen or heard. Analysis also involved a systematic search for common elements or themes as they emerged. Focusing on emerging themes during the interviews provided an opportunity to explore in greater detail those areas which were of particular concern to a participant.

Within two weeks of each interview, the transcripts were returned to each participant for the purpose of clarification and verification of the content. Guba and Lincoln (1981) state that such member checks provide a means of testing the credibility of the research findings. Leininger (1985) adds that giving the participants a copy of the interview transcripts engages them in the research process. Such member checks ensure that the information is clear and understandable and expresses what the participant intended to say. This process also provided an opportunity for the participant to delete any information contained in the

transcripts which they did not wish to be used in the investigation.

Participants in this study were quite willing to read the transcript of their interview. There were no deletions made and minimal changes were suggested. However, comments contained within the returned documents reflected a unanimous concern with grammar and the lack of coherence in the verbal expression of their thoughts and feelings. Leininger (1985) states that informants in her study were similarly distressed by the disorganized and inconsistent transition between thoughts in the interview transcript. She attributed this to the difference in the spoken word when it is transcribed to a written form.

The purpose of analysis in interpretive research is to discover commonalities in meanings, situations, practices and bodily experiences, according to Benner (1985). By identifying common themes and recurring elements, Oiler (1982) states that the investigator is able to identify the ingredients of the phenomenon and the way in which these ingredients relate to each other.

Through a systematic analysis of the whole text and a systematic analysis of parts of the text, two interpretations may evolve. This permits a comparison of the two for conflicting themes and for understanding the whole in relation to the parts and vice versa. Smith (1983) states

that in order to achieve a meaningful interpretation through a hermeneutic approach, a process of constant movement between the parts and the whole is necessary. Benner (1985) states that a shifting between the whole and the parts of the transcripts may reveal new themes, issues or questions which are relevant to the process of understanding. Thus, to understand the meaning of a particular part of the text requires an understanding of the whole. Although the research questions provided a framework in the search for themes and elements of commonality, they did not confound the discovery of unexpected themes.

Three interpretive strategies which were employed in the systematic analysis of the text of the interviews are described by Benner (1985). Two presentation strategies are paradigm cases and exemplars, and each permits a depiction of the person in the situation. A paradigm case is a significant instance of a particular pattern of meanings whereas an exemplar is a smaller but strong instance of a particularly meaningful transaction.

Paradigm cases and exemplars provided a focus for this investigation. Participants were asked during the interview, to describe particularly significant situations in their past experience which exemplified their perception of an ethical dilemma. The context of such situations was then explored for patterns of meanings and concerns in relation to

feelings, attitudes and beliefs of the participant.

Thematic analysis is the third interpretive strategy described by Benner (1985). This involved a search through the transcript for common themes and patterns. Once each interview transcript was analysed utilizing these three strategies, transcripts were then compared to discover similarities and differences in the interpretation. The goal of all three interpretive strategies is to discover meaning and to achieve an understanding of the participant's subjective experience of reality. Each strategy is not only a discovery but also a presentation mechanism in that the participant's verbatim descriptions provide the means for presenting the findings.

Credibility of the Findings

Several mechanisms to establish credibility or truth value were conducted in this study. Guba and Lincoln (1981) suggest that a member check or host verification is the most important mechanism for establishing credibility. Member checks were conducted at two stages. Interview transcripts were verified by the participants shortly after each interview occurred. The interpretation of each interview transcript was also returned to the participant for

verification following analysis. At this time participants were asked to verify the legitimacy of the interpretations as a realistic reflection of their perceptions, attitudes, beliefs and feelings (see Appendix E).

Another mechanism is triangulation, which Guba and Lincoln (1981) describe as a verification of the interpretive analysis by an independent observer. Triangulation was achieved by the use of independent individuals who were willing to read the transcripts and the interpretation to verify that the analysis was a valid interpretation of that participant's lived experience. This mechanism also served to ensure that the interpretations were reliable, or as Guba and Lincoln (1981) state, dependable. Replication is virtually impossible using a qualitative approach because of the changing conditions of the individual and the situation. Traingulation, however, provided a degree of consistent agreement in the interpretation of the data.

A third mechanism which Guba and Lincoln (1981) describe as establishing credibility, is that of phenomenon recognition. When the phenomenological description guides the reader to a personal lived experience of that phenomenon, which Oiler (1982), states may be either actual or potential, then such a description is considered to be a valid depiction

of that phenomenon. Benner (1985) states that this is a means for the reader to be an active participant in the validation process.

Summary

Ethical issues may be a significant deterrent to the psychological well-being of the nurse and may also be reflected in compromised quality of care for the critically ill patient. This chapter described the background and the plan for an investigation designed to explore the perceptions and beliefs of nurses in relation to ethical issues in critical care. A phenomenological approach provided the basis for the conceptualization and the process of this study and facilitated the discovery of an interpretive understanding of the experience of ethical issues in the selected group of critical care nurses.

Organization of the Thesis

This thesis is organized according to a standard format. Chapter one includes the background information, purpose, research questions, limitations and significance of the study, as well as a discussion of the methodology. Chapter two is a review of the current literature. Chapter three is a presentation of the findings of this investigation. Chapter four presents a summary of the findings as well as the relevance of these findings in relation to the current literature. Suggestions for further investigation of this topic provide the conclusion to this thesis.

Chapter Two

Review of the Literature

The intensive care unit is sometimes the end of the medical line, where the final acts of social tragedy are played out.

(Youngner, Korbin and Jackson, 1983, p.834)

Ethical issues occur in critical care more frequently than in other areas of health care primarily because the patients are critically ill and are often being treated with a variety of life support interventions. Mechanical ventilation, aggressive pharmaceutical therapy, and a variety of invasive monitoring devices are commonly used to support the patient in crisis. Unexpected emergencies and problems can materialize with perisistent regularity, and problem-solving and decision-making in such instances may frequently involve considerations of an ethical nature. For example, the terminally ill patient has a right to a dignified and peaceful death, but this patient may be the recipient of emergent intervention aimed at sustaining life at any cost.

In a survey of more than one thousand practising

physicians in the United States, Pellegrino, Hart, Henderson, Loeb and Edwards, (1985) found that respondents perceived ethical dilemmas to be a frequent occurrence in their daily practices. Participants in a study conducted by Wilkinson (1986), indicated that moral distress occurs frequently, that is, at least weekly, in the practice of nursing. Ethical issues may be a concern for the critical care nurse because of their potential for frequent occurrence as well as the degree of moral distress that may be produced.

In her book From Novice to Expert, Benner (1984), states that "the nurse is frequently required to make painful and unpopular decisions" (p.266). The role of the nurse, in many of the ethical issues which were described by participants in her study, was often to identify the issue and to insist that necessary decisions be made judiciously and by a responsible person. Benner adds that these kinds of incidents have not only made lasting impressions on the nurse but they have also required a lengthy period of resolution.

Ethical issues in the care of the critically ill patient may be extremely complicated. The factors involved in such issues may be associated not only with the rights of the patient, but also with conflict in role relationships, personal and professional accountability and legal implications. In order to provide direction and clarity, this review of the literature is organized under three major

headings: ethical issues in critical care, factors which influence the nurse's response, and resolution of the ethical issue.

Ethical Issues in Critical Care

White (1983) describes an ethical dilemma as "the intellectual problem associated with the weighing of the competing principles that suggest alternative courses of action" (p.41). White sharply criticizes the labelling of situational problems or personal conflicts as ethical dilemmas. An ethical dilemma, states White, is not resolved in situational terms but rather by a philosophical analysis which involves giving reasons, enunciating principles and considering outcomes.

A situation which involves a conflict between nurse and doctor in relation to a plan of care may contain an ethical dilemma. However, according to White, when a physician withholds information which a client requests, the situation of the nurse is not an ethical dilemma, but rather a situational problem.

The following information may not concur with White's definition; however, it is a reflection of ethical issues as they are described in the current literature. Although these issues reveal common themes or patterns, they are also unique

in nature because of the individual variables present for a particular patient in a particular situation at a particular time of life.

It is possible to categorize ethical issues into major areas, according to Thompson and Thompson (1985); however, any such grouping involves extensive overlapping. Four major issues identified in a review of the literature are: informed consent; quality of life; allowing death; and death with dignity. The following discussion will focus on these four areas and conclude with a presentation of several other issues which may generate ethical dilemmas for the critical care nurse.

Informed consent is a legal term which refers to the right that every human being of adult years has in determining what should be done with his body. In "Impaired Autonomy," (1983), the author states that the patient must be given adequate information personally and with care, and that consent must be voluntary and uncoerced. Thompson and Thompson (1981) state that the adult of sound mind should be able to choose whether to accept treatment or not and also to what extent, regardless of how necessary that treatment is in a life-threatening situation. This means that the patient should be well informed of the essential nature as well as the consequences of any intervention that is medically

necessary, and that the decision as to whether this treatment is acceptable be left to the patient. '

One ethical principle which relates to informed consent is autonomy. According to Davis and Aroskar (1983), this implies that the individual has the right to determine a course of action based on sound as opposed to arbitrary principles. Autonomy is limited when the individual's capacity or capability to consent to treatment is uncertain. Storch (1982) indicates that conditions such as mental retardation, mental illness, blindness, deafness and illiteracy can limit a patient's autonomy.

In the critical care unit, autonomy may be limited by the patient's level of consciousness, the effects of sedation, the stress of a life-threatening illness or an unexpected emergency. An emergency situation may require an immediate intervention with treatment necessary to reverse a life threatening problem. When the patient suffers a sudden cardiac arrest, for example, time does not permit the health care team to determine whether or not the patient wishes to be resuscitated!

In an emergency situation, states Kiely (1985), the relationship between patient and physician may assume a coercive or paternalistic nature, that is "the imposition of values and beliefs without benefit of self determination or choice" (Thompson and Thompson, 1985, p. 76).

Problem-solving and decision-making with regard to a treatment plan while the patient is not able to participate or actively seek an alternative course of action is generally justified according to Brown (1985), who describes this behaviour as weak paternalism. Rosovsky and Rosovsky (1985a) state that treatment in a medicolegal emergency should be limited only to that which is necessary to stabilize the patient's condition or to alleviate a life-threatening problem.

The chain of events, according to Cann and Crawford (1985), begins when the patient's condition suddenly deteriorates. Lacking documentation of that patient's wishes, the emergency interventions required to alleviate the problem may require the establishment of life support systems. The patient is often unconscious at this time and the family may subsequently have to participate in a decision which involves active withdrawal of life-sustaining therapy.

The issue of informed consent may also generate an ethical dilemma as a result of a lack of documentation of a patient's expressed wishes, poor communication between family and health care professionals and the medicolegal obligation to respond to a sudden deterioration in physiological status.

Decisions in the care of the critically ill patient are not always made in accordance with what might be that patient's expressed desire. Wallace-Barnhill, Roth, Briggs,

Bastra and Barrocas, (1982) state that patients who experience sudden loss of consciousness have seldom left specific instructions or proper legal documents to provide direction for such a medical emergency. Relatives are not always aware of such an individual's wishes nor do they always agree on the best course of action when decisions regarding life support interventions are necessary. Cann and Crawford (1985) describe an intense atmosphere, a disoriented patient, an anxious family and the number and diversity of staff caring for the patient as other possible explanations for the occasions when patients and families are either not consulted during the decision-making process, or their expressed wishes are not considered or documented.

The nurse, according to Aroskar (1985), is often caught in the middle of such patient care situations. Witte (1984) states that the nurse is the health care person who spends the most time with the patient and may therefore be most aware of the patient's feelings about dying. Having to participate in an emergent resuscitation process while at the same time knowing that the patient would never have agreed to this aggressive form of intervention is an ethical problem for the nurse.

The concept of a person as an autonomous agent requires the health care team to respect the values of the patient and not to permit their own values to influence decisions

regarding treatment, as Thompson and Thompson (1985) state. However, accepting a patient's decision to refuse treatment may conflict with one's personal and professional value system, and create significant personal anxiety. Moskop and Kopelman (1985) discuss the personal conflict that a physician experiences when a patient refuses treatment, and they describe as an example, a patient with chronic lung disease who refused the option of mechanical ventilation as a treatment for an acute respiratory infection and thereby hastened his death.

Patient competence may be a problematic issue. Meisel, Grenvik, Pinkus and Snyder (1986) state that, although the unconscious patient is clearly not capable of making an informed decision, competence is uncertain when the patient's mental status is only partially compromised. For example, Pinch (1985c) cites a confused patient's questionable consent to treatment as a source of an ethical dilemma. In the critical care unit, a patient who is sedated or stressed by the sudden onset of a severe illness may not be able to participate actively in an informed decision-making process. Kemp (1985) asks the question: "Who should make the decision when the patient is not competent?" (p. 356). As Pinch (1985c) writes, decisions should be patient-centered within the constraints of a collegial health care practice.

Patient competence is more frequently questioned when the

patient refuses treatment, according to Annas, Glantz and Katz (1981). In agreeing with this statement, Dracup (1986) adds that greater conflict is experienced by the health care team when the patient's competence to refuse treatment alternatives is uncertain. By questioning the patient's competence in such a situation, health care professionals may be imposing their own values and beliefs on the patient. Decision-making when patient competence to participate is not certain may be a significant challenge as well as an ethical dilemma for the interdisciplinary team and the patient's family.

The critical care unit is a service setting which is also used as an experiential learning laboratory for critical care nursing students. Corcoran (1977), in discussing this as an ethical issue, raises a significant concern by asking: Is the patient's right to quality care compromised by the student's right to learn the skills of the profession? Several factors must be considered, according to Corcoran, before the patient is assigned to a student who requires experiential learning. One that relates to the ethical problem of informed consent is that the patient should be fully informed, have the opportunity to ask questions and consent to the experience with the option to withdraw consent at any time. This may not be possible in the critical care unit, particularly when the patient is unconscious and unable

to respond appropriately.

The patient has a right to be informed that the nurse in the critical care unit may be a student, acquiring the art and skill of critical care nursing through an experiential learning process of caring for him/her states D'Amato (1985). Ethical concerns evolve from such questions as: Should this nurse inform the patient that this is a learning experience, that some of the procedures that must be performed are being done by him or her for the very first time? Should the patient be informed when the nurse is trying a new or alternate technique of positioning, changing a dressing or administering a drug? Although these procedures or actions may seem relatively innocuous, they still have an experimental nature and may be a source of an ethical problem for the critical care nurse.

In summary, informed consent is well defined as a patient right. However, it may be a source of an ethical issue in the critical care unit, when it is compromised during an emergency situation or by the uncertainty of a patient's competence to participate in the decision-making process.

Quality of life for the patient is a second issue which may create an ethical issue in the care of the critically ill patient. Kiely (1985) defines quality of life as the plan of one's life, or the interrelated purposes of an individual

that give life its unity and thus bring us to regard the individual and ourselves as irreplaceable and beyond price. Quality of life is a personally meaningful term and difficult to define in a universally acceptable manner, because as Thompson and Thompson (1985) state, life at any price may be preferable to one person while death may be a merciful end to a life that is intolerable for another.

The ethical issue in critical care is not associated with the preservation of a meaningful existence, but rather, with the extension of a comatose life, a life filled with pain and suffering or a life in which there is little hope of recovery. Parsons (1985) indicates that modern medical treatment has not provided us with a longer life but a slower death. The debate on quality of life is perpetuated, according to Gilmore (1984), by a lack of agreement on the degree to which a patient is benefited or burdened by treatment.

The problem is also perpetuated by a degree of ambiguity and confusion in the use of the quality of life and sanctity of life concepts. O'Rourke and Brodeur (1986) state that sanctity of life refers to the fact that the individual is valuable, regardless of the state of health. One source of confusion is the tendency to interpret the sanctity of life concept in an extreme sense. This position is referred to as vitalism, meaning that physical existence should be preserved

and is morally required even when human potential cannot or can no longer be realized.

The sanctity of life principle, according to Keyserlingk (1979), has religious origins. It is an expression of a basic intuition about life which is inherently related to the mystery which surrounds all finite existence. The nature of this mystery may be specified in religious concepts, however, Schils (1966), states that " the Christian doctrine was enabled to maintain its long prosperity and to become effective because it was able to conform for so many centuries to a deeper, proto-religious 'natural metaphysic'" (p. 41). Beliefs about the sanctity of life are upheld because of a respect for life as mysterious and this is described by Schils as deeper than religious or cultural origins.

The sanctity of life principle supports a belief in the fact that human life is precious and worthy of protection and respect. Quality of life, according to O'Rourke and Brodeur (1986), means that an individual's capability to achieve life goals partly determines the value of that life. When these capacities no longer exist, then any obligation to prolong life ceases.

The issue of quality versus sanctity of life centers on the relationship between biological life and human qualities and the significance of this relationship in a medical

decision-making process. McCormick (1978) states that a separation of these two concepts is a false conceptual split and that "quality of life assessments ought to be made within an overall reverence for life, as an extension of one's respect for the sanctity of life" (p.35). A false dichotomy exists, states Reich (1978), when one fails to acknowledge the fact that "the sanctity of life principle depends on moral judgments concerning qualities of human life that go beyond mere biological life" (p. 832).

Quality and sanctity of life are not opposites, states O'Rourke and Brodeur (1986). The two approaches should not be set against each other, according to McCormick (1978), but rather the concepts of quality and sacredness should be utilized in a decision-making process which focuses on the benefit of the patient.

One issue directly related to this debate is the fact that patients can now be kept alive mechanically for almost indefinite periods of time, as stated by Aroskar (1985). One example of such an ethical issue is the brain dead individual who is being maintained on life support in the critical care unit prior to organ retrieval. Aroskar poses two questions in relation to this type of situation: Is this individual still a person and is the care of such an individual a wise use of scarce nursing resources and expertise?

Caring for a patient in a deeply comatose state when the

prospects for recovery are uncertain may be a depressing experience especially over an extended period of time, as described by Flaherty (1982). An unconscious patient may require intensive nursing care as well as mechanical life support for several years. Caring for the human being who does not respond in any way may be morally distressing. Kiely (1985) questions whether the mechanical support of this patient prolongs his living or his dying. Flaherty (1982) states that because the nurse is the individual who is with the patient twenty-four hours each day, the personal conflict in this type of situation is a greater challenge to the nurse than it is for other health care professionals who do not have this kind of intimate contact.

Quality of life is also compromised by the extreme measures that are sometimes necessary in the care of the critically ill. Kiely (1985) states that medical heroics may inadvertently augment or fail to relieve an individual's suffering. The widely disputed question, according to Cohen (1982) is when, if ever, should therapy for a critically ill patient be terminated? From her experience as an intensive care nurse, Bishop (1978) describes as tragic, the misuse of medical and technological skills which may ultimately lead to an abuse of human dignity. The dying patient should not receive painful and useless treatment, yet Cohen (1982) agrees that this problem is emotion laden and difficult to

approach in the course of hectic daily work.

In some situations, according to Kemp (1985), health professionals do everything possible to prolong life in order to avoid facing ethical decisions regarding critically ill patients. Choosing to intervene with complex technological solutions to the patient's physiological problems is sometimes done to avoid the reality of the fact that there is no way to solve the problem. Fenner (1980) suggests that death is often seen by health professionals as an indication of failure.

"Life and death have never been closer to each other than in the Intensive Care Unit" state Jorgenson and Crabtree (1986, p. 189). Death is often inevitable and yet seen as a sign of defeat. Sudden life-threatening events played out in a limited time span have generated a view of death as a symptom that demands an immediate response and technology has enabled the health team to alter what once was destiny. However, saving lives is not easily equated with doing good and the dilemma produced from defining life by physiological parameters is not easily solved.

the quality of life in some people, if they survive
.....I question this; what are we doing here?
.....because they've lived.

(Jorgenson and Crabtree, 1986, p.190)

Setting appropriate treatment goals and desisting from care which does not serve to correct the disease or repair the injury, rather than persisting with treatment which only prolongs patient suffering and death is a physician's duty, according to Shragg and Albertson (1984). These authors identify chronic critical illness as a current problem in health care, and cite as an example, a patient with multisystem failure who required costly critical care intervention for eight months. The care of this type of patient has the potential to generate numerous ethical concerns, particularly in relation to the patient's quality of life.

Medical experimentation may also compromise quality of life. Gramelspacher, Howell and Young (1986) state that patients in the critical care unit are often the subjects of such experimentation. Informed consent is required, according to Grad (1984), but this process may be complicated by the patient's competence. The experimental treatments may have significant deleterious side effects which will affect the patient's quality of life. This is further complicated by the fact that the patient may not have understood the consequences of the medical intervention. Also, it may not have been possible to predict the degree of pain or discomfort that the patient might experience. Patient

discomfort and distress as a result of frequent repositioning and interruption of rest periods or visits with family occurs because of the necessity to monitor physiological response to the experimental therapy. In caring for this patient, the critical care nurse may be frustrated by a desire to meet the patient's needs for physiological and psychological comfort while also obligated to measure and record the data required by the medical experimentation.

Quality of life may be compromised by unsafe or substandard practice from which, Kiely (1985) states, the patient must be protected. Observing and failing to report a colleague whose standard of practice does not follow established protocol or who functions in an incompetent manner can form the basis for negligence litigation, according to Rosovsky and Rosovsky (1985c).

The nurse is responsible for the well-being of the patient, as stated in the Canadian Nurses Association, Code of Ethics for Nursing (1985). When incidents of unsafe or substandard practice are observed, the nurse is faced with an obligation to maintain the well-being of the patient. However, reporting such behaviour may result in the nurse's being labelled as a "whistle blower", according to Kiely (1985). This reputation, states Glazer (1983), is frequently associated with serious personal and professional harassment. In an effort to optimize the patient's quality of life, the

nurse who witnesses unsafe or substandard practice is morally challenged by an obligation to report such behaviour, yet may be personally at risk as a result.

In summary, quality of life for the critically ill patient may be associated with a variety of ethical problems. These are related to the care of the long term unconscious patient, termination of life-sustaining therapy, medical experimentation and unsafe or substandard practice.

The third issue associated with ethical issues in critical care is that of allowing the patient to die. Decisions to resuscitate or not to resuscitate, to treat or not to treat with aggressive therapy or to withdraw or not to withdraw such interventions generate serious ethical concerns in the critical care unit. Such problems have generally been discussed using the term euthanasia, which Cawley (1977) states is "the intentional and express termination of a life whose quality is such that it is not worth living" (p.859).

Euthanasia according to Curtin (1977), has been used in many different and confusing ways and she suggests that the word has lost its utility in that it no longer functions to clarify understanding. Keyserlingk (1979) states that euthanasia may mean allowing to die with care but more commonly means the direct killing of a dying patient.

In an effort to clarify the use of the term euthanasia,

Curtin (1977), describes sixteen different kinds of situation to which this term might be applied.' Some of the examples she utilizes to illustrate the application of the term euthanasia to patient situations are: voluntary mercy killing with prior voluntary authorization or proxy authorization; involuntary mercy killing with prior voluntary authorization or proxy authorization; involuntary mercy killing by refusing or withholding treatment; reasonable and humane care of the dying; and deliberate medical triage. Curtin suggests that the word euthanasia be replaced with more appropriate descriptive terms.

Qualifiers such as active or passive, or direct or indirect are also used to specify situations which are described using the term euthanasia. Keyserlingk (1979) states that these serve only to confuse the issue. He suggests that since we cannot restore this term to its original meaning of 'a good death', it would be more appropriate to discuss the immorality of euthanasia and the morality of dying well.

Euthanasia in a customary usage, suggests an active choice of death as well as the means for accomplishing it. Allowing death with care should not be described as euthanasia, but rather as appropriate care.

Death's cause is not advanced by acts of omission or by refraining. Death's cause is advanced by the disease state itself, which is now useless to fight.

(Keyserlingk, 1979, p.123).

A major problem associated with the issue of allowing death is related to the use of resuscitation equipment. Rosovsky and Rosovsky (1985b) state that the use of such equipment symbolizes one of the greatest ironies in our society. Although it was originally designed to assist the patient who suffered sudden cessation of respiratory or cardiac function, it is often used to maintain respiration in the patient who has suffered irreversible brain damage.

Termination of life support, according to Beechler and Steinmetz (1985), is a frequently confronted gray area in medicine. Fear of litigation as well as the lack of clear cut direction from institutional policy, professional associations and the law are reasons that Rosovsky and Rosovsky (1985b) suggest for the extended utilization of life support equipment. Regardless of the reason, the use of life support equipment creates complicated ethical problems for health care professionals.

The order not to resuscitate a patient is a medical decision and before this can be initiated, the consent of the patient must be obtained. This is a difficult task and

Rosovsky and Rosovsky (1985b) state that the physician is legally required to inform the patient completely as to the purpose and nature of the order, the risks and benefits involved (death as opposed to continuation of suffering), and the availability of any reasonable options. In the event that the patient is not competent to make such a decision, the next of kin must face this responsibility.

"Verbal orders or the failure of any such orders regarding critically ill patients have traditionally resulted in much confusion and frustration for critical care nurses" (Kemp, 1985, p.355). Documentation of a 'do not resuscitate' (DNR) order is important for two reasons according to Rosovsky and Rosovsky (1985b). A patient should not be resuscitated in error or labelled DNR by mistake. Also, the accurate documentation of such an order is essential to defend any legal claim of negligence.

Physicians, states Kiely (1985), sometimes circumvent the system by refusing to write the orders that they are verbally giving, especially to the critical care nursing staff. And in the rigid adherence to the principle of continuing life, Bandman and Bandman (1979) state that physician's may leave orders which are contrary to the patient's or family's wishes either to continue life or to end suffering. Nurses are often caught in the middle of such ambiguous situations and conflicting viewpoints.

The 'slow code' is described by Huttman (1982), as the instruction to respond slowly to monitor changes and the 'show code' as the instruction to respond to the situation as urgent rather than life-threatening. This author also states that these instructions are an inappropriate means of avoiding the decision to write a DNR order.

When the medical orders are not appropriate to the situation, Jameton (1984) states that the nurse may respond slowly and intervene half-heartedly hoping that the terminally ill patient will not revive before the physician arrives to halt the resuscitation officially. Verbal orders or the absence of such an order in the care of the critically ill may generate confusion and frustration and also be the source of an ethical problem for the nurse. The critical care nurse has a legal obligation to intervene when a terminally ill patient suffers a cardiac arrest, yet that nurse may be personally frustrated by a moral sensitivity to the patient's right to die.

The problem of when to allow death is not straightforward. Cawley (1977) states that the patient should decide when he or she is ready or willing to allow death to occur. In the event of an urgent critical illness, according to Kiely (1985), the physician's opinion should prevail, with possible consultation with the family. Not to allow inevitable death to occur forces a slow and

dehumanizing process; so that this kind of situation must be seriously and carefully considered in the care of the critically ill patient.

A need to prioritize human and material resources may also generate ethical issues. Meisel, Grenvik, Pinkus and Snyder (1986) state that the patient who has made a decision to forego a particular treatment remains fully deserving of that therapy or care which has not been specifically declined. However, supportive care for the DNR patient may involve advanced nursing expertise and complicated technological interventions as Lewandowski, McClish and Youngner (1985) discovered. The ethical problem occurs when the demand for human and material resources in critical care exceeds the supply.

In summary, allowing death and the preservation of human life are issues which may create serious ethical problems in critical care. These situations may be associated with the appropriate use of life support equipment and decisions to withdraw treatment or not to resuscitate.

Death with dignity is a third topic which generates dilemmas of an ethical nature in critical care. Fenner (1980) describes death as the unacknowledged enemy of the health professions because it is often seen as an indication of failure. Death is the final stage of the life process, a

natural occurrence, and yet it remains the "final frontier for human exploration" (p.156). The mystery that surrounds this stage of life generates anxiety and fear because it is a stark reminder of our own vulnerability.

To be with a dying patient makes us conscious of the uniqueness of the individual in this vast sea of humanity, aware of our finiteness, our limited lifespan. (Gill, 1980, p.288).

Each individual has the right to pass through this final stage of life with dignity and grace, but when that individual is a patient in a critical care unit, this may be compromised.

Several case examples are cited by Johnson (1977), in which the patient's right to a dignified death was denied. One patient, who suffered from multiple problems as well as severe complications following surgery that he did not want, eventually became dependent on a mechanical ventilator in the critical care unit. As the days passed, he became familiar with the dials on the machine. One night, when the nurses were busy with an emergency elsewhere in the unit, he turned off the alarms and the machine. The patient died, having made a decision that no one else could face.

Personal values and beliefs, religious and cultural

background as well as past life experiences affect the manner in which the health professional cooperates with the patient's dying. Patients may have the values and beliefs of the staff imposed on them and the dying process then becomes a prolonged and dehumanizing affair. Levine (1977) cites an incident where a nurse responded to a terminally ill patient's cardiac arrest by using her own moral beliefs as a guide rather than the patient's request for no resuscitation. The patient was resuscitated and transferred to the critical care unit where she died several days later, having never regained consciousness. The moral injustice to the patient resulted in a prolonged death and unnecessary emotional torment for the family.

Medical intervention in such situations may involve the extensive use of drug therapy which may cause physiological damage to retrievable organs. The imposition of personal moral beliefs and values on the patient cited in the preceeding paragraph deprived that patient of a dignified death and also of the possibility of donating her kidneys, a gift of life which she fervently desired.

Death with dignity may be an issue with legal implications for the nurse, even when behaviour is guided by the code of ethics for nursing. Carey (1985) cites a situation (the case of Waltham versus Toms River Community Hospital, New Jersey) in which a nurse was fired from her job

in a critical care unit for refusing to carry out a dialysis procedure which she felt was not in the best interests of a terminally ill patient. Her belief was that the dialysis treatment was prolonging life, causing unnecessary harm and preventing a dignified and peaceful death. She was dismissed for refusing to perform a dialysis procedure even though she had previously asked and received permission to be relieved from the care of this patient. The nurse acted within the American Nurses' Association, Code of Ethics, but lost her legal suit. The Superior Court of New Jersey ruled that the Code of Ethics describes a standard of conduct which may be beneficial to the individual nurse but not to the public. The hospital administration was found to be acting appropriately by firing this nurse.

The nurse cannot impose personal moral or ethical beliefs on the patient. In Canada, "it is possible that a nurse who disregards a direct order to carry out treatment based on her personal moral or ethical code could face dismissal" (Rosovsky and Rosovsky, 1985d, p.13). The nurse must abide by the policy of the institution and the professional code of practice even if he or she disagrees with the content of these documents. The only circumstances that would permit the nurse to depart from these policies are those that may appear to jeopardize the well-being of the patient. The nurse can never abandon the patient, but must

institute appropriate measures to safeguard the well-being of the patient.

In summary, death with dignity may be the source of an ethical issue in critical care. The problem results from the uncertainty of knowing when to allow death to occur and the conflict between personal beliefs, institutional policy, the professional code of ethics and the law.

Several other issues which may be the source of an ethical issue in critical care are related to interdisciplinary role relationships, confidentiality, communication and competency. The following is a presentation of several of these issues which are relevant to the practice of critical care nursing.

The most complicated issue relates to the role confusion that nurses sometimes experience. Youngner, Jackson and Allen (1979) state that the nurses' role places them in a much closer human contact with the patient's suffering, pain and feelings of helplessness, and nurses have responded to this by becoming patient advocates. French (1984) describes patient advocacy as a concept which emphasizes the welfare of the patient as the end purpose of nursing. The Code of Ethics for Nursing which was released by the Canadian Nurses Association in 1985 states that "the nurse is obligated to advocate the client's interests" (p.9). As a patient

advocate, the nurse is obliged to represent the patient who may be unable or limited.

The problem with patient advocacy, states Winslow (1984), lies in putting the theory into action. French (1984) indicates that a nurse who is strongly committed to serving the patient's best interests may become an adversary to the physician with regard to moral issues. When the nurse confronts a situation in which the choice is to follow the established norms or to depart for the benefit of the patient, a personal dilemma occurs. "If the critical care nurse follows the doctor's order or the policy and procedure directive, the patient may experience an adverse consequence. On the other hand, if she does what she believes is correct, the episode can result in disciplinary or job action" (Rosovsky and Rosovsky, 1986, p.15). This type of role confusion is often the source of a frustrating ethical problem for the critical care nurse.

Allocation of health care resources is an issue which may also generate ethical issues. Zawacki (1985) describes the difficulty that physicians face in planning for appropriate patient care within a socio-economic context. Parsons (1985) states that one difficulty is in reconciling society's expectations for health care with criticism of rising costs. The care of the critically ill patient, according to Sanders (1986), costs more than four times that of any other patient.

This author also indicates that death within one year of hospitalization is twice as likely for the critically ill patient than for any other patient. Cost-containment in the critical care unit may be a significant ethical concern.

The problem of prioritizing patients' needs for critical care when the unit is fully occupied and a bed is required for an emergency admission is a problem described by Pinch (1985a). This type of situation requires a decision to discharge one patient to an alternate setting in the institution where patient-staff ratios are greater and nursing care is less intensive. Such decisions are often made with a degree of speculation as well as risk for the patient who may be deprived of monitoring equipment before physiological stability is certain. As the increasing cost of health care results in less money available for capital equipment purchases and staffing, Kiely (1985) predicts that there will be even more numerous ethical concerns of this nature in critical care.

The critical care nurse, according to Kiely, is obligated to demonstrate and maintain competence in the practice of critical care nursing. However, when staffing is inadequate, the neophyte critical care nurse may be required to assume responsibility for a patient situation that is beyond his/her capacity to function safely and effectively. An ethical issue results from feeling personally inadequate to meet the

needs of the patient, and having no alternative but to accept the patient assignment or be legally accountable for abandoning that patient.

Confidentiality is an area which may also be the source of an ethical issue in critical care. When one is disturbed by the ethical nature of a controversial patient care situation, Kiely questions the degree of information one should share with colleagues, and under what circumstances? The critical care unit does not afford much privacy for discussion. Violating a patient's right to confidentiality by discussing such matters in public raises the potential for slander or a libel suit.

Confidentiality and sharing of information may also form the basis of a dilemma in relation to disclosure of information to the terminally ill patient. Edwards (1983) states that, because of their intimate and continuous contact with a patient, nurses are often asked questions that should be asked of doctors. Being confronted with a question such as "Am I going to live?" creates a conflict. The nurse may know the answer, but may not be able to answer it honestly. This is a moral issue which focuses on the question of who is the best person to inform the patient. Curtin and Flaherty (1982) state that this may not be exclusively within the domain of medicine.

The function of the critical care nurse includes

detailed and continuous documentation of the patient's condition. Kieller (1985) states that when the patient's condition is unstable, these demands are nearly impossible to fulfill, yet the nurse is legally responsible for performing and recording these observations. A lack of flexibility in this function also creates a problem when the patient's condition has stabilized and such close monitoring interferes with rest and sleep periods. Priorizing the patient's need for rest within a total nursing care plan may be desirable, but also limited by the medical orders and the bureaucratic protocol.

Ethical issues in critical care occur with significant frequency. They are related to the patient's rights to informed consent, quality of life, allowing death, and death with dignity. It is not possible to clearly separate dilemmas into specific categories because each contains elements of the other. Ethical issues in critical care also evolve from other sources such as the accountability of the nurse to the patient, the institution and the law, scarcity of material and human resources, confidentiality and unreasonable role demands.

Factors Which Influence the Nurse's Response

Mayberry (1986) indicates that in their own inner world, nurses struggle with the dynamics of an internal and external environment. The potential for active moral conflict for nurses is created when these dynamics are associated with the external systems of policies, rules and norms. This review of the literature will focus on those factors, either internal or external, which may influence a nurse's response to an ethical issue.

Walleck (1983) describes internal influencing factors as those which are related to the individual's personal values, beliefs, attitudes, past experiences, knowledge and philosophy of life. Bishop (1978) states that religious considerations are also a component of ethical decision making. With or without formal ethics training, Pellegrino et al. (1985) state that personal values and beliefs are the most powerful factors which influence an individual's approach to ethical issues.

"Nurses are individuals with personal values, beliefs and attitudes" (Thompson and Thompson, 1985. p.75). Values, states Greene (1985), are one's conceptions of the desirable, of that which appears worthy of appreciating, of that which is believed to be good or right. The culture into which one

is born provides a network of customs, codes and rules, so that one's earliest experiences in life are influenced by socially accepted standards of what is good or bad; right or wrong. Our personal life history also affects how we perceive and respond; and inevitably colors reasoning processes. Nursing behaviour involves moral judgments and choices in deciding what is right or good in a particular instance. Greene states that such moral choice is not made in a vacuum, and is inevitably influenced by personal values and beliefs.

Professional background, which includes education and work experience has a greater influence on attitudes than either sex or religious upbringing, according to Youngner et al. (1979). Education and experience, writes Stone, Jebson, Walk and Belsham (1984), enhance the critical care nurse's sense of personal accomplishment and determine the degree to which situations are perceived as stressful or threatening.

Educational experience stimulates moral development, according to O'Rourke Vito (1983). This author utilizes Kohlberg's (1975) theory of moral development as a conceptual framework, describing moral development as a reorganization of thought structures which occurs when a student's capacity for critical thinking and moral reasoning is stimulated. O'Rourke Vito (1983) states that moral development coincides with education and tends to stabilize at whatever point

formal education is terminated.

A nurse's capacity for critical thinking and moral reasoning was found by Ketefian (1981a, 1981b) to be directly related to the level of formal education. In a study to measure moral judgment in nursing dilemmas, Crisham (1981) found that formal education and previous deliberation with a nursing dilemma was positively associated with how a subject judged a moral issue. Age alone was not found to be a significant variable. Formal education and past experience appear to enhance principled thinking ability as well as to influence one's behaviour in a moral dilemma.

Although educational experience largely determines a nurse's role orientation, Ketefian (1985) determined that professional role conflict adversely affects moral behaviour. That is, within the reality of the work environment, nurses may abandon professional role orientations when internalized beliefs and values conflict with bureaucratic expectations. The older and more experienced nurse, states Mayberry (1986), moves towards obedience and conformity by developing loyalty to the institution and to peers.

Although formal nursing education may enhance critical thinking ability, Cameron (1986) describes the nurse as coping with moral and ethical dilemmas in a highly individualistic and intuitive manner. Intuitionism, according to Thompson and Thompson (1985), is knowledge

without rational thought, that is, a natural awareness of what is right or wrong. Intuitionism, states Kemp (1985), assumes that an individual with a good character and an educated mind will know intuitively what is right and what is wrong. Intuitive knowledge, according to Lumpp (1979) is enhanced by the totality of life experience; parental example and teaching; formal and informal educational experience; religious and cultural influences; and social contacts. Huckaby (1986) states that intuitive feelings are inadequate in finding resolutions to moral and ethical dilemmas.

The critical care nurse's sense of, what Benoliel (1983) describes as a human or compassionate response with respect to the individual, may be an internal factor which has a very personal effect on the nature of the response to an ethical dilemma. Caring, according to Carper (1979), is a professional and personal value and provides a normative standard which guides our attitudes and actions towards individuals for whom we care. Roach (1984) states that "nursing is the professionalization of human caring through deliberate affirmation of caring as the human mode of being" (p. 1). "To be truly human is to care" (p. 8), and within the concept of care "is subsumed the essential characteristics of nursing as a helping discipline" (p.12). Caring is professionalized in nursing within a context of

time and situation and is actualized in concrete moments of caring behaviour.

Critical care nursing activities involve human relationships and these are shaped by the caring nature of the individual nurse. Gilligan (1982) states that "women not only define themselves in a context of human relationship but also judge themselves in terms of their ability to care" (p.17). Thus, relationships and the interconnectedness of individuals may be integral to the decision or selected choice in a given situation. Although Gilligan's findings are specific to women, Jorgenson and Crabtree (1986), in a study designed to explore the practical knowledge in expert critical care nursing practice, found that the acts of both male and female nurses appeared to reflect this ethic of care and responsibility.

Serious illness or injury often compromises the ability of the patient and family in the critical care unit to choose freely or to make wise decisions. The critical care nurse, guided by the caring nature which constitutes the core of nursing, may accept the responsibility of helping such individuals through difficult or distressing phases of an illness, according to Jorgenson and Crabtree (1986). Caring then, could be considered a distinct internal influence in how a nurse perceives and responds to situations which are complicated by ethical issues.

As nurses we have the freedom and individuality to express care and compassion. We also have a responsibility both to be willing to make choices in how we care and to act on them.

(Tschudin, 1986, p.41).

In summary, a nurse may be influenced by internal factors such as values, beliefs and attitudes in response to an ethical issue. These factors evolve from cultural and religious background, as well as personal life history. Education and work experience are also internal influencing factors which are reflected in the individual's capacity for moral reasoning and judgement within the context of the work setting. The nurse's response may also be influenced by a deep sense of caring for the patient as another human being.

There are several sources of external influence which may affect the manner in which a nurse responds to an ethical issue. Active and potential moral conflict may originate from the nurse's interaction with the social system of the institution, as well as from its informal and formal policies, according to Huckaby (1986). In the clinical setting, the nurse's multiple loyalties to patient, family, physician, employing agency and professional standards may

conflict. Lamb (1986) states that such intervening variables in the context of the setting have a significant influence on nursing behaviour and decision-making.

There are several categories of external factors which may influence a nurse's response. Role conflict; the professional code of ethics and standards of practice; the institutional policy; societal and legal expectations; and the patient's family are presented in the current literature as factors which may influence nursing behaviour in an ethical dilemma.

Patient advocacy is a professional obligation which is often the source of confusion and conflict for a nurse confronting an ethical dilemma. Rosovsky and Rosovsky (1985c) state the nurse's chief responsibility is to the patient, that is, the nurse must assume responsibility for action which is coincident to serving the best interests of the patient. Huckaby (1986), indicates however, that a nurse must assume different roles and responsibilities, each demanding a different allegiance.

In a study to determine the response of critical care nurses to hypothetical dilemmas, Lawrence and Farr (1982) found that legal consequences, patient rights and wishes and physician authority would all be considered in determining nursing behaviour. The study indicated that respondents were divided on the issue of the nurse's role as independent

decision maker. Nursing behaviour is guided by the obligation to advocate the patient's best interests, but this may be in conflict with other intervening variables.

The nurse functions in a system in which, according to Youngner et al (1979), there is an apparent contradiction between the appearance of an interdisciplinary team approach to problem solving and a traditional hierarchy within which the physician assumes ultimate authority in the decision making process. Aroskar (1982) states that nurses generally bear the burden of having to carry out a medical decision regarding patient care, often without having had any part in the decision making process. When the nurse, as a patient advocate, does not agree with the treatment plan, a conflict arises and the nurse is faced with an ethical problem.

Nursing behaviour is guided by a code of ethics. The Canadian Nurses Association (1985) states that the Code of Ethics for Nursing is an attempt to provide guidance for nurses who face ethical dilemmas. A code of ethics is limited in application to specific situations, according to Huckaby (1986), because of its abstract and general nature. Levine (1977) describes a code of ethics as a code of etiquette, because of its lack of specificity, while Tschudin (1986) states that nursing codes direct but do not protect and that they stimulate thought but do not provide walls within which one is safe to act. Although it may be

peripheral to the interests of the patients, the code of ethics is an external influencing factor in relation to how the nurse responds to an ethical dilemma.

Another significant external influence on the individual's response may be factors in the work setting. Mayberry (1986) states that factors such as administrative policy and organizational structure may make even reasoned decision-making difficult. Obedience to authority and a need to maintain harmony within the institution are characteristic of experienced nurses, according to Crisham's (1981) findings. This 'milieu effect' on moral judgment implies that subjects are influenced by peer response as well as other pressures from within the setting. Mayberry (1986) states that personal ethical decision making may be limited by these environmental factors.

Societal attitudes, definitions of justice and legal definitions of right and wrong also influence the nurse according to Walleck (1983). Society, states Benoliel (1983), develops its values in a process of cultural evolution, where values arise in a response to social needs. The individual nurse will be affected in her response to an ethical dilemma by the norms or acceptable standards of society. A social attitude which does not agree with active euthanasia may influence the nurse who is caught in a dilemma of having to care for the patient as life support equipment

is discontinued.

The nurse is obligated to abide by the law in the practice of the profession and legal parameters may also be an external influence on a nurse's response to an ethical dilemma. Activities that are not clearly within the legal limit of the law will be influenced by the nurse's interpretation of the law. For example, large doses of narcotic sedatives are sometimes necessary because of severe and unretractable pain or unmanageable confusion and restlessness. If the terminally ill patient is heavily sedated to relieve pain, it becomes difficult to assess whether the sedation is actually relieving pain or hastening death. Is the nurse actually committing murder by administering such sedation? Levenson (1981) states that it is important to allow flexibility in ethical decision making because it is not possible to create strict guidelines to cover all possibilities. However, legal accountability, according to Kapp (1986), can serve as an impediment to decision making. A nurse's response to an ethical issue may be externally influenced by legal obligations or by the perceptions of same.

The patient's family may also influence the nurse's response to an ethical issue. The presence of a distraught family in the critical care unit places stress on the nurse as he or she becomes a participant observer in their crisis,

according to Flaherty (1982). In the consideration of an ethical dilemma, the nurse may have attitudes or beliefs which have been influenced by an awareness or concern for the welfare of the family.

Other external influences which may be determining factors in how the nurse responds to an ethical dilemma are related to personal support structures, according to Price and Murphy (1985). For example, a positive and cohesive team of nurses within the unit is necessary for the emotional and spiritual well-being of the staff. As well, a nursing administrative body which is responsive to the critical care staff, influences the overall tone of work in the unit. These factors serve to create an environment which will determine the critical care nurse's sense of worth and ultimately are reflected in the manner in which the nurse responds to the stress of an ethical dilemma.

In summary, the external factors which may influence a nurse's response to an ethical issue are related to role expectations, the code of ethics, bureaucratic policy, societal norms, legal obligations and working ethos.

Resolution of the Ethical Issue

Clinical situations raising ethical questions often involve suffering or deep personal conflicts. Anxiety, guilt and doubt are almost inevitable reactions. It is illusory to hope that being right or having a method will relieve all difficult feelings in these cases. Even if one chooses the right pole of a dilemma, one must still forgo the lesser value. Good decisions remain open to new doubts and reexamination.

(Jameton, 1984, p. 66).

Resolution of an ethical issue in relation to the care of the critically ill patient may require a multidisciplinary approach to problem solving and decision making. Davis (1979) indicates that such situations are a major factor in the stress experienced by critical care nurses. Although nurses are a critical part of the process of problem-solving in ethical dilemmas, Aroskar and Veatch (1977) indicate that they do not make the decisions.

A decision which compromises one's personal integrity is particularly stressful. When stress is caused by externally controlled factors, Anderson and Basteys (1981) state that

greater personal distress occurs and is related to one's inability to control the source. The critical care nurse, according to Oskins (1979), must be able to cope with and manage such stress in order to be able to function effectively in the critical care area.

The nurse's ability to come to terms with an ethical issue is dependent on several factors. This review will focus on those determining factors, as described in the literature, which lead to either the ineffective or effective personal resolution of an ethical issue.

Ineffective personal resolution of an ethical issue is described by Wilkinson (1986) as moral distress, that is, "a psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision" (p. 388). Wilkinson also describes the phenomenon of moral outrage which she states is related to but clearly distinct from moral distress. Although the effects of both phenomena may be similar, the difference lies in the fact that when the nurse experiences moral outrage, the feelings occur because of the actions of others that are perceived to be immoral. Moral distress, on the other hand is the result of actions that are or are not taken by the nurse her/himself.

Factors which are associated with this feeling state, according to Zablow (1986), are those of powerlessness, helplessness, indecision and uncertainty. Wilkinson (1986) lists feelings of anger, frustration and guilt in association with moral distress.

Prolonged exposure to a stressful work environment, according to Price and Murphy (1985), eventually leads to a state of emotional depletion and spiritual exhaustion. Other personal characteristics of this feeling state are described by Price and Murphy as a loss of enthusiasm, fatigue, irritation or hypercritical reaction, depression, sleep disturbance, loss of risk-taking behaviour and psychological withdrawal. The personal discontent associated with moral distress may eventually lead to the phenomenon that Gervaise and Howard (1984) describe as 'burnout'.

Psychological disequilibrium generates great personal indecision and uncertainty, according to Zablow (1986), and this disequilibrium may be reflected in the nurse's ability to give patient care. Wilkinson (1986) suggests that when nurses experience moral distress as damaging to their personal and professional wholeness, their ability to give quality patient care may be significantly altered. From a study of the reality shock experienced by new graduate nurses, Kramer (1974) suggests that the nursing care given by a nurse who is experiencing moral outrage, disillusionment,

hostility or despair will certainly be different and less effective. The climate which surrounds the patient is instrumental to that patient's well being. The nurse who experiences moral distress, according to Kramer, may have difficulty in effecting a climate which is conducive to the well-being of the patient.

Ineffective coping with moral distress is exemplified by behaviours which Wilkinson (1986) describes as avoiding patients or situations, changing jobs or leaving nursing. Nurses who are not able to cope with moral distress may also experience a lowered self esteem. Wilkinson states that the nurses who do not leave the situation may experience even greater damage to their self esteem, which may be reflected in further deterioration in patient care.

An alternative behaviour which a dissatisfied nurse may choose is described by Aroskar (1982) as that of 'whistle blowing'. There are three elements of 'whistle blowing' listed by Murphy (1981). These are; disagreement with an authority which is made public; a conflict of loyalty between peers and society; and an accusation related to ethical concerns. 'Whistle blowing' is rarely an effective means of dealing with personal moral distress, and Glazer (1983) states that it may result in personal and professional harassment, loss of job, status or security, or defamation of character and personal integrity.

In summary, a nurse's inability to cope personally with an ethical issue may be associated with stress and loss of self esteem. Ineffective behaviour may be described as "whistle blowing", avoiding patients or situations, changing jobs or leaving nursing.

The effective resolution of an ethical dilemma, that is, successful coping, is reflected in a feeling of control over the situation, according to Wilkinson (1986). Such coping mechanisms are associated with particular attitudes and behaviours.

The nurse should have the personal qualities of intelligence and capability, as well as sincerity and truthfulness, according to Sheehan (1985). Nursing behaviour should also be guided by the professional code of ethics, institutional protocol, and the law. Rosovsky and Rosovsky (1986) state that a nurse should act sensibly in any situation which challenges personal beliefs or professional responsibility. The nurse should also utilize sound professional judgement in order to act in a reasonable and prudent manner. Such actions should be based on reasoned and critical thinking.

The nurse should ultimately be guided by a sense of caring for another human being, states Flaherty (1982). Caring describes a characteristic which is not unique to

nursing, that is, caring does not distinguish nursing from other occupations. Caring, however, is unique in nursing, in that, as Roach (1984) points out, all attributes which are used in a description of nursing are derived from caring. Caring is particularly applicable in situations, for example, where a patient is deeply unconscious and quality of life is questionable.

The serious and intense atmosphere of the critical care unit often generates a norm of solemnity, which can be a significant deterrent to the emotional well-being of the staff. Humour is a deep and spiritual function which enables one to assert or reassert perspective, according to Price and Murphy (1985), and they suggest that critical care nurses need to be able to laugh as a self-medication against the insidious threat of burnout. Such behaviour may be a factor in a nurse's ability to cope successfully with difficult ethical situations.

Nursing behaviour and responsibility in relation to an ethical issue may be guided by clearly defined bureaucratic protocol. Rosovsky and Rosovsky (1986) state that the critical care nurse can be actively involved in establishing such guidelines. This includes well written job descriptions and clearly defined policy and procedure manuals. By participation on the part of nurses in the formulation of such documents, the areas of such responsibility can then be

more clearly delineated in terms of the nurse's role as a patient advocate.

The critical care nurse should define his/her role as one of a patient advocate, states French (1984). Promotion of a more autonomous role requires more autonomous attitudes and behaviour according to Pinch (1985c), and requires that the nurse play a stronger part in the problem-solving or decision-making process, particularly in relation to ethical dilemmas.

The nurse must be familiar with the legal boundaries within which one functions in critical care in order to avoid potential legal liability. Brent (1985) states, for example, that advanced knowledge and skill are required in critical care nursing. The legal implications of this advanced standard of practice may complicate the ethical issue that a critical care nurse confronts. In order to narrow the possible legal dimensions of an ethical issue, Brent (1985) suggests that the nurse inform the manager when he/she does not feel knowledgeable enough or suitably skilled to meet the patient's needs. Clear and concise documentation of nursing activities, careful delegation of duties to colleagues, and practice within the guidelines of the unit's documented policy are also suggested as means of avoiding legal liability in the resolution of a complicated ethical issue.

The critical care nurse is in a unique position of having

intimate knowledge of the patient and family. Kemp (1985) states that the nurse should actively participate in establishing facts regarding situations which require ethical decisions. The nurse can collaborate with the physician in the interpretation of the objective data concerning the patient's condition and can also, according to Kemp, add significantly to the more subjective information regarding the patient's and family's ability or willingness to participate in ethical decision-making. In providing direct care to the critically ill patient, the nurse may be able to determine that individual's feelings, knowledge and understanding of the situation in a comprehensive manner. This knowledge may be essential in determining a patient's ability to share in the ethical decision-making process.

A more studious and reasoned approach in the resolution of an ethical dilemma is what Aroskar (1982) describes as preventive ethics. As Clouser (1980) states, the difficult and sophisticated work is in the analysis of the circumstances that are to be morally appraised. An ethics committee made up of a variety of health professionals as well as a philosopher or a theologian, can offer expertise and serve a multitude of purposes. Education, development of guidelines, emergency review of cases, clarification, communication and deliberation of moral issues and legal problems, counselling of staff and families as well as a

retrospective study on decision making processes are examples of the issues that could be considered by such a committee, according to Fowler (1986a). This committee could be a valuable resource for the critical care nurse.

The establishment of an interdisciplinary ethics committee is challenged by Lestz (1977), because of the potential control that such committees may assume over the decision making process. He compares such potential control over life and death decisions with the coercive influence of a Big Brother, as depicted in Orwell's (1949) book Nineteen Eighty Four. In spite of this possibility, an interdisciplinary ethics committee could serve a useful function as a resource in the problem solving process.

A clinical ethicist, that is, an individual with advanced knowledge of ethics, may be an effective resource to the critical care nurse in the resolution of an ethical dilemma. Davis and Aroskar (1983) state that this individual can assist the staff in the resolution of an ethical problem by delineating the elements that may be involved and providing an alternate perspective which is grounded more in philosophy and theology than in the health sciences. Utilization of such a resource in critical care, according to Fowler (1986b), provides a way of clarifying or illuminating a problematic situation for the nurse.

An ethical round is described by Kiely (1985), as a

discussion which occurs within a multidisciplinary framework and incorporates a didactic exploration of ethical issues for the purposes of ethical analysis and education. This is similar to the ethics committee approach but perhaps less formally established and more readily accessible to critical care nursing staff. Davis (1979) states that when ethical rounds are led by a nurse for a group of nurses, the nature of the issues that arise are different than in rounds led by physicians. Ethical rounds which focus on nursing concerns may result in a more effective resolution of an ethical issue for the critical care nurse.

Support systems for the critical care nurse are an important element in facilitating the effective resolution of an ethical dilemma. Stone et al (1984) identify the coffee and meal breaks as a source of an informal support network. Krawcyk and Kudzma (1978) state that when the environment is not associated with the stress of the clinical area, greater participation and discussion occur. Crisham (1980) describes the enriched environment as one in which individuals are encouraged to share their views thoroughly and systematically. This process encourages principled thinking and may result in more effective resolution of ethical issues in critical care.

In summary, the ineffective resolution of ethical issues may generate significant personal distress for the critical

care nurse, erode personal integrity and dramatically affect one's ability to give quality patient care. Attitudes and behaviour which result in a more effective resolution of an ethical issue are related to competence, reasoned judgement and adequate support systems. Communication between peers and colleagues, the availability of an ethics committee or a clinical ethicist, and the opportunity to participate in ethical rounds are mechanisms which assist the critical care nurse to resolve ethical issues.

Conclusion

Care of the critically ill patient involves a complex plan of care delivered in an environment charged with the tension of potential crisis. The health care that is currently available to the patient experiencing a life threatening event has the potential to provoke a variety of concerns which are ethical in nature. This review of the literature has described the kinds of ethical issues which are possible in relation to critical care as well as factors which may influence the manner in which a nurse responds to the situations which are ethically problematic.

It is evident that many of these ethical issues have the potential to generate great personal distress for the nurse

involved in a particular patient care situation. It is also possible that the quality of patient care may be dependent on the nurse's ability to cope with the moral distress that is often associated with such issues.

The ethical problem for a particular patient is determined by the unique circumstances of that patient's life situation and by the care that is required. It is also affected by the health care givers who are responsible for determining the plan of care. The nature of the problem solving process generates numerous possibilities for conflict which may be personal or interpersonal and may have a significant impact on the stress experienced by the staff.

The actual resolution of an ethical issue may be straightforward in consideration of the alternatives which are available for the care of the patient. However, the personal resolution of the issue may be far more complex, particularly when the final decision contradicts one's personal values or moral beliefs

From this review of the literature, it seems evident that the ethical dimension of patient care decisions in the critical care unit are not only complex, but may also be the source of a lack of team cohesiveness in an environment which demands unity in coping with the ongoing tension of unexpected life threatening emergencies.

Everything is neither right nor wrong. The
right or wrong is in the choosing, the keeping,
the losing. All paths are light and shadow,
and every path is a different thing to each man.
The right and the wrong, the good and the bad,
lie not upon the silent pathway,
but in the man that walks it.

(Anonymous)

CHAPTER THREE

Presentation of the Findings

The information presented in this chapter is separated into several sections. The biographical information obtained from the participants is followed by a description of the participants' definition of an ethical dilemma. The subsequent three major sections reflect the dominant themes or patterns which emerged in the analysis of the transcripts. This information is presented under the topic headings of: the kinds of situations that participants described as being ethical dilemmas; the factors which influence perceptions and response; and finally the manner in which they responded to and coped with the situations which were described.

Biographical Information

The information obtained on the biographical data form revealed descriptive characteristics about each group of participants. The group of instructors or experienced critical care nurses are all female and between 31 and 50 years of age. Three of these women are single and two are married. One participant in this group indicated that she is Roman Catholic and four indicated that their religion is

Protestant. In relation to educational background, all of the instructors are graduates of a diploma program in nursing as well as an Intensive Care Nursing Program. Two participants in this group have a baccalaureate degree in nursing and the remaining three are currently completing the requirements for a university degree. With regard to work experience, responses indicated that each member of this group of nurses has between seven and ten years of experience in a critical care setting. Three of the group members have worked as an Assistant Head Nurse in a critical care unit. Participants also indicated that their experience as an instructor in the Intensive Care Nursing Program ranges from two to seven years.

The group of neophyte critical care nurses are also all female, but between 18 and 30 years of age. All are single. Three members of this group are Protestant, one is Roman Catholic and one member did not respond to this question. Educational background information revealed that each member of this group has obtained a diploma in nursing and a certificate in Intensive Care Nursing. None of the group members has post secondary-education at a university level nor are any currently enrolled in post-secondary educational programs. Work experience for this group varies from one and a half to three years, and occurred in an acute care facility (as opposed to a community health setting).

In summary, the group of instructors is characteristically older, has more practical experience as a critical care nurse and also has more educational preparation than the group of neophyte critical care nurses. All participants are female, only two are married and all except one indicated a religious affiliation. The majority of the participants indicated that they are of a Protestant faith.

Ethical Dilemma Defined

At the beginning of each interview, participants were asked to describe their definition of an ethical dilemma. Responses to this question revealed that participants perceive such a dilemma to be associated with differences between right and wrong or good and bad. Intra and inter personal conflict was stated to be the result of a difference in personal values or beliefs. Past life and work experience, culture, education and professional/legal obligations were described as influencing one's perception of what might feel morally right in a given situation.

General Examples of an Ethical Dilemma

Participants described a variety of situations as general examples of what they believed to be ethical dilemmas in critical care. Included in these responses are situations involving: informed consent; prolongation of life when quality of life is compromised; discontinuation of therapy; treatment decisions; admission criteria; organ retrieval from a brain dead patient; patient's loss of dignity/privacy/confidentiality; role conflict/confusion for the nurse as a member of the health team; when to allow death; restraining the patient; and communication with patients/families/peers/administration/health team members.

Situational Context of an Ethical Dilemma

This section of the chapter presents the data in the form of exemplars (a small instance of a particularly meaningful transaction) and direct quotations from the transcripts, in relation to what the participants described as the situational context of an ethical dilemma. When they were asked to describe one situation in which they had been personally involved, participants talked about incidents which were related to specific topic areas. An analysis of the interview transcripts revealed that the common themes

which emerged in these descriptions could be grouped into those situations which dealt with either excessive treatment or discontinuation of therapy. There are also several other issues which emerged in relation to the situational context of an ethical dilemma. These are presented under the heading: the interpersonal dimension.

Excessive therapy

In this category of ethical issues, participants described situations involving patient care which they perceive to be excessive in view of their understanding of the particular disease process, the patient and/or family's wishes and the prognosis.

The following exemplar describes a patient care situation which seems excessive to the nurse even though the patient has expressed a desire to live.

She was so ill and so malnourished, she was just in really bad shape and her lungs were... there was nothing left of them..just to see her coughing up all this blood and kind of laying there in a ball... every time I had to suction her, I just thought, why am I doing this to her? I knew at the time that she wanted

to live. I knew I was doing good by suctioning it out, but it was getting to the point where it almost looked as if we were pulling up lung tissue with it... I just thought, what am I doing to her, what is left of her... to put her through all that trauma of having to suction down her ET tube seemed almost inhuman to me at the time.

The next exemplar describes a situation of a hopelessly ill woman who did not want aggressive therapy and who eventually died after several weeks in the critical care unit.

She was rejecting her kidney.. she was septic and she was basically dying.. and they kept treating her.. the family had said she was tired of all this and she'd been through so much in the past eight months that she had said she didn't want anymore and here they were doing all this to her, and you couldn't help thinking this is wrong, they shouldn't be doing this. It just seeme to linger on so long in my eyes.

It was a hopeless situation, this lady was not going to survive. I just thought, we're torturing this woman, let her die.

The preceeding descriptions are a depiction of the nurse in the situation where therapy was perceived to be excessive for the patient. There are several elements which were seen to be common to these kinds of situations and which add to the understanding of the meaning that these incidents have for the nurse involved. Four elements which recurred throughout the transcripts in relation to the issue of excessive therapy are: the loss of patient dignity associated with compromised quality of life, maintaining patient comfort, violation of the patient's right to determine care and the nurse's perception of the family's suffering. These elements are seen as factors which affect the nurse's perception of the situation. and are described using excerpts from the interview transcripts.

Loss of patient dignity

Loss of dignity for the patient is an element which recurs throughout the transcripts in relation to several issues and topic areas. Loss of dignity, in situations involving what is perceived to be excessive therapy, is

associated with compromised quality of life. Nurses describe loss of dignity in several ways.

The following two exemplars illustrate the situations where loss of patient dignity is associated with the use of invasive types of procedures. Nurses in these instances perceive loss of patient dignity to be associated with the use of such interventions as endotracheal intubation, mechanical ventilation and invasive lines used for central monitoring.

Intubated, lined, septic... it's one of those hopeless kinds of cases ... you really don't anticipate that they're going to get any better... they just seem to be getting progressively worse. Are we really doing this person a favour? What is the quality of life? What is the real prognosis here? Do you really believe they'll ever recover and walk out of here?

Patient is in end stage cardiac failure... she recognizes that her heart has reached its end point where its not going to be able to function and if they can't do things by manner of not invading her, then just let her

go peacefully. Physicians intubate the patient... now she can't even verbalize to her family. She's put on the ventilator, sedated, they put in lines and the patient ends up looking like a pin cushion.

In this next exemplar, the nurse associates loss of dignity with the progressive deterioration in physical appearance associated with the advanced disease state prior to the patient's death.

She was comatose and it was awful... she was so swollen, every type of tubing she had in was leaking and she was bleeding from the eyes... there was no hope and the family knew and accepted that. We let her go on so long. I believe that when people die, they should die with dignity and this lady had gone beyond that.

Loss of dignity is perceived by nurses in these situations to be directly related to excessive therapy. The use of invasive and mechanical interventions as well as the physical deterioration caused by the advanced disease state are factors associated with loss of dignity for the patient.

Patient comfort

Excessive therapy sometimes affects the patient's comfort by causing or increasing suffering. Nursing care of the patient may directly cause discomfort for the patient, may be extremely unpleasant or may make no difference to the patient's state of health.

Her skin just peeled off everywhere and she was just continuously oozing and bleeding... whenever you would change those dressings she would just flinch and that bothered me cause no matter how much pain relief you gave her, it didn't seem to do very much... there was absolutely nothing you could do to make her look comfortable. We couldn't turn her because she was so big and her skin would tear and she would bleed.

Just ordinary routine care that we take so much for granted can be extremely painful if someone is acutely ill.. simple things like turning and suctioning... doing treatments, dressing changes, It's obvious that it's painful. You give them all the analgesic that you can, but you have to be

careful, there's only so much you can give. You come away at the end of the day and you feel as though you haven't improved the status quo, you're just inflicting pain.

She didn't want to do a whole lot. Every time we turned her, it seemd like we were giving her so much pain...

These situations exemplify the nurse's perceptions of instances where basic care, such as turning, dressing changes and suctioning is the direct cause of pain or suffering for the patient. Compromised patient comfort is one element which nurses describe in situations where therapy is perceived to be excessive.

Violation of the patient's rights or wishes

Situations which are perceived by the nurses to involve excessive therapy may be characterized by a violation or lack of consideration of the patient's rights or wishes. Participants described several situations in which this was perceived to be the case.

Patient (states) that if they can't (avoid) invading her, just let her go peacefully. She wants her family around. Nurses indicate this information to the physicians but the physicians intubate the patient. The family is kept out during the procedure... the doctors disappear, the family comes in and starts screaming at the nurse, 'what have you done to my mother?'

This situation depicts a lack of consideration of the patient's wishes before invasive therapy (intubation and mechanical ventilation) are instituted. A related issue which seems relevant to this particular situation is that of informed consent. It is not clear that consent to treatment was obtained prior to the initiation of therapy in this situation.

He'd had surgery... it had been futile and he was at this point unable to wean (from the ventilator)... chronic temps... pleural effusions... however the surgeon remained very optimistic that he would somehow wean. Also some of the doctors in the unit thought that if they optimized

this and optimized that and optimized the other thing, that he'd be able to wean... Despite all this, the patient took forever to wean, was not weaning and was therefore actively requesting to be taken off the ventilator.... The saddest thing about this whole issue was that for the longest time they denied this patient his rights. The bottom line was, his rights were violated.

Denial of the patient's right to refuse treatment is evidenced by the fact that the plan of care involved treatment designed to assist the patient to wean from the ventilator. Despite the fact that the patient actively requests that the ventilator be discontinued, the treatment continues over a period of several months. In the end the patient's wish to be removed from the ventilator is achieved and he dies within fifteen minutes.

The following exemplar describes a situation in which the patient is unconscious. Even though her previously stated wish for no further treatment is known to the family and the health team, therapy is continued.

The family had said she was tired of all this and she'd been through so much in the past eight months that apparently this woman had said she didn't want any more treatment and here we were doing all this to her, and you couldn't help thinking this is wrong, we shouldn't be doing this.

When therapy or treatment regimes are perceived to be excessive, this group of nurses indicated that patients' rights or expressed wishes may sometimes be ignored or actively violated. The exemplars presented in relation to this factor describe such instances in the reality of practice.

Family suffering

Interviewer: What was the most difficult thing about that situation?

Participant: Dealing with the family, watching the pain they were going through.

Situations involving excessive therapy for the patient also pose difficulties for the patient's family. The suffering of the family is a factor in how the nurse perceives such situations.

Prolongation of life when there is minimal hope of return of a quality lifestyle... and treatment is still very aggressive... but ultimately that patient will die anyway. You're really putting a lot of misery not only to the patient but to the patient's family. It all seems so futile. You're torturing in a sense that poor patient and his family.

The following exemplar describes a situation in which the patient's wife is caught in a conflict between what the health team believes is best for her husband and what her

husband wishes himself. Therapy is perceived to be excessive by the patient, yet the personal conflict that the wife experiences is shared by the nurse.

His poor wife was talked to by all sorts of doctors. What this woman was trying to do was to be a voice for her husband and also trying to sort out her own feelings, trying to get the facts and she had all kinds of different opinions from different people, but basically she would be sort of pushed into the corner and told 'yes your husband can wean and there's no physical reason why he can't', implying that she should be more supportive and that she's giving up hope on him. I felt very sad for the wife because she was torn between the devil and the deep blue sea and was receiving all kinds of guilt-ridden messages.

The next two exemplars describe situations in which the family is unable to accept the seriousness of the patient's condition. The nurse perceives therapy to be excessive while the family is still hopeful of the patient's recovery.

Her family would come in and they would look for every ray of hope and you don't want to give them false hope, but you don't want to keep them hoping that she was going to get better too, so that was hard to deal with... the family suffering.

I could sense with the family that they really hadn't sort of come to terms with it, they didn't realize the seriousness of the situation. I guess in my mind knew that she was eventually going to die and they of course had to keep having hope. It was really hard.

Family suffering is a factor in situations which the nurse perceives to involve excessive therapy. Suffering may be in the form of anguish over the situation of the patient, conflict resulting from the divergent views of patient and health team or the need for hope even when the situation seems futile.

Discontinuation of Therapy

Discontinuation of therapy is a second kind of situation that participants described in relation to their experience with ethical dilemmas in critical care. The care of the critically ill patient sometimes reaches a point where therapy will not reverse or halt the disease process. Withdrawing therapeutic interventions is necessary to allow the patient to die. Such situations may involve the removal of life support equipment such as mechanical ventilators, or discontinuing drug therapy. Drugs are administered in the critical care area through infusion pumps which participants described as 'the pump or the sage pump'. Discontinuation of therapy may also involve the use of large doses of sedative/analgesic medication for relief of discomfort or anxiety.

The incidents involving discontinuation of therapy are characterized by two recurring themes which are relevant to an understanding of what this kind of experience means to the individual nurse. The situation of discontinuation of therapy is presented in relation to the 'care versus kill' conflict and the problem of decision-making/not-making.

The 'Care versus Kill' Conflict

Participants describe patient care situations in which it was necessary to take deliberate action in order to allow the patient to die. These actions are equated with a deliberate act to end the patient's life.

All we did was discontinue the medications and that was assuring us that he would die shortly. It was just a matter of pushing a little button off.

The doctor came in. He gave her several doses of morphine and we waited and she was still awake. So he said 'well, just hang on, it'll catch up and eventually accumulate, and she'll go into a sleeping pattern'. Adjustments were made on the ventilator and eventually the machine was turned off. She struggled, gasped for air and died.

Some instances of discontinuing or withdrawing therapy involve the use of sedative agents in order to lessen the patient's discomfort or anxiety prior to death. Participants describe this kind of situation as being different from situations requiring deliberate action to withdraw interventions.

I've sat with patients, not necessarily turned anything off but given them morphine and that's doing the same thing in a sense as turning off sage pumps but wasn't as obvious. It was the idea that I gave the needle for pain. You can always rationalize it that way. But in this situation, this was it. When I turn that off, he's going to die. And that was the hard part. The pumps were very vivid. I can still see the ones I turned off.

The situation of discontinuation of therapy may also involve not taking action which is contrary to the normal helping role of the critical care nurse. The following two exemplars illustrate this.

You go down on a drug and watch the monitors and see what's going to happen and you might see a lot more ectopics or something happening on the screen. It was kind of strange seeing all these things happening and not doing anything. Standing there and watching.

She grabbed my hand. We hadn't touched the ventilator. We were waiting for this sleep pattern. She was a very frightened woman. It was a terrible situation because

if you saw someone drowning, your immediate reaction, if you know how to swim, would be to save them, but when you're in the situation at the bedside, they're asking you to save them with their expression and their fear and you're standing right there and you're not doing anything. All I could do was hold her hand.

Participants describe the conflict they experienced in these situations in terms of their perception of the role of the nurse as care giver.

You always think of your patients as getting better rather than not and you feel a little helpless and useless when you know that you're not going to be able to cure this person.

You were taught, the nurse, to make everything better. You learn in the real world that you just can't change everything.

Participants then describe the conflict that they experienced when they realized that care was not going to cure the patient and that therapy should be discontinued.

I was appalled that this (discontinuation of therapy) even went on. You know it happens, but not to me. You're a critical care nurse, you save people's lives, you don't help them die. I agreed with what they were doing. I understood why they were doing it to the patient and that when we turned it off he would die peacefully. But it wasn't any easier to actually do it. I saw both sides of the story and I stood somewhere in the middle saying 'oh my God, I don't know what to do. Can I do it and live with myself later. You get sent to prison for killing people' and that's exactly how I felt.

Another nurse stated her perceptions in the following excerpt.

This is the end point. There is brain death. At one point we're faced with the fact that this is the terminal event. You shut off that ventilator, that person dies and who has the right. It's like 'oh my God, this is it and I am a part of it'.

The following exemplar describes one nurse's perception of the dilemma in relation to the action of discontinuation of therapy.

To me it felt like we were putting her out of her misery and all the anguish that we were putting her through, but at the same time, it felt like we were killing another human being. I would be happy to know that she was finally at peace and that she was relaxed and comfortable, yet at the same time, it's hard to know that you've taken someone else's life.

One participant described a dramatic incident of discontinuation of therapy which was an extremely difficult experience for her to participate in.

When I went home that night I could not get this day off my mind. I felt that I had participated in a murder. I felt accessory to a murder.

In some instances, the nurse may suggest to the health team that discontinuation of therapy be considered. In one incident, where therapy was considered to be excessive and the patient was asking to be taken off the ventilator, the nurse did question the aggressive plan of care and was accused of wanting to murder the patient.

The surgeon actually ended up telling me and the nurses in front of the patient's wife that we were murderers and that we were just not helping the situation at all.

The 'care versus kill conflict' is related to situations which may require the nurse either to take deliberate action or to ignore life-threatening symptoms. Participants perceive this kind of situation as contrary to their beliefs about the helping role of the nurse. The deliberate action, for example, of turning off the ventilator, is sometimes equated with a feeling of having participated in or of having committed a murder.

Decision-Making/Not-Making

Decision-making is a second theme which recurred in the participants' descriptions of situations involving discontinuation of therapy. Decision-making involves several dimensions. Participants described situations where decisions were either made or avoided, where patients rights or wishes were not considered and where there was confusion because of a prolonged decision-making process.

The following two exemplars describe situations where the patient's wish to have therapy discontinued was perceived by participants as not being considered by the health team.

An end stage respiratory patient who absolutely did not want to go back to the respiratory centre, did not want to ever go home again and the wife was at her wits end. She didn't know what to do. She felt that she could not voice her opinion and she felt very very guilty asking us not to be so aggressive because her husband did not want to get better. He pleaded with her to stop all this aggressive nonsense. Yet, we didn't want to.

This woman was a chronic COPDer and they were keeping her alive on the ventilator and she kept writing notes 'let me die, I want to die, I can't live like this'. She wasn't able to wean off the ventilator and doctors said 'let's give her one more day and we'll try this'. Her husband didn't want her to suffer any more and she didn't want to suffer any more. She said 'I'm suffering, this is no way to live'. She arrested and they reintubated

her. When she woke up she said 'why did you do this? You should have just let me die'. In the end, they finally did.

Patient participation in the decision-making process varies depending on several factors; one being the patient's level of consciousness. When the patient is unconscious, the decision to discontinue therapy may be complicated. The following exemplar describes a patient situation in which the decision to withdraw therapy is prolonged creating a confusing and disturbing situation for the participant.

It was a hopeless situation. This lady was not going to survive. What I'd been hearing all along was that they're going to probably discontinue on her on Monday. They hadn't dialysed her for three days and she was fluid overloaded and her kidneys weren't working and then when I came back on Monday, they were dialysing her again. I couldn't believe it. They eventually did stop everything, but it just seemed to linger on for so long.

The next exemplar describes a situation where the decision was made to discontinue therapy on a conscious patient without consideration of that patient's wishes.

I went to a meeting which included all of the team members. I felt more of an observer than I did an actual participant because this was something new for me. We discussed this lady's case, the long term effects of her COPD, how this was end stage and that she physiologically could not come out of this state. It made sense to me. The other team members agreed and the decision was made that she was going to be discontinued from the ventilator. After leaving this meeting, coming down the stairs, it hit me that we had missed a very important part of this decision and that was the patient and maybe even the family to some extent.

Decisions to discontinue therapy may have a situational context. The following exemplar describes an incident in which the participant perceived factors other than the patient's condition to have an influence on the decision-making process.

I was angry because of the situation, just the circumstances that were leading down to it. On the first set of rounds (in the morning) they decided 'no we'll continue treatment' and on the

second set of rounds (afternoon) when they were short of beds, that's when they decided to discontinue treatment.

A second exemplar in relation to situational factors is the following which describes a situation involving a patient from a lower socio-economic class.

He was a man who lived on the street, had no next of kin, chronic obstructive lung disease, and they were wanting to just pull the plug on him. We had no meetings. We had no discussion. It was, 'we're going to take him off the machine, just take him off'.

Decisions which are made or not made to discontinue therapy are perceived by participants to be colored by such elements as the patient's rights or wishes, patient's level of consciousness and situational factors.

A theme which recurred throughout the transcripts and which is relevant to the preceeding information is the way in which the participants' perceive death. Several examples indicate that death is viewed as something to be controlled, allowed or prevented rather than as a natural part of the life process. The following excerpts illustrate this.

The patient was steadily going downhill, but it was very slow and it was going to take a long time. It was just going to be a long, slow, grind to a halt.

All he really wanted to do was to slip away and we wouldn't let him.

Within a week we were withdrawing aggressive treatment and we allowed the patient to die.

They should have just let her go peacefully, make her comfortable and just let her go.

When death is viewed as an event to be controlled or allowed, the care of the patient is then seen as an investment. The following excerpt describes this.

They had invested so much up to this point and they were just not willing to let go at that time.

So much is invested that you find it difficult to know when is the time to stop all that aggressive treatment

Care of the critically ill patient is described by one participant as an investment of time, as well as human and material resources. Viewing death in this manner is reflected in the difficulty with which the decision to discontinue therapy is associated.

In summary, discontinuation of therapy is a situation which participants described in relation to a 'care versus kill' conflict and factors involved in the decision-making process.

The Interpersonal Dimension

The interpersonal dimension of patient care situations is related to several issues which emerged from the interview transcripts. Participants described situations involving the recurring themes of interpersonal communication and professional relationships. This section of the chapter will describe the situational context of perceived ethical dilemmas in relation to these two major themes of the interpersonal dimension.

Communication

Communication between colleagues, patients and families is a theme which recurred in the participants' descriptions of the situational context of an ethical dilemma. The following examples from the transcripts illustrate the issues related to interpersonal communication and informed consent.

Interpersonal communication is described as an ethical issue when the treatment decisions are controversial. The following exemplar describes an incident in which emergent surgery is performed on a young patient in the critical care unit. The participant was the charge nurse on night shift.

One night he became extremely ill, acidotic probably due to an infarction in his gut. So they proceeded without consent of the family, to actually do surgery in the cubicle on this man, and I'm talking a laparotomy. I talked to the attending doctor who was at home, because I was very emphatic that they would not do the surgery in the cubicle. I was also emphatic that they would inform the family about what was happening. I did not receive the support of the attending physician. It was a very political situation. They did go into the cubicle and start to do the laparotomy. I felt very sad that this family

did not know what was going on because it was quite possible that this patient's last moments were going to be spent in the surgery. I felt that the family was deprived of being able to say good-bye and that they were deprived of being able to make a decision (about the surgery). I was very angry at the doctors. I was confused because I couldn't follow their line of reasoning. I felt angry that they would not listen to me.

This exemplar describes difficulty with communication between the doctor and the nurse regarding the plan of care. It also describes the nurse's concern regarding the lack of consent for the surgery and the fact that the family has not been informed about the patient's condition.

Another factor in this particular situation involves the nurse's concern for the patient's comfort during the surgical intervention.

They gave him pavulon (paralytic agent) and they touched him up with a little bit of morphine (pain relief/sedation) and they proceeded to do the surgery, whereupon his blood pressure rose. I felt the patient was partially aware of what was happening, so I just created a big scene. I went

in and sort of spoke up loudly, almost grabbing the surgeon's arm at one point saying 'excuse me but this patient is aware'.

These exemplars demonstrate an interpersonal conflict between the nurse and the surgeon regarding appropriate care and illustrate patterns of ineffective communication.

Not being listened to by the medical staff is illustrated in the next exemplar which has a different situational context. The patient is an elderly lady who has requested that no aggressive measures be instituted and the family has agreed with her wishes. However, aggressive therapy is instituted in the form of mechanical ventilation and central monitoring lines while the family is not in the unit.

What else can I (the nurse) do if I've already told them that that was the patient's wishes. It's documented in the chart and in the progress notes. Nobody listens.

Communicating concerns about a patient's condition to the medical staff is also described as a real problem for the nurse when no appropriate response is forthcoming. The

following two incidents are illustrations of such a problem. The outcome of both situations was' deleterious for the patient.

I was in charge of a respiratory patient who had a lot of secretions and I had read that you can have a mucous plug that acts as a one way valve in an ET tube. The patient developed a tension pneumo and at the same time obstructed his ET tube. We called the doctors, nobody would do anything about it.

Another participant described a similar type of incident where it was difficult to get a response after communicating her concerns about a patient to the attending doctor.

The doctor had seen him in Emergency and sent him to the unit. He was in some sort of junctional rhythm, I knew he wasn't well. The doctor wouldn't come in. We phoned him at home and he still wouldn't come in. He (the patient) gradually went into cardiogenic shock.

Communication sometimes involves mediating between the patient and/or family and the health team. The following exemplar depicts the nurse in the situation of communicating

the patient's or family's wishes to the health team. The situation involves an elderly man who was in the end stages of respiratory disease and who did not want to continue with aggressive therapy. Communicating the patient's wishes to the health team is met with a negative response.

One day I found the wife crying. She felt she could not voice her opinion and she felt very very guilty asking us not to be so aggressive. She did not want to say 'stop this, my husband does not want to live any longer' especially when we were coming on so strong. I was really quite bold and I reported it during rounds. Of course I was shot down and told that it was absolutely ludicrous to think of anything like that at this stage.

Interdisciplinary communication is described as an ethical issue when there are conflicting thoughts about what is appropriate care within the context of a situation, when the patient's rights to comfort and family's rights to be informed are not considered and when the nurse presents a patient's or family's concerns to the health team.

The patient's right to informed consent is another theme which relates to communication in the critical care unit. Participants described two different kinds of incidents which portray this issue. The following exemplars describe a patient whose right to refuse treatment was denied.

A woman came in, required some emergency surgery, decided she did not want the surgery. She had the right, there was nothing wrong with her mental status. She did not want the surgery. It was explained to her that the likelihood of her dying was going to be increased if she didn't have the surgery. She said 'no', she didn't want the surgery. So they ended up declaring her incompetent and somebody else signing it.

The next exemplar concerns a situation in which the patient was perceived by the nurse to be poorly informed prior to surgery.

We had a patient who was going for surgery, so they (the surgeons) discussed it with the fiance and they came back and the only explanation that

the patient got was, 'we're going to do a dye test and then we're going to take you to surgery. Now we want you to sign this consent'.

Informed consent is perceived to be an ethical issue when the patient's right to refuse treatment is not accepted and when the patient is perceived to be poorly informed prior to the institution of essential treatment.

Professional Relationships

A second theme related to the interpersonal dimension of an ethical issue is that of the professional relationships which the nurse experiences in relation to a patient care situation. Participants described several type of issues which illustrate this theme.

The critical care nurse works as a member of an interdisciplinary team in any patient care situation. This is described as a problem in situations which are perceived to be ethical dilemmas. When the care is perceived to be excessive, one participant describes the following role conflict that she experienced in trying to provide comfort when required care is painful for the patient.

You have a certain responsibility to your colleagues. You have to support them. I feel very strongly about that. I felt badly for the patient. I felt I had to carry out some of the procedures in order to be loyal to the health team, but at the same time, I had a responsibility to the patient.

The effort of the team was emphasized in several instances as a significant part of the process of caring for the critically ill patient. However, when the nurse does not agree with the plan of care because it is perceived to be contrary to the best interests of the patient, an ethical problem arises. In the following exemplar, the nurse describes the situation of the nurse who is assigned to care for a patient who is being aggressively treated in the hope that he will be able to wean from the mechanical ventilator. The patient has persistently requested that therapy be discontinued.

This (the situation) presented a big problem for the nurses because, the nurse had the choice of going along with the patient and therefore leaving him lying in bed and not sort of actively pursuing things, in as much as the

doctors orders allowed, or they had the choice of totally disregarding what the patient said and weaning him and getting him up to walk and so on. It was a real problem for the staff.

In another situation, the nurse describes the loss of team support after being involved in a meeting where the decision was made to discontinue therapy on a conscious patient.

I now had to face the patient alone. Everyone else from the team who had participated in this decision had gone in their own direction. I knew that I wasn't going to be the one to tell her (that she was going to die), but I felt guilty having that knowledge. I felt so uncomfortable and I thought 'why am I the one that's having to face this burden alone? Where is the team? I felt very comfortable with the team. Where had the team gone. The support service had been taken right out from under my feet. The team was gone and I was now alone to face this on my own.

Professional relationships also involve dealing with the inappropriate behaviour or attitude of other members of the health team. Participants described several examples of situations which exemplify such inappropriate behaviour or attitude. These incidents relate to such issues as the patient's right to privacy and confidentiality. The following excerpts describe examples of these issues.

There's a great problem with privacy. There's always bare bottoms flashing around and it just takes the dignity away.

You can walk through the unit and take one look around and sometimes they don't even put a little sheet on them.

I've heard nurse talking right over top of the patients. In rounds, we used to always move down a little so the patient couldn't hear and the last time I was on rounds, I had to suggest that. The patient's sitting right there and we're talking about the lady possibly having a heart lung transplant. If we haven't discussed that with her, then we should move down a little bit.

Participants described situations which involved a lack of respect or caring for the patient as a human being. The following excerpt describes a patient who was from a lower socio-economic class and who had no next of kin.

This man was taken down to the morgue by the unit assistant and instead of laying him on his back, he was flipped over on to his face. The face was beyond repair and there was no way the funeral home could do anything to prepare him for a funeral.

Lack of caring is also described in relation to the highly technological orientation of the critical care unit. The pressure on the individual nurse to be skilled in the technical aspects of patient care is perceived as a problem when the nurse is not able to recognize the human element in the care of the patient.

Over the years in ICU, you tend to become very proficient in technology. You can't help it. That must be at your fingertips. I think we all feel that way at sometime, that we are performing technical tasks.

There are nurses in critical care who cannot define nursing. They see it 'as a subdivision of medicine. And you see that in terms of the super nurse, knows every bit of skill and technology. It's not playing the role of the nurse in terms of working with that patient, it's just dealing with an inanimate object and pushing or pulling people to deal with that individual as an inanimate object.

Peers may then be perceived as insensitive to the human being who is the patient and one participant describes an indication of this in the following excerpts.

I hear a lot of conversation in the coffee room, from nures who feel it is absolutely ridiculous to carry on (with caring for certain patients) 'Why don't they just pull the plug'.

I see nurses suctioning without preparation of the patient .

Caring for the patient is described in terms of the nurse's attitude by one participant.

It's the attitude with which people are treated, the gentleness with which the care is given, the manner in which the patient is spoken to, the infringement on the patient's rights.

When the nurse's attitude lacks a caring and respect for the human being, this is reflected in the kind of decisions that are made for the patient. The following are two examples of how a non-caring attitude may be reflected in patient care decisions.

The patient is combative. Does the nurse have the right to use undue restraint on that patient? Some people approach it, yes, you have to restrain all four limbs to protect the patient. Another nurse feels that her role is to be there, see what's causing this agitation and maybe rectify the situation so that restraints are the last element.

With pain control, the patient is the only person who knows how much pain he has' and imposing beliefs occurs by saying that you don't believe that patient is having pain. It is the lack of wanting to recognize that what is painful for some people may not painful for you and this is evident when the nurse says 'no that patient is not in pain and therefore they're not going to get any analgesics (pain relieving medication)'. .

Dealing with the individual personalities in the critical care unit is also a factor in professional relationship with other members of the health team. This issue is related to the perception of the super nurse which was described earlier. One participant described the following as an example of the inappropriate behaviour of others.

There is a special type of person who wants to work in ICU, quite an ambitious person, wants a challenge and is also power hungry. I have found a great deal of difficulty in dealing with these people who are on a power trip, always picking on the vulnerable. It takes away from my ability to be the nurse that I want to be.

She used the following incident' to exemplify what she meant and described the difficulty she had in fulfilling her role as charge nurse of the unit while having to work with one such individual.

This person liked to be wherever the action was, had to be there, really had to be in the front line, so to speak. There was no way she would let me handle my responsibilities. She took over (from me) whenever there was something exciting going on.

In summary, the interpersonal dimension of ethically problematic situations is related to communication between the nurse, the patient and other members of the health team. It is also reflected in the nurse's perceptions of the degree to which the patient has been informed prior to consent being given for treatment.

Professional relationships involve several elements and this is reflected in the conflicting loyalties that the nurse perceives as well as the perceived inappropriate behaviour and attitude of other members of the health team.

The situational context of a perceived ethical dilemma involves three major themes. Excessive therapy, discontinuation of therapy and the interpersonal dimension of work relationships emerged as major categories of ethical dilemmas in critical care. These themes are exemplified in this section of the chapter using direct examples and quotations from the interview transcripts.

Factors Which Influence Perception and Response

Findings of this investigation also revealed categories of factors which influence participants' perception and response to an ethical dilemma. These factors may be associated with an external or an internal source and are presented in this section of the chapter in relation to these two major categories.

Internal Influencing Factors

Attitudes, beliefs and feelings are considered to be significant internal influences for the participant. The following presentation of the findings describes attitudes

and beliefs as they emerged from the transcripts and secondly the feelings which participants described in relation to ethical dilemmas in the critical care unit.

Attitudes and Beliefs

Participants described their attitudes and beliefs in relation to self, to the patient and family and lastly in relation to life and death. The following information is sequenced to reflect these three elements.

Beliefs about the role of the critical care nurse are described by participants in relation to the way in which they perceived and responded to situations. The following excerpts describe a participant's expectations about the role of the critical care nurse in relation to how she felt in a situation involving discontinuation of therapy.

I was so junior and so unaware, and I didn't want people to think that I was weak and not able to handle this. I thought this was sort of the toughness that you needed to work in this area. This was my first experience. I was scared maybe of not having the right stuff to be able to this (discontinue therapy) and nobody else seemed to be really upset about it.

I felt I guess that if I did cry or if I did look really uncomfortable that maybe I wouldn't meet the criteria to be a good ICU nurse. I didn't want my head nurse to know that I couldn't handle this kind of incident, that I'm very soft.

Beliefs about the role of the student in the same kind of situation are illustrated in the next description.

They volunteered to do it for me (turn off the sage pumps), but then I thought it was something I was going to have to get used to and face. It was very tempting (to let someone else turn off the sage pump), but then I thought, this is what I have to do and this is what I'm getting marked on.

In the following situation, the nurse describes her beliefs about her role as the charge nurse in a situation involving the death of a young woman.

I felt really sad, but I thought, well, I'm the charge nurse and I must be strong for my bedside nurse. So I was trying to be sort of business like

and also trying to be supportive. I felt that I had to be very strong because I was in charge of the situation.

Attitudes and beliefs about the role of the critical care nurse reflect a perceived characteristic of toughness and capability in handling difficult situations without letting inner feelings show. These perceived expectations appear to influence the participants' response to the situation.

Beliefs and attitudes about the patient and or family also emerged from the transcripts. The following excerpts describe beliefs that participants stated in relation to the patient's right to be informed and to be actively involved in decisions involving treatment plans.

Patients should be able to control their own destinies. They should have the choice in terms of therapy. They should be able to make some decision.

Patients choose their destiny, not someone else.

If they're conscious and they can make the decision, then that's their decision to make. I believe they have that right.

If the patient is able to make the decision rationally, then that patient's decision should be considered utmost.

You have a right to know what they're going to do to you prior to them doing it.

Respect and caring for the patient as another human being is reflected in the following statements of belief.

I think everyone should be treated equally and given the best care of our ability.

Respect of the individual is extremely important.

If you cannot empathize with that individual, then you can't really meet the needs of that patient.

It is a patient, a human being in that bed and we need to respect that.

You have a person here, that's my philosophy.

I don't feel good about my day unless I feel for the patient. That's why I'm here.

My basic belief, certainly my sentiment is to the patient first and I am a big believer in patient comfort. You have a responsibility to make these individuals' last days as comfortable as possible.

The family is also seen to be important factor in influencing the participants' attitudes and beliefs

I really believe in the access of the families, that it's their right to see their family member, even if they're dying and gravely ill and have zillions of physicians hanging over them. Families should never be denied access to their relatives except in very extreme situations.

In summary, attitudes and beliefs about the patient and family are described in terms of the patients' right to be informed and to make decisions for themselves. A respect and caring for the patient as a human being is important as well as the right of the family to be present in the critical care unit.

Attitudes and beliefs about life and death are also evident in the interview transcripts. Life is seen to be of value when there is some quality which participants describe as an interaction with the environment.

Quality of life rather than quantity of life is very important to me. Life should be lived rather than, you're breathing so that means you're alive.

Sometimes the end result of the technology is not always beneficial to the patient. If someone's mentation or their ability to live and to be able to participate is not going to be there and they're going to be left in a vegetative state, then to me that's not living.

The following two excerpts reflect a somewhat fatalistic view of death which may influence perceptions and response.

When life becomes a misery is it really worth living? Why not let nature take its role?

Usually it's (death) the best thing for that patient. Usually there's nothing that really can be done and why prolong life.

Religion influences attitudes and beliefs about life and death. Several participants described their beliefs from a religious perspective.

I think that life is sacred; death is not an end, it's a beginning of a different kind of life. It's the end of our earthly life and ultimately we'll all die.

There's a heaven and something beyond this. Once you're dead, you're not just put somewhere and the body rots and that's that. There is something more. In a lot of our patients, death is more of a relief. They're finished with this suffering now and they're gone on to something better.

That's my religious belief, that a patient should die with honour.

Attitudes towards death reflect a belief that it is an event that should occur with respect for the patient and consideration of the family.

I sort of value life and I have a very strong feeling towards people. And I think that when you die, it shouldn't be a experience that family and the people around are left with a state of shock and dismay over.

It makes me feel good to know that they won't suffer anymore, that they'll be able to die in peace, have the family there. It'd be nice for them to have the family there.

Past life experiences also have an effect on how participants perceive and respond to life and death situations which they face in the practice of nursing. Past experiences for several participants focus on the death of a grandparent.

I nursed my grandmother all last year when she was sick. I had never dealt with death before that. She talked a lot about what she was going through. I found that dealing with her has really helped me to understand a lot. I was really really close to her so a lot of what she talked about and explained, I can understand now when it comes from other people.

One nurse described the death of her grandmother as a significant event which helped her to decide to become a nurse. Her sensitivity to and awareness of the person that her grandmother was has been a significant influence in her response to the uniqueness of each patient that she cares for.

I think what has kept me so sensitive to nursing is my family. My grandparents meant the world to me and I decided to go into nursing when I was twelve, when I saw my grandmother die of cancer. I wrote her a letter every day for four months when she was in the hospital, hoping that a nurse would read her the letter because I couldn't. Even though Grandma had cancer and she was dying, she was still very much a person to me, so I've never forgotten that.

Attitudes and beliefs, as internal factors, influence participants' perceptions and response in several ways. Perceived expectations and beliefs about the role of the critical care nurse reflect a need to be strong in emotionally difficult situations. Beliefs about the patient and family are described in relation to rights and the need to respect and care for the human being. Participants also describe beliefs and attitudes about life and death which reflect a fatalistic or religious view and the influence of past life experiences.

Feelings

A second theme which emerged from the transcripts in relation to internal influencing factors is that of feelings. Participants described feelings about self, about the patient and about other individuals in the situation. The following information is presented in a manner which reflects these three views.

Feelings about self are described in terms of an inner turmoil. Such terms as frustration, anxiety, panic and agitation are used to convey the emotive quality of the experience for the participant. In situations which they perceived to be particularly tense, several participants

described severe emotional distress associated with their role in the incident.

The following description relates to a situation in which the nurse perceives that the doctor's plan of care for the patient is not appropriate for the setting.

I was very agitated, very agitated. I was obviously upset. I don't think I was out of control. They could see that I was upset. I didn't usually lose my cool and that bothered me. I wasn't usually near the point of tears.

Another nurse describes feelings which occurred as a result of a situation in which a decision was made to discontinue therapy without considering that patient's wishes.

I felt really uncomfortable and I started to feel really panicky. I felt guilty having knowledge that she didn't have. I felt that I had invaded her privacy (by having this knowledge). It scared me. I felt all of a sudden that I was involved in something that was very wrong. I felt that I had betrayed my patient. The conflict was going

on inside of me to such an uncomfortable extent that I wasn't sure if I was going to be able to handle this.

In describing the feelings associated with her first experience in having to discontinue therapy on a patient, one nurse stated the following:

I was sick to my stomach. I was really sick.
I was very upset. I really had a bad time.
It wasn't very easy. To me that was really traumatic and still is.

Feelings about the patient are also evident in the interview transcripts. Feelings ranged from sadness and hurt for the patient's suffering to feelings of anger at the patient for dying.

The following excerpts describe the feelings that four nurses experienced in relation to their patients. Each incident refers to situations where therapy was perceived to be excessive.

It's a very frustrating situation to be inflicting pain (with the routine care). 'It's very depressing. My main feeling was one of frustration and almost a disappointment in yourself that you know that's what you're coming in to do that day.

I felt badly for the patient. I hurt inside when I have to do anything that would hurt the patient.

Putting her through so much pain. I was really frustrated with that.

I felt very sad for the patient. I felt that he was going through hell. I was very upset about what was happening to the patient.

One nurse described feelings associated with the patient's death. Feelings vary from a sense of failure to anger at the patient for dying.

We're so geared to saving those lives and our feelings of satisfaction, accomplishment, success, always seem to gravitate to getting that patient out of the unit in a healthy state. When you have death occurring, you're faced

with feelings of failure. People may come up to you at the end of a resuscitation and say you did a really good job, but that person (the patient) is still dead and you feel down.

I can be really mad at someone for dying on me. If a patient goes sour on me when I've spent three quarters of the day working really hard and then they have the audacity to go sour on me, sure I can be angry.

Participants also describe feelings that they experience about others in association with ethical dilemmas. These feelings were described in relation to colleagues, the patient's family and to the situation.

Feelings of anger towards the doctor(s) is described in several ways and in association with several kinds of situations. The following excerpt illustrates the anger that one participant described when the doctor gave inappropriate verbal orders regarding discontinuing therapy on a patient.

At first I thought he was joking because I really couldn't believe what I was hearing. And then when I realized he was walking away, and he wasn't joking, I felt quite angry with that.

Anger is also described by participants when communication with the nurse or the patient is perceived to be insufficient or ineffective. The following excerpt describes a situation where the nurse perceives that the patient is poorly informed prior to surgery.

An angry outrage. I just wanted to stop the doctor and say 'excuse me, could you say a little more please".

When treatment decisions are contrary to what the nurse believes to be appropriate for the patient and the situation, anger is one feeling that is described by participants.

I felt angry at the doctors. I was very angry. I really couldn't follow their line of reasoning. I felt angry that they would not listen to me.

I was angry because of the situation, just the circumstances that were leading to it. I was really angry.

Other participants described anger in situations involving what was perceived to be excessive treatment of the patient.

I just thought, we're torturing this woman, let her die. I was mad because everybody wanted to discontinue except for this one doctor. So I was mad at the medical profession.

I was angry at the doctors. I felt a little angry at the attending (staff doctor) who did not take a hand in this situation. He had made a bad situation worse.

Participants described feelings of anger toward other staff members as well. The following excerpts describe participants' feelings in relation to behaviour of another staff member which was perceived to be inappropriate.

I just shuddered. I was so angry that I felt that they should be severely reprimanded for something like that. I felt so strongly that I thought they should be fired.

I have felt extreme anger at that person.

Frustration is another recurring feeling that participants described. One participant described the feelings she experienced when her communication with the doctor did not result in the appropriate response. The patient's condition was deteriorating, the doctor was at home and the nurse could not convince the doctor to come in to assess the patient.

I felt desperation because I knew that the patient wasn't going to make it. I just felt frustrated and desperate.

Frustration is a feeling which is described when the situation seems hopeless and care either does not make a difference or is very painful for the patient.

Frustrating. Because we were doing all these heroic measures and I knew that she was going to eventually die.

It's just a very frustrating situation,
to be inflicting pain. It's very depressing.

There was no hope for her and to me, that
was frustrating that we let her go on so long.

Feelings about the patient's family are described in
terms of sorrow or sadness for their suffering. The following
excerpts illustrate this.

I felt very sad for the family who did not know
what was going on.

You can't help but feel sadness for the patient.
I felt very sad for him. I felt that he was
going through hell and I felt very sad for the wife.

I just started to cry too, because I had cared
very much about his wife and I cared very much
about his sorrow.

I felt sorry for them. I guess I felt a lot
for the daughter. I would see her later on
when I wasn't looking after her mother and
I'd think 'gee you're still going through all this'.

Dealing with the family, watching the pain they were going through. I could imagine how I would feel in that situation and they were very helpless in the end, totally out of their element. Just a lot of sympathy for them.

It was very difficult when they came up to say their last goodbyes. I just had to get out of the cubicle, because I did start to cry. It's hard not to.

In summary, feelings are described by participants in terms of what they felt about themselves in a situation, what they felt about or for the patient and what feelings they had about other colleagues or the patient's family.

External Influencing Factors

External factors which influence perceptions and/or response are those related to professional relationships and the patient and family.

Relationships with other members of the health team are perceived to be an influence in a variety of ways. A sense of unity as a health team is described by participants in

relation to decision-making and to following-through with a plan of care. The following excerpts' illustrate how nurses perceive team effort as an external influence.

It takes a whole team. It takes an entire team of people to be able to perform something like this, to be able to see patients die, and feel comfortable within all of us. We each have our level of comfort, our own inner beliefs and I think that we have to respect each person's beliefs and comfort.

We're a team. You have a responsibility to your colleagues. You have to support them. I feel very strongly about that. Even if we don't agree, we need to work as a team and if we don't agree, we need to discuss it.

One neophyte nurse describes the support she recieved from the team in a situation where therapy was discontinued on a patient she was caring for. This was her first experience with this type of situation.

I sat down for awhile and the staffman came and talked to me. The head nurse came and talked to me. My buddy came and talked to me. They explained

the situation to me. They volunteered to do it for me (turn off the sage pumps). I did get a lot of support from the staff that I was with. They were truly concerned. I realized that I was not the only one that felt that way, especially when the staff man came over and he had tears in his eyes. It was easier when I knew I was feeling what everyone else experienced.

Another nurse describes her feelings in the same kind of situation. It was also her first experience with discontinuation of therapy; however, there was no team support.

I thought to myself, Why am I the one that's having to face this burden alone? Where is the team? I felt very comfortable with the team. Where has the team gone all of a sudden? The support service had been taken right out from underneath my feet. The team was gone. I was now facing this on my own, by myself, for the very first time.

Participants describe role models or significant individuals in their work life who influenced their perception and response in stressful situations. One

participant listed a number of individuals such as a teacher, a doctor, a clergyman and peers who 'accepted and encouraged her to be a caring nurse. Other participants described role models as being an important factor in influencing them.

The following excerpt describes one nurse's perception of her peers in a situation involving discontinuation of therapy which severely distressed her.

Peers around me that I respected and who were knowledgeable and experienced in this seemed comfortable. The doctor seemed awfully cool. This was very comfortable to him. There were a lot of people who seemed to feel very comfortable with this kind of death. I guess looking at your social role model and what looks comfortable then you go along with it.

Another nurse described peer support in an extremely stressful situation which was perceived to be an ethical dilemma.

Two other senior nurses saw the situation and came to me armed with morphine and said, 'why don't you let us go in? Why don't you just wait outside? You obviously don't want to participate'. They felt

the same way, but they were fresh. It was a very touching thing. They felt that I had done my best and that I needed a break. I think it was a show of confidence for me.

Professional relationships influence nurses in a variety of ways in situations described as ethical dilemmas. Team support or lack of, as well as significant role models and peers also influence one's perception and response in such situations.

The situation of the patient and/or the family is described as a second type of external influence by participants. When it is necessary to do nursing care which causes the patient discomfort or when care is perceived to be excessive, the patient's level of consciousness is a factor in how the nurse perceives and responds to the situation.

If the patient is totally unconscious. I can tolerate it for a longer period of time.

Level of consciousness is also an external influence on how the nurse responds to a situation of discontinuing therapy. When the patient is unconscious and decisions regarding treatment are made for him, greater distress is

experienced than if the decision is made by the patient. One nurse compared two different situations of discontinuation of therapy involving an unconscious and a conscious patient.

One was conscious and knew what she wanted. It didn't bother me, cause she had made up her mind. I just thought that was her right and good for her. But the other one wasn't. It was like, you're running this guy's life without him ever being awake to participate. The circumstances were different. I could handle one, but I just couldn't handle the other one. I think it was because someone else was deciding and it wasn't his wishes. It was someone else deciding for him.

The presence of the family in the critical care unit is an external influence for the nurse. The ability of the family to cope with the situation and the distress that they experience affects the nurse's perception and response. The following excerpts illustrate participants' perceptions of the family.

They, to me, just didn't seem to be coping with it as they should have been. They just didn't seem to be realizing the seriousness of the

situation, so it was really hard. I didn't know how I should talk to them or how much more I should say to them. I didn't know what I should be doing in order to help them. You can't help but get caught up in the families. You want to try and help them as well as the patient. I felt like I couldn't help them. I didn't know what to do.

I found the wife crying and I could really relate to the conflict in her. She did not want to say, 'stop this, my husband does not want to live any longer'. I felt very strongly for the significant other, that it should not have been her decision.

Concern about the family may extend beyond the period of time that the patient is actually cared for in the critical care unit. One nurse describes this in the following exemplar.

We received a letter about three months after he died and this lady wrote to thank us for the care. She just wanted us to know that he was a courageous man. The whole letter made me very sad, because I realized that we'd totally

missed the boat with her. She probably thought that we thought he was not a courageous man and that he was wanting to give up and die. That sort of feeling was left with this woman and really, there was nothing we could do about it at that point. I'm sure that woman did not have an easy grieving process. That bothered me.

This nurse then went on to say that she generally feels concerned about families after a patient dies in the unit.

We really don't know what happens to families after they leave here. We have no idea what kinds of thoughts they're left with and I often wonder about that. There are situations I can think of where I worry about the families now and wonder how they relate, what they're thinking.

The family may be an external influence on the nurse's perception and response during the acute phase of a critical illness and also affect the nurse long after the patient has left the unit.

In summary, external influences are those factors associated with relationships the nurse has with other health professionals as well as with the patient and family. The effort of the team and loyalty to the goals of the health team influence perception of and response to in an ethical issue. Role models and significant supporting relationships are also an external influence in this category. The family, particularly when they are distressed by the situation, is a factor which also influences the nurse. Concern for the family may persist long after the patient leaves the unit.

Response To And Coping With The Ethical Issue

In this final section of the chapter, findings are presented which describe the participants' response and the manner in which they coped with the ethical dilemmas they perceived in the critical care unit. Analysis of the interview transcripts revealed two major themes. Response and coping are described in a manner which reflects a degree of effectiveness in dealing with ethically problematic situations. The following information is presented in relation to reactions or actions which were either effective or ineffective for the individual in responding to the situation or in coming to terms with the incident.

Ineffective Reaction/Action

Participants response to a situation which is perceived to be an ethical dilemma, is reflected in the way in which reaction to or action in the situation is described. Ineffective reactions or actions are those which do not appear to benefit the participant or the situation. The following information describes reactions and actions which appear to be ineffective in response to or coping with an ethical issue. Information is also presented which gives evidence that issues remain unresolved for some participants for several years. Personal moral distress affects patient care and this is described in the latter part of this segment of the chapter.

Reaction

Ineffective reaction to the situation is described in terms of both inner feelings and behaviour. Sarcasm is described by one participant as a deliberate response in a situation in which communication with the doctor is ineffective, that is when the doctor has not responded appropriately to the nurse's assessment of a patient situation.

In some ways, I use manipulation and I use sarcasm to get the point across. It is one of the techniques that I will employ.

Crying is described by several participants as a response to a situation perceived as an ethical dilemma. Crying is described by one participant as a delayed reaction to what she perceived to be the needless death of a patient.

I went home and tried to sleep that day and I couldn't. I was quite depressed. I felt really sick. So I started talking to my mom and then I just started crying. I felt better after but it still bothered me.

The following excerpt describes an experienced nurse's crying as an immediate reaction to a situation which she perceived to be excessive therapy and a violation of the patient's wishes.

I had just had it. I went into the office and cried. That was the culmination.

She describes other nurses' response to caring for the same patient in the following manner.

A lot of nurses that would really talk to him were really bothered. This was the only patient I can ever recall where nurses would be crying in the hall at 9:00 o'clock in the morning.

Action

More deliberate kinds of action are also described by participants. These actions range from doing what seems right according to the behaviour of others, to leaving the job. One nurse describes her actions in her first experience with a situation involving discontinuation of therapy. She describes her response to the situation as being based on how she saw others responding.

This was my first experience and like many other experiences I had, they got easier as time went on. So I attributed this (my feelings) to my

inexperience in the situation. Peers around me that I respected seemed comfortable and what looks comfortable (to others), then you go along with it.

However, the remorse that she later experiences is described in the following.

I'm very sorry that I didn't express my feelings a bit stronger. I felt that I had participated in something that was very wrong. I've had to work at (dealing with this incident) for a very long period of time.

A neophyte nurse describes her actions in a situation involving discontinuation of therapy. These actions are described as being influenced by the expectations she perceived for herself in the role of student.

I don't think that day I really agreed with it, (the decision to discontinue therapy), but it was more, this is an expectation of the course. I don't think I was quite ready for it, but I did it because I was in the course. It was very tempting when one of the nurses said 'I'll turn off

your sage pumps for you', but then I thought, this is what I have to do, this is what I'm getting marked on.

Interviewer:

What do you think you would have done if you hadn't felt that expectation as a student?

Participant:

I would have gotten someone else to turn off the pumps. I kind of regret that I didn't, cause I don't think I was prepared for that.

One of the actions that is utilized by nurses in such situations is mentioned briefly in the preceeding exemplar. Nurses sometimes help each other by turning off sage pumps or ventilators for each other.

My buddy volunteered to shut off the sages. She said, 'you know, when I have a situation like that I have someone else turn off my pumps and I'll turn them off for someone else. It's easier for me because I'm not working with that patient trying to save him all day. It's easier for me to turn off those pumps that it is for you'.

Participants describe action ' and behaviour of withdrawing from the situation. Such action may be as simple as taking a coffee break or it may involve actually having to remove oneself from the situation when the stress is unmanageable. The following excerpts illustrate this in the participants' own words.

It felt like a torture chamber and I'd look forward to my coffee and lunch breaks.

I felt extreme anger, I would withdraw. To a great degree I avoid [peers who appear to be on a power trip]. I will be very matter-of-fact, professional, straightforward, business-like.

In any circumstances I get frustrated, I just leave the cubicle for five minutes and go into the coffee room.

Sometimes, the distress is such that the nurse must leave a situation and allow others to take over.

I could not participate in the situation and I just went and stood out by the desk. Two other senior nurses went in and took over for me. I felt that if there was any way I could avoid being in the room I would. Quite frankly I was near tears.

Participants described actions which they took after the incident was over. Such behaviour varied from an inability to talk about the incident to resigning from the job. Following a particularly distressing incident, which occurred early in her career as a critical care nurse, one nurse describes the following.

I just didn't even really feel comfortable to talk about it. It was almost the whole pain of the entire incident was too difficult to talk about. It tempted me to leave the area. I questioned whether this was the area for me. I really went through a dilemma. I questioned whether I would ever be able to become tough to this type of treatment (discontinuation of therapy), and I

questioned whether I ever wanted to be. If this was critical care nursing, I wondered if it would destroy me as a person.

Another experienced nurse describes her thoughts following an incident which was perceived to violate the patient's right to have therapy discontinued and in which the nurses or the wife's opinion was not considered.

If ever I thought of truly leaving the Intensive Care Unit and never coming back, it was during that time period. It was a time of real crisis in the unit. It took a long time to resolve that.

I can remember wondering whether I wanted to be a part of this whole mess and I can distinctly remember thinking that I really didn't believe in intensive care units.

The situation may be sufficiently distressing for the nurse, that resignation from the job is the outcome. One nurse describes her actions following what she perceived to be a needless death:

I walked out, picked up a resignation form and resigned right there, gave them two weeks notice. I did not have a job, did not know what I was going to do, but that was it. It was sort of like my inner self saying, Im leaving, I can't work here anymore.

The Unresolved Incident

The issue may remain personally unresolved for a considerable period of time. One experienced nurse described through tears, her distress about an incident which had occurred ten years previously.

When I look back and think about it now, I really don't know how I handled that the way I did without cracking up literally at the seams and not returning another day to work.

Other nurses describe with vivid nonverbal behaviour, (agitation, finger-tapping on the table, flushing of the face and dilated pupils) their thoughts about incidents which occurred more than five years ago.

It's not a resolved issue. It's still there.
I'm still very very angry.

Yes, it does agitate me when I talk about it. I thought about it a lot, especially because I didn't usually lose my cool, and that bothered me.

One neophyte nurse described an incident which had occurred within the past three months and which she has still not been able to resolve or talk about easily.

I had to work it out a lot. I still haven't worked it out. It's something inside that I have to work out. I try to put it on the back burner, but it still kind of catches me. I am going to cry if we don't change the subject.

Effect on Nursing Care

When the nurse is distressed by a situation, her response to and care for the patient may be affected. Nursing care then becomes compromised. Having to leave the situation has been previously described. In some instances, the nurse describes having to withdraw from the situation in order to escape what she cannot deal with.

That was the culmination, so I just said, 'Excuse me, I've had it' and I went into the office. And then of course, I calmed down.

In other instances, care is directly compromised by the nurse's inability to deal with the situation.

I wanted to dodge going back into the cubicle. I felt really uncomfortable and wanted to avoid her. I didn't know what to say. I felt very uncomfortable even doing small treatments for her. It was very difficult to carry through the basic care.

The family may also be poorly cared for when the nurse is distressed by the situation.

Thinking back on it now, I was so wrapped up in myself, I never even really appropriately dealt with that family. I could have helped them deal with this problem, by giving them some time so that they could stay (with the patient when she died), but they left.

When an ethical dilemma or issue arises, one's reaction or action in response may indicate the degree to which the problem has been personally resolved. The preceeding information has described the kinds of reactions which emerged from the interview transcripts and the actions that participants describe when the issue was difficult or impossible to resolve. The effect of such distress and difficulty in coping may be reflected in the kind of nursing care that the patient and the family receive. Participants decribed difficulty in giving basic care, wanting to avoid the patient and inability to respond to the needs of the family. Evidence of unresolved feelings about issues which occurred in the past is also presented.

Effective Reaction/Action

Participants describe actions or reactions in a situation which have more positive characteristics. This section of the chapter presents those findings which are perceived as effective actions or reactions to an ethical dilemma.

Reaction

Assertiveness is described by participants in relation to several kinds of situations. The following excerpt describes one nurse's reaction when the doctor walked away after giving her orders which she perceived to be inappropriate for the situation.

I brought him back and said 'You're not going to leave me with that kind of responsibility. You're going to leave me with some kind of orders as to what you want done here'.

Giving information to the patient is another kind of action that the nurse may take. The nurse sometimes perceives the patient to be poorly informed prior to surgery. One participant describes the reaction that she had in such a situation.

I just saw that the patient needed more information. After the doctor got the consent (for surgery) signed, he left and I was left talking to the patient, explaining what they're going to be doing.

Assertiveness is also evidenced in the manner in which one nurse reacted to a situation in which she was concerned about the patient's comfort during an emergent surgical procedure.

I just created a big scene and I went in and gave the guy more morphine. My response was 'I'm going to give him some morphine', sort of giving it at the same time that I was saying it. It was probably an act of defiance and certainly a statement. You know, 'Excuse me, but this patient is aware'.

Action

Participants describe action in situations perceived as ethical dilemmas in relation to those actions involving self, those involving other health professionals and those involving the patient and/or family. Information is presented in this section in relation to these three topic areas.

Actions involving self and which are qualified as being a more effective response or manner of coping are varied. Talking to peers is described by several nurses.

The first thing you have to do is to vent to others, so you tend to do that on the unit, talking to the charge nurse, the head nurse, the people that you work with. You talk at coffee or at lunch.

I think that the majority of ethical dilemmas are dealt with informally, over a cup of coffee or when you go home and phone another person. It's venting, a release of some of the pressure.

Beef about it, to each other. You sit in the coffee room and say 'Isn't this a dumb thing to do'?

I talked to a lot of girlfriends that night.

It is interesting to note at this point that nurses stipulated that they choose to talk to individuals who have experienced the same kinds of situations. They did not talk to family, friends or others who were not associated with their work environment.

Someone else who's not involved can't really understand. They can't appreciate it. It's very cut and dried for them cause they're not experiencing the situation. They can listen, but it's not the same.

I've talked to my boyfriend. It's hard though because he doesn't really see it from a medical point of view. He doesn' really understand.

Diversion, physical activity, and caring for basic personal needs such as sleep and adequate nutrition, are also described as methods of coping with the emotional distress participants experience as a result of an ethical dilemma.

I do crafts if I'm upset. I do things like house-clean, just something physical or totally different that is distracting.

I'm pretty active. I find that physical activity helps. Something that I also find crucial is that I have to have enough sleep when I come to work. If I don't have enough sleep, I'm sunk.

I can't cope. And sugar, I need sugar. If I don't get those, then I'm apt to be in tears in the coffee room at lunch.

Humour plays an important part in alleviating tension and stress. Humour is described by several nurses and is illustrated in the following excerpts.

We laugh and joke a lot, not because of certain situations that are going on, but I think that's probably one way we cope with working in intensive care. There's a lot of joking that goes on between each other.

We'd go out as a group and talk about things and laugh and joke. We had a lot of fun together

Two neophyte nurses describe their view of intensive care nursing as being just a job. They emphasize that they try very hard to look at it from this perspective and not to become involved or take it home with them.

Usually I can forget about most things on my days off. I usually like to forget about work and just leave it there, otherwise I'd probably go crazy if I took it home with me.

I try not to dwell on it. It's just a job. You can't be depressed about what you do at work. You can't bring it home. You can't live it. It's your job. You have to somehow find a way to separate yourself from it. If you became involved with every patient you looked after, you'd be an emotional wreck. It's a job.

Education is a means that one nurse chose to gain some insight into the kinds of situations and the behavior of colleagues in the critical care area.

A lot of my university courses I've taken have been circled around this, trying to help me understand behaviour. I've chosen those courses to try and understand.

When they are in the process of coming to terms with an ethical dilemma, participants describe several actions that they found helpful. These involve a purposeful, rational

thinking-through the situation, using the situation as a learning experience and a base from which to improve subsequent experiences.

Rational thinking is described by participants as a deliberate activity which they go through in their own minds to sort through an ethical issue.

Interviewer:

How do you think you cope?

Participant:

A lot of it is logical, a result of the brain, not of the heart. Sitting down and going through a problem solving process, identifying what has produced those emotions, going through it in your head, rationalizing it out.

Another nurse stated her process of coming to terms in the following way.

I think as long as I can sit and think about it and have the time to think about it and in my mind maybe rationalize what they're trying to do, then I can sort of understand and feel a little better,

to sit down and look at both ends of the spectrum, what they're trying to accomplish and why they're trying to accomplish it versus what I believe.

Following an incident in which she perceived herself as not coping well, this experienced nurse describes the process which she went through once the incident was over. This process was described as a necessary part of her being able to feel justified about her feelings and actions during the actual event.

I just thought the situation through. One of the first things I did was just to review the situation and make sure that within myself I'd done the right things. I felt so upset that I thought, gee, maybe I was really inappropriate. But I went through it and felt that I had, from a sort of intellectual point of view, followed the correct procedures. I felt that I had done what I could, so that I reassured myself from that point of view.

Sometimes the process of rational thinking may not be sufficient to resolve the emotional aspect of the dilemma for the nurse. One experienced nurse describes this as an outcome of an situation in which she was involved early in her career.

I kept resorting to the biological-medical model, that scientific proof that this is okay. If you look at it from that theory, and you can't dispute that theory, then it makes you very comfortable. So I resorted to the medical model. It made me feel comfortable for awhile, put the lid on it. But something inside of me kept coming out and saying despite all this theory, there's something here that still doesn't sit right

A neophyte nurse describes the process of coming to terms with her first experience involving discontinuation of therapy as one of trying to look at the good side of the situation. Religious beliefs are also evident in this description.

I usually think of the good side of it, because that's the only thing you're left with, to make you feel a little better. Yes, this man is out of

pain. His family is going through the grieving process and that's good. Yes, he was loved and yes, he had a good life. And yes, he must have been something special to be taken from this earth.

Participants describe how they used this process of rational thinking-through the situation. Learning from the experience and thinking about how they would behave in a similar situation in the future are several outcomes of this process.

I just had to think it through and sort of try and put it into perspective. Try and decide what I would do if that ever happened again. It probably wasn't the best thing I could have done. If it were to happen to me now, I would go further. I would have taken more concrete steps in trying to assure that this would not happen or that it came to the attention of the higher-ups that this had occurred.

One experienced nurse was unable to rationalize the situation in terms of her concerns about the patient and her own response at the time.

Something inside of me kept coming out and saying, despite all this theory, there's something here that still doesn't sit right; I was coming to the conclusion in my own mind that this was wrong. Despite all medical science and their theories, this is wrong based on my feelings.

In order to come to terms with the situation, she had to accept that her action was wrong and to decide to use the situation as a learning experience.

The major thing I learned from this situation was that it was never going to happen to me again. Witnessing this once was enough. I was never going to go along with a situation which I had even a little wee bit of uncertainty about. I was going to say no until I felt comfortable with the situation. I think that what made me feel comfortable working it out was that I felt that I could use this as a learning experience. It was almost like I could say, 'It's happened this time, but this won't happen again to me. Next time I'll handle the situation differently'.

Subsequent experiences are a factor in helping the nurse to come to terms with difficult ethical problems. One experienced nurse describes her perception in relation to this.

When I feel that failure, that frustration, what I need is to be able to work it out and to have a pick-me-up, a success story, to balance it out. Life goes on. We have the bad and we have the good. It doesn't necessarily have to be a success story right then and there, but somebody you can get satisfaction from, accomplish something positive. If you go in and you know that the patient is gravely ill, but at the end of the day you have made a difference, that you can see, then there's that satisfaction.

Another experienced nurse describes how she used her distress and sense of having failed her patient to control and ensure that subsequent similar situations are more satisfying for patient and family as well as the staff.

I put that dramatic incident to good use and I tried my best from then on to develop my own philosophy. I was bound and determined that in any way I could

I would help someone else through something like that. It wasn't until I saw how it could be done differently that I could be at peace with myself.

This nurse describes the way in which she utilized her previous experience which involved discontinuation of therapy, to make a similar situation less traumatic for herself, the patient and family and the neophyte nurse that she was supervising.

This was an experience with sadness which happened in a way which I think we could best allow it to happen. I didn't leave the hospital going home in fear, feeling that I had participated in a dramatic death with feelings of guilt. I made it happen. I made sure those family members were there. I made sure we were all involved and that we all felt comfortable with this and that we didn't push this incident. We (neophyte nurse and self) stayed behind and had a nice talk about this whole thing and she didn't have the same feelings that I had had (in the previous incident), I know she didn't. I allowed these things to happen.

In responding to or coping with an ethical dilemma, participants described actions which involved other health professionals. The following information reflects the manner in which participants described such action in the interview transcripts.

Support from other health professionals is described as a factor in assisting the nurse to respond to or cope with a situation which is perceived as an ethical dilemma. Supportive actions of other health professionals has been described in previous sections of the chapter in relation to the team effort, venting to others and in the section on feelings about self and others. These actions involve concern from others, offers to relieve the nurse from the situation, and talking about the situation with peers at break times.

One nurse described the cohesiveness of the group that worked together as a significant factor which affected coping ability.

The group was a very cohesive group. The group had a lot of fun and the tendency of the group was to work hard and play hard. The group was a great support, had a great sense of humour. We'd go out as a group and talk about things other than the unit and we had a lot of group cohesiveness and a lot

of sensitivity within the group too. For instance, with that one patient who had the 'weaning problem, and nurses were crying in the hall at 9:00 o'clock in the morning, you would see another nurse walk over and talk about it with the person and be very supportive.

Another nurse described the support she received from the hospital chaplain.

He gives me little blessings, he listens, he touches me, holds my hand. There's a trust there. He would stay and talk to me for a little while. Sometimes, he'd say 'I'll pray for you today' and I'd go back into my cubicle and I'd feel better.

The chaplain was a significant resource in helping this nurse to come to terms with and resolve an extremely traumatic incident which she had experienced several years previously.

He made me feel a lot better, helped me sort out a few things. I guess maybe having his blessings too, you know, it was almost like I was forgiven. And maybe that's what I needed, I never thought of that

until just now, but maybe all that time I was asking for forgiveness. I would like to have gotten it from her (the patient) but I got it from him.

Participants described actions that are taken to help them to cope with ethically problematic situations. The following description indicates how a neophyte nurses describes coping with the situation of a patient for whom therapy was perceived to be excessive.

We changed staff through her really quickly. You had her the most two days. And if you couldn't cope more than one day, then you only had her one day.

Participants also described how they help each other to care for the patient in a situations involving discontinuation of therapy. Turning off the sage pumps for each other is described by a noephyte nurse in an earlier segment of this chapter and is a practice that some nurses participate in as a means of coping with the traumatic act of withdrawing life sustaining therapies.

Actions are also described by participants in terms of those that involve the patient and family. Nurses take deliberate action in response to situations which they

perceive to be ethical dilemmas. These kinds of actions may be specific and involve communication, altering the treatment regime or more subtle actions involving prayer, caring and respect for the individual. This final segment of the chapter presents information to illustrate these actions.

Communication is one area that participants describe in relation to the actions which they took in situations. The following excerpt describes one nurse's communication with family in a situation which was perceived as excessive therapy.

You felt better if you knew that they at least had an understanding about what was going on. Explaining to them really did help. It made me feel better, that you weren't just running around doing tasks. You were actually helping people understand what was going on and hoped you were making it a little easier.

Communication may also involve clarifying information that the patient or family is receiving from other health professionals. A description of one nurse's efforts to give the patient information about impending surgery is described earlier in the section on effective reaction. Another nurse describes clarifying information for the wife in a situation

which was perceived to involve excessive therapy and a violation of the patient's right to be removed from the mechanical ventilator. The wife was confused by the different opinions and information that she was receiving from different individuals.

I just didn't feel she was getting a good picture. There were three or four people talking to this woman telling her different things. I tried to be present so that I knew what kinds of comments were being made, and I tried to make sure that they (doctors) knew what each other was saying. I tried to support her and if there were destructive comments made about her sense of responsibility, I tried to support her.

One experienced nurse described how, when a patient died, she used prayer as a means of preserving the patient's dignity during death.

I remember distinctly when this lady died; it bothered me so much to see someone die like that, that from that instant on, whenever anyone died, I always kind of bowed my head and prayed. I just

kind of quickly close my eyes and say a little prayer.
It just kind of reminds me that whenever people die,
it is a person there.

Patient comfort is a factor which participants describe as an important source of satisfaction for them in situations which are perceived as ethical dilemmas.

When you could look at her and say she
looked comfortable, that was satisfying.

Manipulation of situational variables to ensure patient comfort is one strategy that experienced nurses describe in such instances.

When it's a patient that I feel inside is not going to make it anyway and that probably all these things are just torture, I tend to go lax on that (limit care that is uncomfortable or exhausting, for example, getting up to sit in a chair). I will lean more heavily on the comfort side.

Usually I'm able to do something about the situation. I'm usually able to feel that I'm providing some element of comfort to that

individual just through provision of decent nursing care, backrub, touching, holding their hand, chatting with them, sometimes sedation, sometimes having the family members in. There are usually things you can manipulate. Even if you're not able to change the whole situation, you're able to, at least from a nursing standpoint, do quite a bit to make a difference in this patient's state.

Caring for the patient as an individual is described as a distinct factor in enabling nurses to remain in the critical care unit. One experienced nurse describes how her decision to stay following a period of disillusionment was influenced by this realization.

The bottom line is, aside from all the technology, that you have this responsibility to make these individuals' last days as comfortable as possible. That just sort of helps me to rationalize some of the things that go on in the unit.

Another experienced nurse describes how her belief in the value of the individual and the need to make the death process a caring event guided her in a situation where therapy was discontinued on a man from a lower socio-economic class.

I looked after a man whose address was the bus shack outside of the Mall Hotel. I sat there and I held his hand and I watched him die, through a whole night. It was a Saturday night and I thought to myself, this is a very strange job I have. You know, you're looking outside and seeing the stars and you know people are out and it's Saturday night and I'm sitting there holding a man's hand...because he's going to die. He has nobody to be with him when he dies. It made me feel very rewarded. I felt in some ways pleased that I could be with him. He didn't have to be alone. He opened up his eyes occasionally and he knew someone was there and I held his hand.

Participants describe actions in response to or in an effort to cope with an ethical dilemma in relation to those which directly involve the patient and family. Communication

with the family, provision of comfort and manipulating variables to optimize the patient's comfort are actions that nurses describe.

Conclusion

This chapter has presented the findings of this investigation under three major topic headings. Following a description of the biographical information about the two groups of participants, their definitions and general examples of what an ethical dilemma is, the major part of this chapter focused on descriptions of the situational context of an ethical dilemma, factors which influence perception and/or response and finally the manner of response and coping with the ethical dilemma.

An ethical dilemma is a multi-dimensional phenomenon, and the perception of such a situation is influenced by factors which may be contained within the context of the actual situation or which may be the result of individual interpretation. Analysis of the interview transcripts revealed many themes and patterns related to the three main topic areas. Thus, the descriptive findings of this investigation are complex and lengthy.

The information provided by the nurses who participated

in this investigation has provided a rich and meaningful description of the phenomenon of ethical issues in critical care.

CHAPTER FOUR

In this final chapter of the thesis, the findings of this investigation are summarized as well as presented in relation to the information documented in the review of the literature. The implications of the findings of this study for further investigation into several topic areas are included in this chapter.

The purpose of this investigation was to explore and describe the perceptions and beliefs that critical care nursing students and their instructors have in relation to the ethical dilemmas that occur in their clinical practice. The methodology selected to achieve this purpose provided a rich description of this phenomenon from the perspective of the ten participants.

Summary of the Findings

Findings were presented under three main topic areas in chapter three: the situational context of an ethical dilemma, factors influencing individual response to the situation and finally the manner of response and coping with an ethical dilemma. The summary of these findings is presented in the same manner in this chapter.

The Situational Context

Analysis of the interview transcripts revealed major themes in relation to the situational context of an ethical dilemma. Situations involving excessive therapy and discontinuation of therapy as well as an interpersonal dimension were three themes which evolved.

Excessive therapy was described by participants as a patient care situation in which care was perceived to be excessive for a particular patient in a particular phase of illness. Four elements which emerged as factors in this kind of situation were: loss of patient dignity, patient comfort, violation of the patient's rights or wishes and family suffering. These four elements were described in a situational context by participants and emerged as factors which affect the nurse's perception of the situation involving excessive therapy.

As a second major theme, discontinuation of therapy is a situation which was also described as a ethical dilemma by participants. This kind of situation was described as one in which a decision is made to withdraw life-sustaining therapy, such as a mechanical ventilator or potent drugs. Participants' descriptions of these kinds of situations revealed two dominant elements. Situations were described in relation to a 'care versus kill' conflict that the nurse

experienced and the issue of decision-making/not-making.

The 'care versus kill' conflict was presented as one in which the nurse's perceptions of her role as care-giver is challenged by patient care activities which involve actions intended to allow the patient to die. Several nurses stated that they felt as though they were committing murder in such situations.

The decision-making/not-making issue was described in relation to the patient's right to determine treatment and also to the perceived influence of the situational context of the decision-making process. Disregard or active violation of a patient's wishes to withdraw or continue with therapy was perceived by participants and illustrated in several exemplars.

The third major theme which emerged in relation to the situational context of an ethical issue was the interpersonal dimension. Interpersonal communication and professional relationships were two recurring elements in this category. Interpersonal communication was described as an ethical issue when treatment decisions are controversial or when the nurse perceives the patient to be poorly informed. Professional relationships, as a second element in the interpersonal dimension were described in terms of conflicting loyalties, the team effort, confidentiality and the perceived inappropriate behaviour of other personnel.

Factors Which Influence Perception and Response

Factors which influence perception and response were described as a second major topic area in the presentation of the findings. These factors were presented as being either an internal or an external influence. Internal influencing factors were considered to be attitudes, beliefs and feelings which participants described in relation to the ethical dilemmas which they perceived in their clinical practice.

In the presentation of the findings, attitudes and beliefs were described as those that the participants stated in relation to self, to the patient and family and in relation to life and death. Perceived expectations about themselves in the role of the critical care nurse reflected attitudes and beliefs of toughness and ability to handle ethically problematic situations without showing personal distress. Attitudes and beliefs about the patient and family indicated a concern for the patient's right to be informed and to be actively involved in the decision-making process regarding treatment plans.

Beliefs about life and death were described in terms of value and quality, and reflected the influence of religious and fatalistic views. Personal life experiences, such as the death of a grandparent, were described by several

participants as affecting the manner in which they perceived and responded to life and death situations in professional practice.

Feelings are also an internal influence and were described in relation to self, to the patient and to others in the situation. An inner turmoil described as a feeling of frustration, anxiety or agitation was apparent in morally distressing situations. Feelings about the patient were described as sadness and hurt in relation to suffering and sometimes anger at the patient for dying. Frustration and anger were feelings that participants described towards the physician and other health care personnel involved in the situation.

External factors influence perception and/or response and were described in relation to professional relationships and the patient's family. Team effort, significant role models and one's peers emerged as elements of the participants' professional relationships. The situation of the patient and/or family was a second external influence for participants. Level of consciousness, pain and suffering and the ability of the family to cope with the situation also emerged as factors in this category.

Response to and Coping With An Ethical Issue

The third major topic area which comprised the findings of this investigation is that of response to and coping with an ethical issue. This topic was presented in terms of an effective or an ineffective reaction or action. Ineffective response and coping was described in terms of actions or reactions which did not appear to benefit the participant or the situation. Crying, sarcastic retorts, withdrawing or going along with the situation are examples of such a response. Several participants stated that they had considered leaving their jobs and one actually did resign following an incident which she described as an ethical dilemma.

Ethical issues may remain unresolved for years. Several experienced nurses described emotional turmoil and feelings of agitation and anger which were still present when they talked about these incidents during the interviews. Crying and difficulty in talking about such experiences were also observed in two participants during the interview. Nursing care appears to be affected by the nurse's emotional distress in these situations. Avoiding the patient, discomfort with giving basic care and having to leave the situation are illustrative of compromised nursing care.

Effective reaction and action in response to or coping

with an ethical issue was described as those which appear to benefit the nurse, the patient or the situation. Reactions of assertiveness in requesting appropriate medical orders, giving information to the patient and family and providing pain relief were described to illustrate such a response.

Effective actions were presented as those involving self or other health professionals and those involving the patient and/or family. Talking to others who have experienced similar situations, humour, diversion, physical activity and caring for basic personal physical needs are examples of self-related actions. Coping behaviour was described by two neophyte nurses as deliberate emotional distancing and viewing their nursing experiences as just a job.

Rational thinking-through was described by several nurses as a way of coming to terms with a situation after it was over. Logical and orderly recall of actions and rationale in relation to the situation were presented as elements of such a process. Several experienced nurses indicated that they had used this kind of process to think about how they would react or act in similar situations in the future. One of these nurses described how she had used a traumatic incident as a learning experience to guide her behaviour in subsequent similar situations.

Actions involving other health professionals were also described by participants. Support from peers, the hospital

chaplain, and other health professionals was one example of this kind of action. Participants also described actions designed to help each other to cope with a situation. Turning off each other's sage pumps, changing patient assignments on a daily basis, and giving each other emotional support were presented as examples of this kind of action.

The patient and family were also described as the focus of nurses' actions in situations perceived as ethical dilemmas. Communication, manipulation of the treatment plan to maximize patient comfort, prayer, and a caring and respect for the patient as a human being were described in relation to this topic.

This investigation has provided a description of ethical dilemmas in critical care from the perspective of five neophyte and five experienced nurses. Findings were presented in relation to three major topic areas: the situational context of an ethical issue, factors influencing response and finally the manner of response and coping with the situation.

Relevance of the Findings to the Current Literature

The findings of this study as they relate to the information available in the current literature are presented in the following section of this chapter. Included also are

the implications of some of the findings of this study for further investigation into specific topic areas.

Participants in this study described their perceptions of ethical dilemmas in a situational context. As White (1983) indicates, this kind of conflict is a situational problem. Labelling such problems as an ethical dilemma, is inaccurate and a reflection of the participants' lack of understanding of an ethical dilemma. Although the term dilemma has been used throughout this thesis, it is not an accurate reflection of the true meaning of the term. It is rather, a reflection of the manner with which it is used in the literature and in descriptions of situations in clinical practice.

The information which was obtained in this study revealed major themes. However, categorizing such themes was difficult because of the degree of overlap which was observed. Topics such as death, dying and informed consent were difficult to isolate into separate categories of ethical issues. Thompson and Thompson (1985) state that this kind of problem occurs in any attempt to categorize ethical issues.

In keeping with the previous format, the relevance of the findings of this investigation to the current literature is presented in three major topic areas: the situational context, the influencing factors and the manner of response and coping with the situation.

The Situational Context

Death appears to be a major focus of both the current literature and the findings of this study. Issues such as the patient's right to determine when death should occur, allowing the patient to die and dying with dignity are recurring themes in the interview transcripts. The review of the literature revealed that quality of life, death with dignity and allowing the patient to die are topics of relevance in current publications. Excessive therapy and discontinuation of therapy, as major themes in this study, incorporate each of these three documented issues in the descriptive findings.

Participants described personal conflict related to their perception of death as a dehumanizing and undignified event when therapy was excessive. Compromised quality of life associated with heroic interventions, as well as pain and suffering in this kind of situation, are factors which are also described in the review of the literature.

The issue of allowing the patient to die was addressed in the literature review in relation to the controversy surrounding the use of the term euthanasia. Participants in this study indicated concern about their role in situations involving the withdrawal of life-sustaining therapy. The

care required in such situations was perceived in a very negative and detrimental way rather than as what may have been appropriate care for a particular patient. Allowing the patient to die and permitting a good death, as Keyserlingk (1979) states, was the source of a personal conflict for several participants in this study when it was necessary to withdraw life-sustaining therapy. Appropriate care of the dying patient becomes confused with the concept of euthanasia as mercy killing in this kind of conflict.

Perceived expectations about the role as a critical care nurse creates a personal moral conflict. A hesitance to show feelings of moral distress or personal discomfort with a situation was described when the participant's perception of the critical care nurse was one of a capable and tough individual. This was evident in descriptions of situations involving discontinuation of therapy, particularly in relation to the way in which participants thought they should be able to respond. Role conflict or confusion was also described in this kind of situation in terms of a 'care versus kill' conflict.

This kind of role conflict is not clearly documented in the current literature. Role conflict and/or confusion is described in terms of the nurse's role as a patient advocate. The focus of the patient advocacy concept is stated by French (1984) as emphasizing the welfare of the patient. Conflict

based on perceived expectations of the critical care nurse's role as tough, capable and caring, emphasizes a focus which involves a concern about self in the situation as opposed to a concern for the well-being of the patient.

Perceptions of death as a symptom, that is, something to be controlled, allowed or prevented is described by Jorgenson and Crabtree (1986). Participants in this study described death in the same manner and elaborated on this concept to describe care of the patient as an investment of time as well as human and material resources. This perception of death, as a symptom rather than as a natural part of the life process, is reflected in the difficulty with which the decision to discontinue therapy is associated.

Participants described delay in the decision-making process, violation of the patient's rights or wishes and inappropriate orders in situations involving excessive therapy and discontinuation of therapy. Ethical issues of this kind are documented in the literature as the imposition of personal beliefs, refusal to write orders, leaving orders which are either inappropriate or contrary to patient's and/or family's wishes.

Communication was described by participants as a factor in the situational context of an ethical issue, particularly when treatment decisions are perceived as inappropriate or contrary to the patient's or family's wishes. The current

literature does not describe the process of interdisciplinary communication in relation to ethical issues in critical care. Similarly, professional relationships are also not well described in the literature, particularly in relation to the presence or absence of team cohesiveness and support which participants described as a factor in the situational context of an ethical issue.

Inappropriate attitude and a lack of respect and caring for the patient as a human being were described by participants as a factor of the situational context of some ethical issues. Deteriorating sensitivity as a result of extensive exposure to human suffering, as described by Fromer (1981), may be evidenced by this inappropriate behaviour and attitude. Carper's (1979) statement that technological advances and the trend towards specialization have fragmented and depersonalized patient care, also supports this descriptive finding. This kind of attitude, which was described about others, may be an indication of what Price and Murphy (1985) describe as emotional and spiritual exhaustion or burnout.

In summary, the findings of this study generally support and are supported by the current literature. What is not clearly described in the literature is the kind of personal role confusion and conflict that nurses experience in relation to the 'care versus kill' conflict and to their

perceived expectations of the role of the critical care nurse. Communication during the decision-making process and in relation to treatment plans which may be perceived as inappropriate is not clearly described in the literature. Team support and cohesiveness, or lack of, as it is presented in the situational context of an ethical issue, is also not well described in the literature. Further descriptive investigation of the interpersonal dimension in the situational context of an ethical issue would provide additional understanding of this phenomenon.

Factors Which Influence Perception and Response

Attitudes, beliefs and feelings in relation to the experience of an ethical issue, were described by participants in this study. These were presented as internal influencing factors. The review of the literature indicated that nurses may be influenced by their own inner values, beliefs and attitudes as well as personal life experiences and professional background.

The findings of this study augment the literature review by providing a description of the kinds of attitudes and beliefs that the nurses in this study have in relation to the ethical issues which they perceive in their clinical practice. Attitudes and beliefs about the role of the

critical care nurse, about the patient and family and about life and death are one component of these findings.

Participants' feelings about themselves, about the patient and about others in the situation of an ethical issue are described by Wilkinson (1986) as moral distress and moral outrage. Feelings of anger, frustration and guilt are described by Wilkinson and also by participants in this study. The findings of this study add to the understanding of the experience and effect of ethical issues and the internal factors which may influence perception and response.

External factors may also influence perception and response. Intervening variables in the context of the situation are described by Lamb (1986) as influencing nursing behaviour. This was evidenced in participants' descriptions of the responsibility they felt not only to support the team effort, but also to consider the wishes of the patient and family when there were conflicting views or beliefs about the plan of care.

The influence of peers, role models and other health professionals as supportive of the nurse in morally distressing situations was described by participants. Considering the conflict which nurses describe as a result of perceived expectations about their role, the support of their action or reaction by significant others in the situation may be an external influence which warrants further

investigation.

The situation of the patient and/or family, that is, in relation to pain, suffering, level of awareness and ability to cope were also presented as external influences. The nurse is a participant observer in stressful situations, according to Flaherty (1982), but the manner in which the nurse is influenced by the elements of such a situation is not well described in the literature in relation to ethical issues. It is particularly interesting to note that nurses expressed concern for the family, even when they are no longer involved directly in their situation. The patient's family, as an external influencing factor may also warrant further investigation.

This study has added descriptive information to that which is currently available in relation to factors which may be an internal or external influence on perception and response to an ethical issue.

Response To And Coping With an Ethical Issue

Response to and coping with an ethical issue was presented either as an effective or an ineffective reaction or action. Feelings of anger, frustration and guilt that participants described were presented in a previous segment of this chapter in relation to the current literature. These

may be considered as evidence of moral distress about the situation.

Psychological disequilibrium is described by Zablow (1986) as great personal indecision and uncertainty. Crying, which some participants described as a response to the situational context of an ethical issue, could also be evidence of a state of psychological disequilibrium. Participants described indecision and uncertainty in relation to their role in the situation. Patterning behaviour after that observed in others or on the basis of perceived expectations of the role is also an indication of such uncertainty and indecision.

Withdrawing from the situation, avoiding the patient or leaving the job were behaviours which Wilkinson (1986) described as ineffective coping with moral distress or moral outrage. These behaviours were also described by participants in this study.

Difficulty in resolving the issue or in coming to terms with the feelings of moral distress may be damaging to personal or professional wholeness, according to Wilkinson (1986). Several experienced nurses in this study described personal distress that they could still feel years after the incident had occurred. It is not clear from the findings of this study, the degree to which this distress affected personal and professional wholeness for these nurses. The

long term effect of moral distress or moral outrage on personal and professional wholeness is another possible topic for further investigation.

The ability of the nurse to give quality patient care is compromised according to the descriptive findings of this study. In fact, the ability of the nurse to give basic care may be significantly limited during the experience of moral distress. Leaving the cubicle, avoiding the patient, difficulty in giving basic care, not wanting to come in to work and rotating the patient assignment on a daily basis were attitudes and behaviours described by participants in this study. Not only the patient, but also the family members may be deprived of quality care when the nurse is experiencing moral distress.

The effect of moral distress on patient care is alluded to by Kramer (1974) and suggested by Wilkinson (1986). This is an area which could be more closely investigated to provide a more meaningful understanding of how care might be affected by the nurse's experience of moral distress.

Effective reaction and action were presented as attitudes and behaviours which appear to benefit the patient or the situation. Successful coping, according to Wilkinson (1986), is evidenced by a feeling of control over the situation. Participants in this study described assertive and independent actions, such as demanding appropriate orders

and giving information to the patient as examples of such coping behaviours.

It is interesting to note that two neophyte nurses described a deliberate emotional distancing and separation of job and personal life as a means of coping with the suffering and distress that they were exposed to. This kind of an attitude is documented in the literature as a decreased sensitivity to pain and suffering, but is described in relation to prolonged exposure and burnout.

The significance of peer support, having someone to talk to and experiencing the cohesiveness of the group or health team is evident in participants' descriptions of coping behaviours. The necessity for personal emotional support during and after the incident is also described as an essential component of the process of resolving the incident.

Although caring for the patient as a human being is well described in the literature as an essential component of nursing practice, caring for each other as nurses and health professionals is not. The manner in which health team members do or do not care for and support each other in situations of moral distress and the effect that this has on their personal and professional equilibrium, is an area for further investigation.

The actions of turning off sage pumps or ventilators for each other is an interesting finding of this study, as is the

practice of rotating the patient assignment on a daily basis when the situation is morally distressing (for example, when care is perceived as excessive). These kinds of behaviours are not described in the literature. It is not clear from the descriptive findings whether this is a successful coping action or whether it is a means of avoiding the reality of the situation. Both of these actions were described by neophyte nurses.

Rational thinking was described by nurses as a deliberate process of resolving feelings and coming to terms with an ethical issue. Wilkinson (1986) describes this as conscious cognitive reasoning. This descriptive finding may be evidence of a process of moral reasoning or critical thinking as described by Ketefian (1981a, 1918b). Since this study did not focus on the reasoning process, labelling such rational thinking as moral reasoning would be erroneous.

Rational thinking-through an ethically problematic situation is described by several experienced nurses as influencing behaviour in subsequent similar situations. This is related to Crisham's (1981) statement that formal education and past experience enhances principled thinking ability and influences behaviour in a moral dilemma.

The participants' actions involving patient and family are described in relation to caring and concern about the individual in the situation. Caring is described in the

review of the literature as a force which guides nursing behaviour and attitude (Carper, 1979). Caring in this study was described in relation to respecting and valuing the individual and providing comfort and emotional support.

Manipulating the situational variables or the treatment plan to optimize patient comfort and lessen the degree of suffering for the patient were deliberate actions that experienced nurses described. This kind of activity is not well described in the literature and may be another focus for further investigation in to the coping behaviors of nurses in the situational context of an ethical issue.

In summary, the results of this investigation have been described as they relate to the information presented in the review of the current literature in chapter two. The similarities between the findings and the literature review support the relevance that this investigation has to information which is currently available about the phenomenon of ethical issues in critical care nursing.

Implications for Further Investigation

Several topics have been identified as possible areas for further investigation into this phenomenon. Nurses in this study described personal distress in the situation of an ethical issue in relation to a 'care versus kill' conflict

and to their perceived expectations of the role of the critical care nurse. This kind of role-related stress could be an interesting topic for further study.

An investigation of the interpersonal dimension of communication and interdisciplinary role relationships which occurs during the process of decision-making in the situational context of an ethical issue might also be useful. This could include a description of the influence of the health team and the situation of the patient and family as an external influence on the nurse's perception and response to the situation.

Moral distress has been described by Wilkinson (1986) and also by participants in this study. The effect of such distress on personal and professional wholeness in the situation as well as over time is another area for further investigation. The effect of moral distress on patient care also warrants further study.

Coping behaviours and actions could be more clearly described. The dynamics of interdisciplinary role relationships as a variable of successful coping as well as the actions and behaviours that nurses employ in the situation might provide a richer and more meaningful description of the phenomenon of ethical issues in critical care.

Conclusion

The critical care unit is the setting for a variety of traumatic life and death situations. This investigation has provided a description of the ethical dimension of such situations from the perspective of a group of five neophyte and five experienced nurses. It is clear from the findings of this study, that the experience of these kinds of patient care situations may be the source of significant personal distress for the nurse who becomes involved with the patient and family in crisis.

The context of the situation appears to influence the manner in which the nurse perceives and responds to the ethical dimension of patient care. The ability of the nurse to respond appropriately and to cope effectively with patient care situations in the critical care unit may be a determining factor of the quality of care that is provided to the patient and family. This study has provided evidence that the experience of personal distress in this kind of situation may require a lengthy period of resolution and may, in fact, be a source of personal spiritual exhaustion.

The critically ill patient requires excellence in quality of nursing care. In order to prepare nurses to deal effectively with the ethical dimension of nursing practice

and to be able to provide appropriate administrative support for them in such situations, further exploration and description of the complex nature of this phenomenon is essential.

At the source of every work, there is an experience.

Camus, 1960, p.184

Debbie

What were you doing...out so late...and all alone?
Were you drinking?... Were you on drugs?
Did you even know what happened?

It is now four days since you came to our unit...head injury,
unconscious, lifeless. Tonight I am your nurse ...
You are so young, your body so lovely, so healthy...
your head so bruised.
You shouldn't be here, Debbie, lying so still...so broken...
You're only 19...

I am so afraid...of the responsibility...of being your nurse,
and of being touched by the fragile thread that is your hold
on life. Can you hear me? I talk and even sing to you,
in the dark as I move around your bed...
checking...charting...caring...
Can you feel me touch you? ...with my hands...
with my heart...

Did you see your mother?... hear her cry...

Her face paled, knees buckled, when she saw you.

And your brother, too young to bear such grief, circled her waist with his arm and held her up.

Watching and sensing the anguish, I felt my heart in my mouth, saw one of my own daughters lying like you, myself in your mother's place...and I was terrified.

You died soon after... I knew you would... and I felt helpless... bitter... and then so very hopeless.

Did it matter... what I did? ... that I was there?
that I cared? ...

At home I cried...laid awake, alone at night, and wondered at the pain I felt. I thought about quitting... never going back... to face again the sorrow of such suffering.

Sometimes it hurts so much to care... to reach out...

I never really knew in the beginning,
how much it would take...

to be a nurse.

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APPENDICES

APPENDIX A

Information Sheet

Please complete the following questionnaire by FILLING IN THE BLANKS or CIRCLING the appropriate response.

This information will be kept strictly confidential. It will be used by the investigator in the analysis of the data gathered in the course of this investigation.

NAME:

ADDRESS:

.....

AGE: (18-25) (26-30) (31-35) (36-40) (41-50) (50+)

RELIGION

SEX: male

Marital Status: Single

female

Married

EDUCATIONAL BACKGROUND:

<u>Degree</u>	<u>Year of Grad.</u>	<u>Institution</u>
.....		
.....		
.....		

PAST WORK EXPERIENCE IN NURSING:

<u>Area</u> (eg. Medicine, Surgery, Pediatrics)	<u>Length of time</u>
.....	
.....	
.....	
.....	
.....	

APPENDIX B

Consent Form

Dear Volunteer,

I am undertaking an investigation of the Ethical Dilemmas in Critical Care Nursing as part of a Master of Education thesis with the University of Manitoba.

This study will involve an interview with you in order to determine your perceptions and beliefs about the dilemmas that you encounter in your clinical practice. The time required for this interview will be approximately one to one and a half hours. Your consent to participate in this study is voluntary and you may withdraw at any time if you so desire.

The interview will be tape recorded with your permission in order to facilitate the analysis of the information gathered during the interview. All information will be kept strictly confidential. The reporting of the findings of this study will be done on a group basis. Anonymity within the group will be assured, however, the small size of the group does make not it possible to guarantee complete anonymity.

Your consent to participate in this investigation is greatly appreciated and will be indicated by your signature in the space below.

Thank you.

Sincerely,

Margret Fenton

Signature of Consentor _____

Date _____

APPENDIX C

Interview Questions

The participants were informed that the questions asked during the interview were intended to explore perceptions, beliefs, attitudes and feelings in order to understand how nurses perceive and respond to ethical dilemmas in critical care nursing. The participants were also informed that they were free to refrain from responding to any question at any time.

1. I am interested in learning about your perceptions of the ethical dilemmas which occur in critical care nursing. Can you tell me what the term ethical dilemma means to you?
2. Could you give me some general examples which illustrate the kinds of ethical dilemmas that you may have experienced in the critical care area?
3. Can you give me some specific examples of situations that you have experienced yourself as a critical care nurse?
4. Can you describe one situation in detail for me?
5. What are your general thoughts about this situation?
6. Can you tell me how you felt when this situation occurred?
7. In what ways did you cope with the feelings that you had at that time?
8. When you think about this situation now, what kinds of beliefs or attitudes do you have that helped you to cope?
9. Is there anything else you would like to tell me about that situation?
10. Are there any other experiences that you have had with ethical dilemmas as a critical care nurse?

APPENDIX D

Interview Probes

The following open ended questions or comments were used during the interviews as probes to encourage the participant to clarify or to expand on the descriptive information.

Can you tell me what you mean?

Can you tell me more?

Anything else?

What were you thinking about?

What were you feeling?

What was most demanding about that situation?

What was most satisfying about that situation?

What were you concerned about at that time?

What was it about that situation that stands out most vividly for you?

Have you encountered similar situations or problems?

Can you identify any personal beliefs that may have guided you at that time?

APPENDIX E

Member Check: Letter of Instruction

Thank you for agreeing to read this interpretation of your interview transcript. The interpretation is comprised of segments of the actual text of the interview as well as an identification of common themes and recurring elements.

The focus of this study was to discover: 1) your perceptions of the ethical dilemmas which occur in critical care, 2) your attitudes, feelings and beliefs in relation to these ethical dilemmas and 3) how you personally have come to terms with these situations.

The situations which you described provided examples of what you perceived as the ethical dilemmas in critical care nursing practice. By exploring the context of these situations, I have attempted to discover patterns of meanings and concerns in relation to your feelings, attitudes and beliefs as well as how you personally coped with these situations.

The analysis of the interview transcript focused on the discovery of commonalities in situations and recurring elements. The purpose of this process was to identify the ingredients of your experience so that I could then describe what these experiences meant to you.

Your participation in the analysis phase of this investigation is one mechanism for establishing credibility of the findings. The interpretation should be a reflection of what these experiences meant to you, for example:

- 1) Do the themes or elements which are identified seem legitimate to you?
- 2) Are they a realistic reflection of your perceptions, attitudes, beliefs and feelings?
- 3) Do you recognize yourself as you read through the interpretation?
- 4) Does it make sense to you within the context of the interview transcript?

If you have any concerns about the analysis, please feel free to add your comments to the interpretation document or call me (489-6266). If you agree that this interpretation is a true reflection of the meaning of these experiences for you, would you please initial the first page of the interpretation before you return it to me.

I appreciate the time you have taken to assist me with verifying the truth of these findings. I look forward to sharing the final analysis with you.

When you have completed your reading would you please return the interpretation and the interview transcript to me: c/o School of Nursing, University of Manitoba.
Thank you.

Margret Fenton