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Nurses' contributions to the resolution of ethical dilemmas in practice

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Abstract

Background: Complex and expensive treatment options have increased the frequency and emphasis of ethical decision making in healthcare. In order to meet these challenges effectively we need to identify how nurses contribute the resolution of these dilemmas.

Aims: To identify the values, beliefs and contextual influences that inform decision making.

To identify the contribution made by nurses in achieving the resolution of ethical dilemmas in practice.

Design: An interpretive exploratory study was undertaken, eleven registered acute care nurses, working in a district general hospital in England were interviewed, using semi-structured interviews. In-depth content analysis of the data was undertaken via NVivo coding and thematic identification.

Participants and context: Participants were interviewed about their contribution to the resolution of ethical dilemmas within the context of working in an acute hospital ward. Participants were recruited from all settings working with patients of any age and any diagnosis.

Ethical considerations: Ethical approval was obtained from local the National Research Ethics Committee

Findings: Four major themes emerged: ‘Best for the patient’, ‘Accountability’, ‘collaboration and conflict’ and ‘concern for others’. Moral distress was also evident in the literature and findings, with moral dissonance recognised and articulated by more experienced nurses.

The relatively small, single site sample may not account for the effects of organisational culture on the results; the findings suggested that professional relationships were key to resolving ethical dilemmas.

Discussion Nurses use their moral reasoning based on their beliefs and values when faced with ethical dilemmas. Subsequent actions are mediated through ethical decision making frames of reference including deontology, consequentialism, the ethics of care and virtue ethics. Nurses use these in contributing to the resolution of these dilemmas. Nurses require the skills to develop and maintain professional relationships for addressing ethical dilemmas and to engage with political and organisational macro and micro decision making.

Conclusion: Nurses' professional relationships are central to nurses' contributions to the resolution of ethical dilemmas.

Keywords

Ethics of Care, Virtue Ethics, Moral Distress, Professional ethics, Qualitative Research, Decision-making, Nurse-patient relationships, Interprofessional working, Moral Dissonance.

Introduction

There is currently a major focus on nursing practice in terms of patient safety, and heightened scrutiny in the UK following failings in the care system¹. In addition new, complex and expensive options resulting from technical developments, has increased the frequency and emphasis of ethical decision making²⁻⁵.

Decision making is an essential part of the nurse's role, as is patient advocacy^{6,7}. Both can lead to ethical dilemmas, which may be defined as a situation in which no single action is most desirable and two or more equally possible actions conflict⁸. The obligation of advocacy in itself may result in conflict^{9,10}. Further considerations are the imbalance of power between nurses and patients¹¹, and the complex relationships nurses need to foster with other health care professionals and patients' relatives, if they are to undertake the role of patient advocate effectively¹². Professional relationships between nurses and doctors in particular have undergone significant change over the past 20 years, with nurses increasingly involved in decision making, managing care and the delegation of aspects of that care¹²⁻¹⁷.

The terms "ethics" and "morals" are used interchangeably by some authors^{18,19}. Hawley¹² describes ethics as the study of moral behaviour; that which is good or bad, right or wrong; in contrast to Seedhouse²⁰ who refers to moral reasoning and ethical action. Others suggest that that ethical action is underpinned by moral values^{10,21-23}. In this paper the term moral reasoning is used to refer to the reasoning that is undertaken based on personal and professional beliefs and values.

Within the auspice of patient autonomy, clinical decision making cannot rely solely on evidence based practice, and should also utilise moral reasoning^{23,24}. Ethical decision-making in nursing practice has been informed and underpinned by medical and bio-ethical approaches^{4,25}. Bio-ethical approaches include deontological and consequential theories that may be characterised as rule-based or act-centred. Virtue ethics and the ethic of care have been more

recently advocated within nursing practice and education and may be considered to reflect a more person-oriented, agent-centred approach^{11,26,27}.

Rule-based approaches to moral reasoning and ethical decision making in the context of nursing practice, fail to recognise the importance of emotion in moral reasoning^{11,26,27}. The development of an individual nurse's reasoned decision-making and the accomplishment of competence through the various stages of their professional development are recognised as important to this decision-making process^{28,29}. The conceptual framework (Figure 1) demonstrates the relationship between individual nurses, ethical theories of decision-making and moral action and was developed by the first author based on a review of the literature³⁰.

Background

Ethical codes express the values of the professional group and guidance for decision-making and behaviour^{31,32}. Nurse's codes of ethics also provide a standard by which the practicing nurse is measured, specifically in cases of professional misconduct heard by a regulatory body. Each country has its own code with an overarching guide provided by the International Council of Nurses⁷ (ICN) originally established in 1953. The ICN code of ethics has influenced nursing ethical codes of a number of countries. However, there is evidence of dissonance between cultural expectations and the more general guidance from the ICN³³⁻³⁴. Whilst these codes are an essential component to regulating practice, their rule-based structure leads to its own set of ethical dilemmas, for example, the rules to respect patient autonomy and to do what clinical reasoning indicates is the best for a patient may come into conflict.

National and local policies have the potential to effect ethical decision-making and the ability to direct delivery of what may be considered to be a good standard of care. Policy can appear to limit the nurse's ability to advocate for patients, and deliver the care which reflects nurses' values^{23,9,35}. This conflict may result in feelings of anger, frustration, guilt and consequently moral distress^{9,36}.

Moral distress occurs when nurses cannot find a resolution to a clinical problem. This may result from nurses delivering care, or working in a context, that contradicts their professional values^{36,37}. Nurses' concerns result from their lack of involvement in decision making, even though nurses are required to execute the care plan^{9,38,39}. Moral distress is different to other types of distress and has distinct characteristics, the health professional having an awareness of their moral responsibility and involves patient well-being, a perception of powerlessness on the behalf of the practitioner involved; and anxieties associated with blame; a threat to the personal or professional integrity⁴⁰. Moral distress is something which occurs not only when faced with an ethical dilemma it is something that signifies the sense of moral responsibility that is felt by the individual⁴⁰. If left unaddressed the consequence for nurses are potentially burn out, resulting in desensitisation to the dilemmas to avoid distress, or choosing to leave the profession^{36,37,41,42}.

Conflict is associated with a number of different issues. For example, relating to perceived differences in resource priorities between management and nurses that effected nurses' ability to deliver care⁴³. Conflict with doctors, identified in situations where the care prescribed and often delivered by nurses did not match the nurses perception of what was ethical, fair or in-line with patients and their families' wishes^{33,41,44}.

Collaboration within decision making involving others brings a range of perspectives, including the nurse, family members and the doctor⁴⁵. Having the opportunity to contribute to this process is particularly important for nurses who are charged with implementing the plan of care³⁸.

In conclusion the literature demonstrates that in-depth inquiry into ethical decision-making in nursing practice is needed and therefore the aims of this research were, firstly to identify the values, beliefs and contextual influences that inform decision making and secondly to identify the contribution made by registered nurses in achieving the resolution of ethical dilemmas in nursing practice.

Design

A qualitative exploratory approach was adopted within an interpretative design, utilising semi-structured interviews as the data collection method⁴⁶⁻⁴⁹. Ethical approval was obtained from the School of Human and Health Sciences ethics panel at the University of Huddersfield, the National Research Ethics Committee and the research and development department at the National Health Service Acute Trust (The Trust) where the data collection took place. A pilot study was conducted to determine the interview schedule and participant recruitment process; three participants were involved in the study. No changes were required to the interview schedule or recruitment process so the decision was taken to include this data in the final data set and consent was obtained from the pilot study participants.

Participants

Purposive sampling recruited participants from a range of backgrounds with differing types and length of experience⁴⁶. The eleven participants, which include the three pilot participants, had a range of post-registration experience from 2 to 40 years; six were in staff nurse roles and five in sister/charge nurse roles. Participants worked in a number of settings including acute and older persons' medicine, surgery, children's services, intensive care, and rehabilitation. In the findings they are represented by gender-neutral pseudonyms. Participants were recruited from a range of settings working with patients of any age and diagnosis in the acute hospital environment; the rapid changes in care provision that nurses working in these areas are likely to be faced with result in ethical dilemmas of increasing complexity²⁻⁵. Coupled with the indications from the pilot study data, it was concluded that this population would offer valuable insights into the nurses' contribution to the resolution of these dilemmas.

Data collection

Eleven participants were interviewed, which achieved a level of saturation within the data. Data collection, via one to one interviews, was initiated with each participant asked to select an ethical dilemma from their own practice experience and to explain their reasoning and the contribution they had made

as a registered nurse to help find a resolution. Each interview lasted between 30- 45 minutes⁴⁵A total of 6.3 hours of data was collected with interviews taking place on 11 separate days between March and December 2012.

Ethical considerations

Participants were provided with information about the study and the opportunity to ask any questions they might have, before signing an informed consent form. Participants were made aware that they could stop the recording at any time and withdraw from the study if they wished. There was a potential that due to the nature of the experiences participants were discussing that they might experience psychological distress, to limit this participants chose what they wished to discuss and probing questions were used cautiously to limit this potential. The employing organisation has counselling available to all staff members and participants were reminded of this service should they experience distress at anytime following the interview.

Data analysis

Each interview was audio recorded to ensure accurate records were maintained, transcriptions were later undertaken to aid analysis⁴⁷⁻⁴⁸. Thematic analysis was undertaken using NVivo 8 software⁴⁶⁻⁵⁰ to support the process. The data analysis was performed following standard coding, relational and theme identification procedures, based broadly on Colaizzi's⁵¹ method. Participants were provided with the opportunity to engage in the final stage of this approach and copies of the findings were made available, however only three of the participants chose to engage with this process. Interactional analysis was also performed to place the contribution nurses make to resolving ethical dilemmas in the context of nursing practice and to examine how the relationships and culture within that practice area have impacted on the contribution made⁵². A reflective diary was kept throughout the research process, to facilitate reflexivity⁵². The analysis and findings of the study were discussed in supervision with peers who were not the study participants and had substantial experience in nursing and research⁵³.

Findings

The findings identified four main themes: ‘best for the patient’, ‘accountability’, ‘collaboration and conflict’, and ‘concern for others’.

Best for the patient

The theme ‘best for the patient’ appeared to be one of the most important aspects for nurses to consider when making decisions about patient care and were felt by participants to be paramount when they were confronted with ethical dilemmas.

Participants talked at length about how they strive to meet the needs of patients and maintain standards of care whilst respecting individual patients’ wishes. Participants clearly articulated and were passionate about that which they understood to be in the best interests of, or ‘best for’, the patients. Although this may appear paternalistic, it is evident from participants’ detailed accounts of their actions that this was not the case. Chris explained how, when faced with the complex discharge of a patient, the nursing contribution was informed:

‘It's knowing, I don't know it's your conscience isn't it? Knowing that if he did go home that he'd end up in the same position or worse, or dead, you know. It's massive, you know, you wouldn't want that for anyone. You wouldn't want that for your own family would you, so.... It's like being an advocate for somebody and getting the best and it would have been easier to do that [send him home without adequate planning], but it's not always the best thing for the patient is it?’

Chris

Chris felt the patient had capacity but did not fully understand the situation, possible outcomes and what options were available to him. The duty of care experienced by Chris for this patient is the duty a nurse has to protect patients from harm and promote independence.

'I don't think he realised the other things that could happen, he could be re-housed, he could go to short term accommodation while he waited to be re-housed, things like that, so I don't think he fully understood his options'.

Chris

Standards of care also emerged as a sub theme with Sam, explaining how managing standards of care were a crucial part of the nurse managers' role.

'I would make her aware that I knew that she had been leaving duty early when I wasn't around, that she'd said something inappropriate to a patient or member of staff and that her whole demeanour was,I expected her to keep the ward functioning in the way that we'd worked hard to get it toI had regular meetings with her, we met and I put objectives into place for her, she had an induction check list and I was constantly reminding her of things that she needed to do...'

Sam

Nurses are required to provide a high standard of care, as indicated in The Code⁶. Providing this standard of care involves using the best possible evidence and treating those within the nurse's care as individuals and working collaboratively, upholding the reputation of the profession. Failing to do this, the nurse described by Sam was putting standards of care at risk, and jeopardising the 'best for the patient' ideal. Sam explained how efforts were made to maintain standards of care on the ward:

'it was like having to work without all your tools and deliver a critical job without all your tools. You knew that when she was looking after a group of patients they wouldn't get the standard of care that they needed, and I was responsible for improving that'

Sam

As the manager, Sam recognises both the responsibility that the position holds with regard to quality of patient care, and as an advocate for those patients who may not be able to speak out for themselves.

Accountability

All participants recognised their accountability and demonstrated how their accountability empowered them to ensure patients' values and rights were upheld, providing the best care they could within the limits of the available resources. This is particularly evident when Ross is asked to transfer patients to the discharge lounge in order to create beds for incoming patients.

'Yes they might feel comfortable back in their own environment once they got home. But we muddled them just by moving them for that short time in between. But the main one the main ethical dilemma for me was she wanted me to move a terminally ill man who was asleep in bed, who was actually going home to die. She expected me to get him out of his bed and sit him out so that she could move somebody else into that bed and I just found that no way umm.... and I said no'

Ross

Accountability is also at the forefront of participants' minds when considering practice standards and the importance of following procedure and recognising their accountability when errors occur. When the nurse refuses to speak to the patient concerning a drug error, Drew takes on this responsibility and informs that patient in order that the patient's rights are upheld.

'So then it was left for myself and some other members of staff to then explain the procedure to the patient. So then it is not necessarily my accountability, I suppose it's more her accountability but I had to intervene because to me she just did not recognise that area of her accountability. She [the nurse who made the error] felt it was important to follow certain procedures in terms of the medical side of things but as to informing the patient and maybe the relatives it wasn't considered important'.

Drew

Collaboration and conflict

Collaboration is evident throughout participant accounts, and occurred between nurses in different clinical areas, doctors and a variety of health and social care professionals.

Chris demonstrates this when working with a patient and his family in organising care on discharge from hospital, recognising the importance of respecting the patient's wishes and maintaining his safety post discharge. Having brought together all those who could potentially contribute to planning ongoing care, Chris explained:

'It's making the link of knowing who you can go to get that extra support and who's the best person to deal with a situation at the time and I think I liaised really well between him and his family and even Social Services and you're an advocate for patients aren't you? And it's important that you know that you're doing the right thing for everybody and it's bridging that gap and that support and not necessarily does he have capacity or doesn't he have capacity you know'.

Chris

Jordan, explained how when the unit lost a nurse specialist due to lack of funding the multi- professional team worked collaboratively to improve the experiences, of patients undergoing lower limb amputation so that a good level of service was maintained:

'Well, we're going to have meetings with the OT and Physio'. Jordan

Conflict was evident in participant accounts, predominately when the use of scarce resources.

'I cannot believe that somebody who is a trained nurse umm.... And actually I had done studying with I'd worked alongside could actually even contemplate moving somebody like that dragging them out of bed when they are actually fast asleep and terminally ill and I just could not believe it to be honest'.

Ross

In these cases, conflict occurred with senior nurses and as such appeared to cause extra distress, exhibited by the feeling expressed, indicating that those

with who they came into conflict were nurses, both participants expressed the feeling that these individuals should understand and support their own view point, demonstrating a perception that nurses have a shared value system which underpin the decisions taken in these situations.

Conflict was also experienced by the participants was that between doctors and nurses when addressing issues around death and dying. It was evident that for some Nurses the requirement to deliver care prescribed by the medical team could be in direct conflict with that the case the nurse felt was in the patient's best interests. This was particular evident in the account provided by Charlie when discussing the care of the dying.

'know you're going to take this man down on Sunday morning for an expensive scan'. Our ward sister said look I'm not happy about taking this man, he's not well enough, I'm not bothered about taking a man who's poorly down and I worked in ICU I've only been here 6 weeks, I'm happy with that, but she said it's not going to change the outcome she said he needs care of the dying pathway, and I felt like we had to fight for this man, I felt we had to fight for him to die with dignity and we shouldn't have to do that'.

Charlie

Concern for others

Participants were not simply concerned with the patient at the centre of the decision, they also considered the impact the decision and consequential action may have on others; patients, the patient's family and other members of the health and social care team.

Brooke explained how, when patient care was under scrutiny, efforts were made to make staff feel valued and maintain staff morale and viewed this as an opportunity for all the staff to improve their knowledge:

'as a manager you've got to then find ways of putting mechanisms in place to stop that happening again, but also to make the staff feel supported and because they are very passionate about nursing and I do believe people do

this job because they want to care on the whole, they take it all to heart and it's all against them and you feel staff morale go down as well'

Brooke.

Brooke attempted, through effective leadership, to empower the ward nurses to improve care and to ensure that they felt valued.

'I've also talked to all the staff as well and I've said 'actually you're very highly thought of', and in fact two of the managers have been on the ward and have been really, really supportive of me as well now, because they realise how sort of passionate we are about it and how we just don't want this to happen, but how just sometimes things like that are unavoidable, somebody will fall [for example], you know you can't stop it all the time'.

Brooke

Sam continued to work with a struggling team member in an effort to bring her practice up to the required standards and to support the ward team. These efforts resulted in Sam having a little time away from the ward and working with senior nurses to try and ensure appropriate professional development was achieved. Like Brooke, Sam (also a Charge Nurse) demonstrated a high level of commitment to the ward staff as well as to patients.

'I wanted her to succeed but the staff who had issues with her, they said she'd never [change].....but I never give up on anybody me, I've always been that kind of person..... Because it's nature to... I've always put a lot of effort into people that are difficult or are struggling..... I think in my heart of hearts I knew how bad it was going to go in the end, I knew eventually something would happen because as every month went by, whenever there was an issue, a dilemma, a complaint, or something it was always worse, it got that bit worse every time.'

Sam

Dilemmas of this kind go beyond direct patient care and those in management positions face different dilemmas to nurses responsible for direct patient care. Similarity in the approaches taken by nurses can, however, be recognised.

Lee, had collaborated with the doctors to access the medication required for a particularly frail patient. Not only did Lee express concerns for the patient but also for his family and the prescribing doctor who 'bent' the rules to achieve what was considered the best action for the patient. Lee, the other nurse checking the medication, and the prescribing doctor all put themselves at risk. Lee justified the decision to take a verbal drug order over the telephone as this was perceived to be what was best for the patient and, by following Trust policy, the patient would have been at risk of experiencing avoidable upheaval and further distress.

'We have got to start upheaving her we have got to get a stretcher we have got to move her out and upsetting basically the whole family and the whole system'.

Lee

Lee also demonstrated concern for all those who were involved in the dilemma, not only the patient, his family and other health professionals.

'I was worried about my registration and I was worried for my staff because she would just pass the blame for things onto other people'.

Sam

When managing patient care in the final days and hours of life, in the context of acute care general hospital, the accounts provided by both Jo and Charlie not only considered the impact the patient's care has on the patient but also the effect on their family, who experience their own suffering during this time. This offered further support to this theme within the data collected from the range of clinical areas within acute hospital care throughout the patient experience.

Moral distress is discussed extensively throughout the literature, which contributed to the justification of this study and was identified in the data collected. However an interesting and unexpected finding from the data analysis was that some nurses with substantial experience had learned to

recognise moral dissonance as part of the dilemmas they faced as nurses and in recognising this began to find a way of recognising and managing this dissonance.

'I think you can't wear your heart on your sleeve, you can't do that. Sometimes you just have to cut off, you can't carry it on, because the other thing is you've got other patients that need you, you know they need your expertise.....'

Charlie

Charlie demonstrates how some experienced nurses have learned to manage moral residue and potential moral distress by recognising the dissonance that exists between the ideal outcome and the real outcome.

Following the analysis of the data and having examined the interactions between participants and others in the data collected, additions to the theoretical framework (as outlined in figure 1) were made to explain the crucial role these relationships play in facilitating the nurses contribution to a resolution of the ethical dilemmas faced in the context of professional practice (see Figure 2)³⁰.

Discussion

The emerging themes from the data, presented above resulted in new insights into the nurses role and contribution to the resolution of ethical dilemmas and as such corresponding literature was explored and is referred to in the following discussion.

The conceptual framework developed following a review of the current literature underpinning this research (figure 1) asserts that, when faced with ethical dilemmas, nurses use their moral reasoning based on their beliefs, expectations and values. Subsequent actions are mediated through ethical decision making frames of reference including deontology [in the use of rules such as the NMC code of conduct and clinical policies⁶], consequentialism and the ethics of care [in the weighing up of patients best interests and the management of collaboration and conflict] and virtue ethics [in the development of personal

constructs about what a right and good nurse would do in a given circumstance].

The thematic analysis of the data resulted in the themes which indicate the values nurse's place at the centre of their practice when undertaking ethical decisions in seeking to do what is 'best for the patient' and the importance of the impact the moral action will have on others emerging in the theme 'concern for others'. The theme advocacy demonstrates the importance nurses place on their professional practice and the acknowledgement that they are happy to be called to account and the strength responsibility nurses feel in recognising their role as patient advocate. These represent the values and beliefs held by the participants used in moral reasoning and represented in the second stage of the theoretical framework and is where the key nurse patient relationship is influential.

An important finding from this research is that in order for this framework to be effective in practice a key additional component is the skilful and complex relationships formed, managed and sustained by the nurse. Figure 2 shows the conceptual framework with the additional links to relationships, which following the interactional data analysis have been identified as a crucial to the nurse's contribution³⁰.

Nurse participants interviewed demonstrated how, by developing and maintaining effective relationships with patients and other professionals, they were able to empower themselves to achieve a resolution of ethical dilemmas. Such relationships are recognised as central to morally correct culture and context and embrace the core aspects of moral agency, identities, relationships and responsibilities⁵⁶. Participants' accounts highlighted the importance of these relationships in achieving moral action, the final stage in the conceptual framework presented here. They influenced the decisions made about patient care through working collaboratively to respect the patient's wishes and work in their best interests.

Best for patient was found to be the strongest theme within the data and the concept is also supported by The Code⁶ and is a major theme in the review by Lord Darzi, High Quality Care for all¹⁷, identifying that the next stage for the National Health Service (NHS) is to progress from a quantity focused agenda to one which focuses on quality this may explain why this relationship is of great importance. Patient advocacy is noted within this theme, as the nurse supports patients' wishes and assists in self-determination, promoting autonomy. Verkerk⁵⁵ explores what he describes as 'compassionate interfering' or 'rational autonomy' in caring relationships. This has become topical in the Netherlands as care is becoming increasingly delivered in the community, as it is in the United Kingdom¹⁷. The risk is that those who are most vulnerable or wary of the health and social care system fail to receive much needed care⁵⁵. What is essential is that patients should be no worse off after receiving nursing care than they were beforehand⁵⁷.

The first and most important relationship identified within the conceptual framework is that between the individual nurse and the patient. Entering into this relationship demonstrates the nurse's commitment to that individual and requires the nurse to invest in its ongoing maintenance. Ashley, a children's nurse explained the importance of trust in the relationships nurses share with their patients, especially where a child may not be viewed as having capacity to make their own decisions.

Relationships in the care process are complex, particularly where the care is provided by a paid carer^{58,59}. Within this ethical relationship, involving trust and compassion, the difference in power between the nurse and patient is one that has the potential to result in those most vulnerable being neglected or abused. Poor standards of care were recently highlighted and a detailed review of poor

standards of care within the Mid-Staffordshire NHS trust was undertaken; the report identified where these relationships may break down¹.

The second relationship is with others, including family and professionals, with the aim of achieving a good outcome for the patient. It has been acknowledged that inter-professional teams appear to work more effectively within care of the older adult, where many of the patients have complex needs^{58,60}. Inter-professional working is effectively articulated by the participants in their work with patients, family, and health and social care colleagues. However, participants also explained how conflict could occur when doctors and nurses had different ideas about what needed to be done in a particular situation.

Effective collaboration has been identified within this study as important to achieving the moral action required to meet the needs of those on whom the dilemma could impact. Within the current literature collaboration has been identified as contributing to high standards of care⁶¹, improving patient outcomes⁶¹ and as an objective of the NHS in the United Kingdom⁶³. Working in a cohesive environment has also been shown to increase job satisfaction amongst nurses⁶⁴. A nurse's role within decision making may involve advocating for those who are unable to advocate for themselves or promoting self-advocacy in the vulnerable by providing support and information¹².

In the accounts where this collective responsibility failed to support the participants view of the best care for the patient they became dissatisfied. In these instances, the nurses needed courage to challenge those in authority, guided by the principles of good nursing practice⁶. In some cases, they chose to take a personal risk by working outside organisational policy if they believed that this would act in the best interests of the patient and secure a more favourable outcome.

The results presented and interpreted in this paper support the premise that, to achieve positive outcomes, nurses have learned that developing and maintaining professional relationships within the context of the secondary care

setting is central to enabling them to contribute effectively and achieve the best possible outcome in the ethical dilemmas discussed.

In their ethical reasoning the participants demonstrated the use of a range of theories. This included consequentialism in the weighing up of ‘best’ outcomes, and deontological thinking in observing the rules and duties embedded in policy and professional codes of conduct. However, virtue theory appears more significant to the resolution of ethical dilemmas through the cultivation of personal qualities such as courage and wisdom. Additionally, the ethics of care underpins the fundamental principle of seeking the best for each patient.

The data also indicates that nurses are able to recognise and develop strategies for managing moral dissonance in order to mitigate the negative impact of moral distress, however the strength of the evidence is limited and requires further research to fully understand how this is achieved and how we can support nurses to develop these strategies.

Limitations within the sample are acknowledged; the data was gathered from nurses working within a single Trust, and organisational culture may vary within different settings. The participants were volunteers, and may have had a disposition that recognised the importance of ethical dilemmas and an awareness of the nurse role in their resolution⁴⁸.

Conclusion

This paper has presented the findings of a qualitative study exploring the ways in which secondary care nurses in the UK seek to resolve ethical dilemmas in practice. In addition to the conceptual framework for ethical decision making that is proposed, the cultivation of sophisticated, complex relationships is the key to the resolution of such dilemmas. The results illuminate the collaborative nature of nurses working within teams to resolve ethical dilemmas and present a theoretically underpinned understanding of collaboration which encompasses concepts of the complex relationship between embedded cultural and conflicting professional drivers.

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