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NURSES CONTRIBUTION TO THE RESOLUTION OF ETHICAL DILEMMAS IN CONTEXT

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A thesis submitted to the University of Huddersfield
in partial fulfilment of the requirements for
the degree of Doctor of Philosophy

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Abstract

Background: New nursing roles and advances in care and treatments have resulted in nurses facing increasingly complex ethical dilemmas in practice; nurses are therefore required to engage effectively in ethical decision-making.

Prior to commencing this empirical study a literature review was undertaken, the databases CINAHL, Science Direct, Medline, Web of Science and British Nursing Index were searched. Peer reviewed papers were systematically reviewed. Emerging themes were moral distress, codes of ethics, conflict within ethical decision-making and policy. The literature included international studies and indicated that ethical decision making is a concern amongst nurses globally.

Aim: To identify how nurses contribute to the resolution of ethical dilemmas in practice.

Method: An Interpretive Qualitative study was undertaken, between March and December 2012, using a flexible approach to analysis. The National Research Ethics Committee provided Ethical approval. Eleven registered nurses were interviewed using semi-structured interview, focusing on how participants addressed ethical dilemmas in practice. In-depth thematic and content analysis of the data was undertaken. The relatively small, single site sample may not account for the affects of organisational culture on the results.

Results: Four major themes emerged: 'Best for the patient', 'Accountability', 'collaboration' and 'policy'. In addition professional relationships were identified as key to resolving ethical dilemmas. Moral distress was evident in the data as identified in the literature, and reflects the emotional labour nurses' experience.

Discussion: Support is required for nurses to acquire the skills to develop and maintain professional relationships for addressing ethical dilemmas in practice. Nurses require strategies to address the negative impact of moral distress.

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

Recommendations: Research is required to explore this phenomenon in other geographical areas and professional settings. Nurses need to engage with political and organisational macro and micro decision making. Further research is required to establish how nurses can manage moral residue and minimise the negative impact of moral distress.

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Contents

Abstract	page 2
Acknowledgements	Page 3
Contents	Page 4
Tables and figure	Page 7
Appendices	Page 8

Section I

Chapter 1 - Background

1.0 Introduction	Page 10
1.1 Context	Page 13
1.2 Background	page 15
1.3 Theoretical Framework	page 20
1.4 Summary	page 36

Chapter 2 –Literature review

2.0 Literature review	Page 39
2.1 Search strategy	Page 39
2.2 Critique	Page 41
2.3 Results	Page 42
2.4 Conclusion	Page 61
2.5 The aim of the study	Page 64

Chapter 3 – Study design

3.0 Study Design	Page 66
3.1 Data collection	Page 66
3.2 Pilot Study	Page 67
3.3 Main study	Page 72

Section II

Chapter 4 - Results

4.0 Results of the thematic analysis	Page 87
4.1 participant profile	Page 87
4.2 Results of the thematic analysis	Page 87

Chapter 5 - Best for the patient

5.0 Best for the patient	Page 92
5.1 Advocacy	Page 93
5.2 Standard of care	Page 100
5.3 Conclusion	Page 108

Chapter 6 - Accountability

6.0 Accountability	Page 109
6.1 Autonomy	Page 113
6.2 Conclusion	Page 122

Chapter 7 - Collaboration and conflict

7.0 Collaboration and conflict	Page 124
7.1 Collaboration	Page 124
7.2 Conflict	Page 134
8.3 Conclusion	Page 141

Chapter 8 - Concern for others

8.0 Concern for others	Page 144
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Section III

Chapter 9 - Case study

9.0 Case study	Page 152
9.1 Reconceptualised theoretical framework	Page 154
9.2 Conclusion	Page 167

Chapter 10 – Discussion

10.0 discussion	Page 169
10.1 ethical dilemmas	Page 169
10.2 The context	Page 170
10.3 Moral Reasoning	Page 179
10.4 Ethical Decision-making	Page 185
10.5 Moral Action	Page 188
10.6 Moral Residue	Page 196
10.7 Conclusion	Page 201

Chapter 11 - Conclusion

11.0 Introduction	Page 203
11.1 Contribution to nursing knowledge	Page 205
11.2 Limitations of the study	Page 207
11.3 Recommendations	Page 208
11.4 Dissemination of the results	Page 211
11.5 Reflection	Page 212
11.6 Summary	Page 225
Reference list	Page 228

Contents

Tables

Table 1 Participant profile	Page 75
Table 2 Themes from the thematic analysis	Page 89

Figures

Figure 1 Theoretical framework	Page 38
Figure 2 Reconceptualised theoretical framework	Page 154

Appendix

Appendix 1: Table of selected literature (background)	Page 243
Appendix 2 : Table of selected literature (Literature review)	Page 247
Appendix 3: Review framework proforma	Page 252
Appendix 4: Participant Information sheet (pilot study)	Page 255
Appendix 5: Participant Consent form (pilot study)	Page 257
Appendix 6: Participant Information sheet	Page 261
Appendix 7: Participant Consent form	Page 263
Appendix 8: European Doctorate Students Research Conference,	
Abstract and PowerPoint presentation	Page 264
Appendix 9: Undergraduate student research conference	
PowerPoint presentation.	Page 276

Chapter 1: Introduction

1. Introduction

This exploratory study investigates the contribution British nurses make to the resolution of ethical dilemmas within the secondary care context. A registered nurse, referred to within this thesis as the nurse, from any field, is one who is currently registered with the Nursing and Midwifery Council (NMC), from any part of the register, and, for this study, employed within secondary care provision and working within the requirements of that registration. Throughout this paper the term nursing practice will be used to refer to this context.

Decision making is an essential part of the nurse's role (NMC, 2008); because nurses are required to advocate for patients (NMC, 2008) this can lead to ethical dilemmas and conflict with others involved in their care (Oberle and Hughes, 2001). It is therefore important that nurses are able to justify their contribution to the decisions made. However, whilst the decisions nurses make may be reflected upon it is the values used to make these decisions which are often overlooked (Harris, 1985). The contributions that nurses make and the values on which such contributions are based are the focus of this exploratory investigation.

The overall aim of the research is thus *to identify the values, beliefs and contextual influences that inform decision making and the contribution made by registered nurses in achieving the resolution of ethical dilemmas in nursing practice*. This chapter will outline the structure of the thesis, locate the context in which it takes place and present a theoretical framework to guide development of ethical decision making.

Chapter 2 presents the results of the review of the literature, which identified four themes: the role of ethical codes; the importance of policy; 'moral distress'; and conflict. In light of the study findings further literature has been reviewed to include collaborative working, professionalism, advocacy and accountability and the impact of both policy and organisational culture. This additional literature is included in the Findings and Discussion chapters.

In order to address the aim of the research a qualitative approach was selected, enabling the collection of rich, in depth data. Chapter 3 presents and justifies this approach. A pilot study was conducted to determine the most appropriate data collection method; because the select approach has proved to be an appropriate choice the pilot data have been included in the analysis.

The transcripts of all the participants' interviews underwent a content and interactional analysis to identify contextual influences on the nurses' contributions to the resolution of ethical dilemmas. Four key themes: Best for the Patient; Accountability; Collaboration and Conflict; and Concern for Others emerged and are explored in detail in Chapters 4 – 8.

Chapter 9 presents a case study from 'Charlie', which critiques the theoretical framework. A re-conceptualisation emerges, with the addition of relationships as central to ethical decision making and the resolution of ethical dilemmas.

Chapter 10 explores the elements of the relationships that the data have identified as central to the effective resolution of ethical dilemmas in nursing practice, in an attempt to define what effective resolution might be. These findings appear to endorse virtue ethics as central to understanding relationships and to add to our understanding of their application in practice. Furthermore, moral distress emerges as a consequence of ethical decision making and as an integral aspect of relationship building in nursing.

Finally, Chapter 11 reprises the thesis and offers recommendations for further research for nursing practice.

The discussion of the findings will argue that nurses do contribute to the resolution of ethical dilemmas and that the nursing values they hold are influenced by their personal, professional and cultural values. Perhaps more importantly, nurses' values and beliefs are influenced by their professional experiences and the findings indicate a strongly held conviction that nurses have a shared belief and value system. The key to achieving moral action is through the relationships that nurses negotiate and maintain with patients, their families and other health and social care professionals. These relationships help nurses to understand the perspectives of the patients and others on whom decisions will impact, thus enabling the moral actions identified as best for the patients. Taking responsibility for decision making in this situation and attempting to resolve ethical dilemmas contributed to the moral distress that the nurses articulated in their narrative accounts.

1.1 The context in which nurses contribute to the resolution of ethical dilemmas

The secondary care setting was selected for investigation as the context of this setting, and the role nurses play within it, has changed significantly. Over the last two decades demand for treatment and the options available have increased (Storch et al., 2004). Policy directives, which include Our Health, Our Care, Our Say (DH, 2006) and the Expert Patient Programme (DH, 2001) have led to changing expectations from patients who now recognise the importance of negotiated care packages and of treatment options. The introduction of Foundation Trusts and private health care companies now eligible to provide National Health Service (NHS) funded care has influenced changes in care provision across this sector (DH, 2008). These changes have resulted in role development for nurses (DH, 2005; 2008) and new dilemmas to face (Storch et al., 2004).

Changes to the role of the nurse and the challenges faced by nurses have been seen as so fundamental that they contribute to the changes in nurses' preparation for professional practice (Ramprogus, 1995; NMC, 2004; NMC, 2010a). Many of these changes have been driven by government policy, which in turn has been informed by public and patient expectations. For example, in the early days of nursing emphasis was frequently put on a person's character. These characteristics would include patience, obedience, devotion and kindness (Storch et al., 2004). These authors also suggest that the context in which people were cared for in the 1930s and 40s began to change, shifting care delivery to hospitals rather than in people's own homes. Thus, prior to and at the time of the inception of the NHS, the role of the nurse was viewed predominantly as to assist the doctor, obey (his) orders and

provide for patients' personal nutritional needs (Pugh, 1944). In contrast to this, nurses are now increasingly expected to be autonomous and to challenge doctors when appropriate (NMC, 2008).

In addition, because of the fundamental changes to the health care system, nurses' roles have become increasingly diverse (Storch et al., 2004). Nurses are now required to manage complex nursing interventions, some of which had previously been undertaken by medical staff (Torjuul and Sørli, 2006). Nurses are becoming autonomous, independent practitioners and, as a result, are faced with increasingly complex decisions which require sensitivity, moral reasoning and clear, justifiable, ethical decision-making (Storch et al., 2004). These changes in the nurse's role coincided with the move of nurse education into Higher Education institutions, commencing with Project 2000 (Ramprogus, 1995) and, more recently, the move to an all graduate profession (NMC, 2004; 2010a).

The move to an all graduate profession recognises that importance be placed on the nurse's ability to think critically (Standing, 2011). Critical analysis of the situation and critical thinking are required in order to make appropriate decisions about patient care, service delivery and organisational policies and procedures (Standing, 2011).

The current position requires nurses to meet the needs of patients and the expectations of patients' families and to work in line with evidence-based practice and government policy, ensuring that high quality care is delivered within current resource levels (Jenkin and Millward, 2006). It is suggested here that it is these competing demands that result in complex ethical decisions, which registered nurses are expected to address effectively, not only by the public and the organisation but

also by their professional body. Investigation into incidences where care has broken down and standards of care have fallen below the standards expected by patients and their relatives and those set for the NHS has resulted in nursing being scrutinised and the Chief Nursing Officer for England, Jane Cummings, calling for nurses to be caring, compassionate, competent, courageous, to communicate effectively and be committed to foster a service with compassion at the centre (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012). The adoption of these '6 Cs' indicates that personal characteristics are once again viewed by patients and policy makers as important when selecting individuals for nurse training and that their importance is equal to that of knowledge and clinical skills in the perception of a "good" nurse. The moral character of the nurse has never, in recent times, been more scrutinised.

1.2 Background: Ethical decision making in nursing

Definitions of nursing identify the importance of ethical values and the professional relationships nurses have with patients and other health care professionals (Royal College of Nursing, 2003). Within the UK nursing is bound by its Code of Conduct (NMC, 2008), in which nurses are accountable for their actions and therefore need to be able to justify their decisions. Seedhouse (1998), amongst others, has suggested that nurses' accountability may be viewed as a moral venture and, therefore, morally special. This suggests that those who choose to work for health care pledge to a powerful set of moral obligations.

The terms “ethics” and “morals” are used interchangeably by some authors (Singer, 1993; Banks and Gallagher, 2009). Clear distinction between moral reasoning and ethical decision making is made by Seedhouse (1998) who refers to moral reasoning and ethical action. Hawley (2007) describes ethics as the study of moral behaviour and moral behaviour as that which is good or bad, right or wrong; almost the opposite to Seedhouse (1998). Others also make a distinction between morals and ethics, suggesting that ethical action is underpinned by moral values (Tong, 1997; Johnstone, 1999; Fry and Johnstone, 2002).

Whilst acknowledging this divergence of views within the literature, the theoretical framework in Section 1.3 presents moral reasoning and ethical decision making as distinctly different and as the first two stages of a three stage model. The term moral reasoning is used to refer to the reasoning that is undertaken based on personal and professional beliefs and values. Ethical decision making refers to the aspects of the decision making that can be seen to be underpinned by ethical principles and theories. The final third stage of the framework is moral action; this is the behaviour and actions, informed by both moral reasoning and ethical decision making, undertaken by the nurse. All cultural groups have a set of moral values and beliefs which influence their choices and behaviour; these choices and behaviours are subject to ongoing revision and refinement (Carter and Klugman, 2001; Banks and Gallagher, 2009). Ethics is viewed as the reflective process within which this group's choices, based upon their values and beliefs, are systematically appraised using ethical principles and rules (Carter and Klugman, 2001).

Harris (1985) has suggested that it is through concern and care for others, including efforts which people are willing to make in providing care, that the value placed upon their lives and the respect for them as individuals is demonstrated. Where differences occur in the ability or willingness to provide care, or the failure to meet the expectations of those involved occurs, a dilemma may arise (Seedhouse, 1998). Harris (1985) further states that nurses need to address these ethical dilemmas, claiming that judgments are based on beliefs and values and, whilst the decisions made to resolve ethical dilemmas are often examined, rarely are the beliefs and values underpinning the decision examined in the same way.

Within current health care practice ethical dilemmas [which are defined in Section 1.3a] not only occur when the nurse is faced with extraordinary situations but, more commonly, in day to day practice, which includes challenging decisions regarding new treatment options and the appropriateness of treatment (Storch et al., 2004). The increasing number of complex and expensive options at the disposal of health care professionals, resulting from technical developments, has increased the frequency and emphasis of these decisions (Bunch, 2002; Aroskar et al., 2004; Storch et al., 2004; Hugman, 2005).

There is a requirement placed on the health care team to consider the person at the centre of care provided, whilst considering broader issues associated with the availability of resources within organisational and political objectives (Padgett, 1998; Chambliss, 1996; Storch et al., 2004). As members of the health care team nurses need to behave in an ethical manner, considering the professional relationships they build with others in the course of their nursing practice (Chadwick and Tadd, 1992).

The nurse-patient relationship, as defined in The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008), places an obligation on the UK nurse to act as advocate and to do what is best for the patient. This obligation in itself may result in conflict, as what the patient believes is 'best' and in line with his or her wishes may conflict with the opinions of others (Fry and Johnstone, 2002). Johnson (1997) identified how the imbalance of power between nurses and patients can result in patients having to conform to treatment regimens. In addition, in order for the nurse to undertake the role of patient advocate effectively, the relationships nurses have with other health care professionals and patients' relatives are vitally important (Hawley, 2007).

Professional relationships between nurses and doctors have undergone significant change over the past 20 years, with nurses increasingly involved in decision making, managing care and delegation of parts of that care (DH, 2011). This brings both opportunities and challenges and, with the publication of Modernising Nursing Careers by the Department of Health in 2011, a number of initiatives were introduced including a 'Nurse Leadership' initiative, the 'Flying Start' programme improving preceptorship for newly qualified nurses. New nursing roles include specialist nurses, consultant nurses and nurse practitioners, who now make decisions about treatments which may have previously been addressed by the doctor whose care the patient was deemed to be under. The changes in these roles have occurred in response to the needs of those accessing health and social care services, underpinned by government policy (DH, 2000; 2006; Darzi, 2008).

Judgement and decision making are also important aspects of nursing practice, as is the resolution of ethical dilemmas which requires the ability to weigh the options in order to identify the appropriate course of action (Thompson and Downing, 2002). Evidence based practice (EBP) has become an important part of clinical decision-making; however, it can be argued that EBP alone fails to recognise the values of the patients and their families in the decision making process. This is particularly important when promoting patient autonomy and in recognising the unique nature of each person, their diagnosis and the potential for intervention (Martin, 2004). It is important, therefore, when making clinical decisions, that moral reasoning and ethical decision making are included rather than relying entirely on science (Martin, 2004).

Ethical decision making in nursing practice has been informed and underpinned by medical and bio-ethical approaches (Chambliss, 1996; Storch et al., 2004). These are discussed in more detail below. They include deontological and consequential theories that may be characterised as rule-based or act-centred as well as virtue ethics and the ethic of care, which have been advocated within nursing practice and nurse education and may be considered to reflect a more person oriented, agent centred approach (Johnson, 1997; Gilligan 1982; Armstrong, 2007).

Gilligan (1982), Johnson (1997) and, more recently, Armstrong (2007) highlight the limitations of obligation or rule-based approaches to moral reasoning and ethical decision making in the context of nursing practice, arguing that these approaches are inadequate in their failure to recognise the importance of emotion in moral reasoning. The development of an individual nurse's reasoned decision making and

the accomplishment of competence through the various stages of their professional development are also recognised as important to this decision making process (Benner, 1984, Carter and Klugman, 2001). However, it is the relationships that nurses have, as students with their mentors and, later, with a preceptor, that can influence their development as competent nurses and maintain their ability to care (Smith, 2012).

1.3 Theoretical framework

Nurses who are required to maintain moral and ethical standards in practice find that they are increasingly restrained by the clinical and caring environments within which they work (Redman and Fry, 2000). To participate effectively in working for health as a moral venture, nurses require moral sensitivity, moral reasoning skills and the ability to recognise a moral issue in a given situation, which results in the need for ethical decision making to inform moral action (Harris, 1985; Seedhouse, 1998; Johnstone, 1999).

This staged approach to decision making is illustrated in the theoretical framework developed for this study [see Figure 1] which recognises that ethical dilemmas occur within the context of nursing practice and suggests that it is a person's moral conscience that alerts them to the fact that things are not necessarily 'right' (Hawley, 2007). It is this moral conscience, informed by the beliefs and values held by the individual, that informs initial expectations (Hawley, 2007). Moral conscience is also described as moral sensitivity, which is guided by feelings of compassion, sympathy and concern of one for another (Storch et al., 2004). However, these authors also

argue that moral sensitivity requires cognitive and imaginative skill in order to apply moral theories to a given situation.

Registered nurses are both accountable for their actions and have an obligation to advocate for those to whom they have a duty of care (NMC, 2008). In order to meet these requirements it is suggested, in this theoretical framework, that some or all of the ethical approaches to decision making, moral action and the resolution of dilemmas recognised throughout the health care literature may be used to explain how nurses respond and to justify their actions.

Through systematic searching of the current literature studies and debates were identified as pertinent to the background and development of the theoretical framework and are detailed in Appendix 1. Sections 1.3a–d below outline the stages of this framework.

1.3a Ethical dilemmas

Some research investigating ethical dilemmas fails to present a working definition of an ethical dilemma, for which there may be valid reasons. [some authors, , justify this omission in their published articles (Oberle and Hughes, 2001; Aroskar et al., 2004; Dierckx de Casterle et al., 2004; Hurst et al., 2005). Authors who do provide definitions of an ethical dilemma include Beauchamp and Childress (2001) and Hamric et al., (2000), explaining that an ethical dilemma occurs when a given situation has two or more conflicting moral principles. This is further developed to include the recognition that, when addressing the dilemma, the available alternatives

appear to be equally undesirable and the correct course of action unclear (Noureddine, 2001).

In nursing practice ethical dilemmas occur in situations where the beliefs and values of the patient, their relatives and/or the nurses and the organisational objectives may conflict in some way (Kain, 2007). This may result in differing expectations which inform the action taken by the health care team. Storch et al. (2004) identified that the ethical dilemmas that nurses are required to address within their practice are becoming distinctly different to those traditionally addressed by physicians in relation to medical ethical dilemmas. As such, these dilemmas may not be adequately addressed through the bio-ethical approach traditionally used in medicine (Storch et al., 2004). This is because the nurse's role extends beyond the medical perspective of treatment and cure; nurses are required to meet the full diversity of patient need. Through the development of holistic relationships (Tschudin, 1999) and providing person centred care for patients (Kitson, 2004), nurses strive to meet the diversity of patient needs (Storch et al., 2004). It may be argued that nursing ethics is now developing as a distinct approach, separate but influenced by medical ethics, to reflect the different mandates to care held by each profession (Chambliss, 1996; Storch et al., 2004).

Ethical dilemmas in nursing often arise from the same issues faced by other health care professionals. The difference is that the engagement the nurse has with the patient and their family is continuous throughout the episode of poor health which may have resulted in the dilemma (Chambliss, 1996). This continuous contact facilitates the development of therapeutic relationships (Kitson, 2004). For nurses,

as for other health care professionals, the context in which they work has changed. Because the role the nurse undertakes, in many cases, is a co-ordinating role for care provision and forms the link between the patient, the family and other health care professionals, the nurse often has a unique overview of the issues involved (Storch et al., 2004).

Ethical dilemmas in health care take many forms. These include the big questions, for example resuscitation orders (Herbert, 1997); issues around care of the dying, withdrawal of and/or withholding treatment (Elger and Harding, 2002); the provision of futile treatment (Hurst et al., 2005; Clará et al., 2006); and organ donation (Bunch, 2002). However, of equal importance are the smaller questions that impact on the daily work of nurses, such as provision of information, confidentiality and the disclosure of information to third parties (Jenkin and Millward, 2006). Whilst there is legislation to guide nursing practice decisions on how to act, this requires careful consideration in the application of the law; dilemmas in relation to this occur when the nurse has conflicting duties and responsibilities (Jenkin and Millward, 2006).

In the UK, organisational policy impacts upon the nurse's ability to make autonomous decisions in relation to patient care (Torjuul and Sørli, 2006). Organisations such as the Department of Health, regional and local Health Authorities and NHS Foundation Trusts are responsible for the allocation of resources, which may be challenging when demand outstrips supply within the current health care system (Oberle and Hughes, 2001). Analysis of organisational decision-making does not fall directly within the objectives of this study, as this is not in the UK nurses' control, however in the United States of America it is a major part

of the role of the Utilisation Nurse, whose job it is to make decisions about best value treatments in relation to patient outcomes (Bell, 2003).

Nurses engage with resource allocation on a daily basis. Nurses have only so many hours in which to manage, plan and deliver care; ward budgets and availability of other health care professionals are limited (Torjuul and Sørli, 2006). The nurse - patient relationship and the closeness of nurses to the patient group result in a perceived increased accountability and the duty to meet patients' needs appropriately (Torjuul and Sørli, 2006). In order to achieve this nurse must be able to prioritise the needs of any patient group and to guide the doctors and other health and social care professionals as to whose needs should take priority (NMC, 2010a). All patients are important and the health care professionals providing care and treatment have to make some tough decisions; these are, for some nurses, everyday decisions (Storch et al., 2004).

Decisions in an acute situation may need to be made quickly with whatever information is available at the time; it may be that these decisions are taken more frequently in secondary care settings rather than in other health care settings. In the accident and emergency department, in the medical assessment unit, in intensive care or theatres, or in life threatening situations, the team has only minutes to decide on a course of action (Farsides, 2007). Not all ethical dilemmas need such urgent attention; these are, however, equally important. Decisions made in all situations may have an impact on the patient's long-term health and wellbeing, however nurses within health and social care teams may have more time to discuss the situation and negotiate what needs to be done, encompassing the wishes of the patient and those

on whom the outcome may impact, weighing the options available in partnership (Farsides, 2007).

1.3b Moral reasoning

Moral problems and moral dilemmas are those which engage our beliefs and values about what is fundamentally right or wrong, good or bad (Hawley, 2007). Diversity of opinion, it has been suggested, through freedom of thought, helps the development of moral character, resulting in self-determination (John Stuart Mill 1806–1873). Self-determination allows each person to make their own decisions about their own life style, with whom they associate and how they pass their time. Nurses may experience moral distress when their self-determination is compromised because they feel they are unable to maintain their personal or professional moral ideals and, consequently, their professional integrity (Torjuul and Sørli, 2006). This is apparent, for example, when nurses are not able to ‘tell the truth’, as they might see it, to the patient in their care, for example not providing full information about diagnosis, prognosis and/or treatment (Torjuul and Sørli, 2006). Caring and upholding standards of care appear to be important aspects of nursing and reflect the professional values nurses hold; when this is compromised nurses may begin to feel dissatisfied with the situation (Torjuul and Sørli, 2006). Further research, of nurses working within the hospice setting, goes on to suggest that maintenance of human dignity is an important moral obligation in their practice (Salloch and Breitsamater, 2010). These nurses strive to be non-judgmental and recognise the need to respect the wishes of the patient in their care even if this is in direct conflict with their professional judgement (Salloch and Breitsamater, 2010).

What may also be of importance when researching ethical decision making in nursing is that it is a predominately female profession, with 89.29% of those currently registered on the Nursing and Midwifery Council's register being women (NMC, 2010b). The percentage of male registrants has remained constant since 2004 (NMC, 2010b). It may be that gendered traits also dominate the nurses' moral reasoning which is used to inform nursing practice.

Gilligan's (1982) seminal work on the gendered nature of moral reasoning demonstrated that girls were inclined to articulate their reasoning in ways that were different from boys. Boys were more likely to display thinking that correlated with Kohlberg's¹ (2008) 'classical' stages of development, speaking in what Gilligan refers to as 'a different voice'. She argued that theorists such as Kohlberg developed their ideas through observations of men and their ways of reasoning, failing to take into account the gendered nature of such research. Male development has thus been taken to be 'normal' and generalisable, making the reasoning displayed by woman participants appear to be less well developed. Further, Noddings (2003) suggests that it is women's moral development that informs an act-centred approach to ethics that may be seen in the ethics of care and in virtue ethics, which are discussed below.

The nature of nursing and the job itself may also impact on nurses' attitudes and their moral views, perhaps influenced by the position of nurses within the health care team and the work they undertake; thus the gendered nature of nursing's professional identity, rather than the actual gender of individual nurses.. The two

¹ Kohlberg first developed this theory as his PhD dissertation in 1958 and continued to publish on it throughout his academic career.

may be intractably entwined because of the constantly high proportion of nurses who are women; however this may be impossible to confirm (Chambliss, 1996).

Moral reasoning is also influenced by the values, beliefs and expectations of an individual's parents, religion and peers as they grow up; these may change according to our life experiences (Cuthbert and Quallington, 2008). Values and beliefs inform moral conscience, which helps in the recognition of the moral quality of behaviour, thus informing actions. Amongst these influences are those of the profession into which nurses become socialised and the experiences encountered as part of nursing practice (Benner, 1984; Settelmair and Nigam, 2007). Taken together these values can be seen to inform the nursing code of professional conduct: The Code (NMC, 2008).

In summary, moral reasoning is influenced by personal beliefs and values, gender, socialisation and professionalisation. Values may become revised and refined over time and through experience (Carter and Klugman, 2001). Challenges to a nurse's moral reasoning may occur when there is a conflict between patients and their family or the health care team when addressing moral issues (Salloch and Breitsamater, 2010), leading to the need for ethical decision making.

1.3c Ethical decision making

Ethical decision making is framed within a number of recognised ethical approaches which are described below and which are the third stage of the theoretical framework.

The four approaches outlined are often characterised as either principle-based [non-feminist] or agent-centred [feminist] in nature. Principle-based approaches have tended to dominate health care ethics, however agent-centred approaches, have enjoyed an increase in popularity amongst such authors as Tong (1998), Storch et al., (2004) and Armstrong (2007).

Whilst ethical approaches fall primarily into these two groups some authors recommend a pluralistic combination of approaches, thus bringing the best from each according to the situation (Botes, 2000a). In practice, as will be seen in the findings of this thesis, all four approaches, or elements of each, may be drawn upon. Hence they are represented, in Figure 1, as equally important.

Principle Ethics These approaches are predominately underpinned by the work of the classical philosophers Immanuel Kant (1724–1804) and William David Ross (1877–1971); these deontological approaches use the language of duty, of what a person ought or ought not to do. David Hume (1711-1776) , Jeremy Bentham (1748 –1832) and John Stuart Mill (1806–1873) developed consequentialist approaches which consider the consequences of the action to be central to decision making, balancing both the benefits and the burdens of that action to inform decision making (Cahn and Markie, 2006).

It can be argued that both deontological and consequential approaches lead to principles, a method that has gained popularity amongst medicine and then nursing as a way to support ethical decision-making in professional practice. The principles applied are those of autonomy, beneficence, non-maleficence and justice

(Beauchamp and Childress, 2001). The principles approach is underpinned by western moral philosophy, which consists of the four principles above and ethical rules of confidentiality and veracity (Hawley, 2007). Philosophy provides both meta-ethics and normative ethics. Meta ethics consider the meaning of moral language; normative ethics are those which are here to provide ethical theory to guide decisions and behaviour (Beauchamp and Childress, 2001).

Deontology encompasses ethical approaches to examine what we ought to do in relation to a given situation. Within these approaches the aim is to consider decisions and actions as if they were universal laws which would apply in any given situation. Such ethics can be seen in religious doctrine, such as the Koran or the ten commandments of the Old Testament. They also underpin professional codes of practice. However, the most recognised theory is Kant's (see Cahn and Markie, 2006, p. 270). Kant provides guidance on how we should act:

1. In a way that we would always act - resulting in 'universal law',
2. Treating each person as an end in themselves, not a means to an end, offering respect to all people with dignity.

He argues that these 'laws' inform us of what ought to happen and how to make ethically rational decisions.

However, applying these laws universally has limitations, for example deciding which law or rule should take priority and whose rights to prioritise in any given situation. The basis or fundamental principle of Kant's approach indicates that no one (including oneself) should be treated simply as a means to an end but as an end in themselves. This fundamental principle or law provides a system of duties to oneself

and others. These duties are referred to as perfect duties and imperfect duties. Perfect duties are actions which must always be observed; there are no exceptions to these rules. These actions, also known as negative obligations, require the actor (in the case of nursing practice this is the nurse) to desist or refrain from an action. Imperfect duties are actions which are positive obligations and require that the actor (nurse) act or behave in a certain way. It is the intention with which actions are performed that is central to this approach, rather than the consequences (Beauchamp and Childress, 2001).

Whilst deontological approaches have dominated medical and health care ethics for some years nursing ethicists argue that, due to their rigid nature, they to some extent fall short of meeting the dilemmas faced by nurses in the current context of nursing practice (Johnson, 1997; Armstrong, 2007). However, Dierckx de Casterle et al. (2004) may support the view that rule based ethical approaches still have a place in nursing decision making. Their empirical work revealed that nurses relied on the convention of practice: rules of the organisation, expectations of the patient's family and colleagues and procedures learned during their education, rather than being reflective in nature. Their findings suggest that nurses struggle to engage effectively in ethical practice as they do not appropriately consider the patient's personal needs.

Consequentialist theories focus on the outcome of an action to judge whether or not a particular course of action is ethical in nature. Utilitarian theories are probably the best-known of this group of theories. These indicate that each person should strive to promote 'the greatest good for the greatest number' in order to maximise the 'utility', or outcomes of a situation when making the decision to act. Philosophers

David Hume, Jeremy Bentham and John Stuart Mill developed the idea of the two extremes, pain and pleasure, to demonstrate the principle of utility (Cahn and Markie, 2006). These theories determine the moral rightness of actions based on the balance of the good and bad consequences of those actions (Fry and Johnstone, 2002).

The main aim is to consider which action will result in the most happiness; the main criticism is that those in minority groups may be disadvantaged (Tong, 1997). In the provision of health care 'cost benefit analysis' is used to analyse expenditure (Hawley, 2007), encouraging health care professionals and organisations to maximise the use of resources available. However, this approach could lead to expensive treatments not being funded in favour of less expensive treatments, resulting in a greater number of people receiving care but perhaps limiting funding being allocated for research and treatment of rare conditions from which only a few will benefit (Beauchamp and Childress, 2001).

Despite the limitations of this approach it remains important, as health services are experiencing increased demand as people live longer and the ability to treat more conditions in more complex ways continues to increase (Bunch, 2002; Aroskar et al., 2004; Storch et al., 2004; Hugman, 2005). Policy making bodies such as the National Institute for Health and Clinical Excellence, NHS England, other commissioning groups with responsibilities for commissioning services and executive board members may find consequential approaches most effective when discussing and planning service provision. For some time the formulas used for the allocation of health services have included Quality Adjusted Life Years (QALYS), which

examines the potential outcome of a treatment (Allmark, 1998). Nurses may be involved in policy development; this is dependent on their role. Nurses working in secondary care are, however, in the position of making decisions associated with the distribution of resources on a daily basis as they work within the context of limited resources (Kälvemark et al., 2004). This approach also encourages health care professionals to consider the patient's feelings of 'pain and pleasure' on an individual basis and, as such, may help in identifying the most appropriate course of treatment or care for individual patients.

Whilst deontology and consequentialism have clear differences, what they have in common, Singer (1993) suggests, is more important; when addressing ethical decisions or judgements ethics should support a universal viewpoint. Not simply that the principle should be applied universally but that the context or situation influences the application of that principle and should move beyond individual likes and dislikes to ensure an impartial standpoint.

Beauchamp and Childress (2001) argue that the principles of autonomy, justice, beneficence and non-maleficence can be justified from both approaches, giving a basis for decision making in health care ethics. In addition, Botes (2000b) views deontological and utilitarian approaches as opposite ends of the same spectrum and calls for compromise in order that a satisfactory resolution be found for complex ethical dilemmas, recommending a combined approach.

Agent Centred approaches may be seen as a counter position to the principle based theories above. In their most recent edition, Beauchamp and Childress (2013)

use an overarching term, 'moral character', to bring together theories related to moral virtue (see below) as associated with the work of Aristotle (384BC–322BC) and more recent work on the ethics of care (Gilligan, 1982). These approaches are located in practice and often seek to find middle ground or compromise between extremes. Thus the focus of agent approaches goes beyond the action, requiring the agent (in this case the nurse) to consider 'how should I be' rather than simply 'what should I do'. The emphasis, therefore, is on the behaviour of the nurse in a given situation. This approach has the potential to facilitate moral learning and development such that, through a mix of emotion and reason, the nurse can develop competence in this aspect of professional practice (Hawley, 2007).

Virtue ethics: Aristotelian virtue ethics has been significantly developed in recent decades, notably by authors such as Hursthouse (1999). Within nursing, Armstrong (2007) provides a strong argument in defence of a virtue based approach, highlighting the importance of the therapeutic relationship between patient and nurse. His work, alongside that of Banks and Gallagher (2009) and Sellman (2011), represents a significant development of virtue theory related directly to caring professions such as nursing and social work. The nurse, it is suggested, needs the following qualities: trustworthiness, honesty, kindness and patience. Virtue based ethics may be akin to moral virtues and moral reasoning in their recognition of the qualities the individual brings to the situation rather than the objective principles of duty based approaches. Virtue based ethics are concerned less with right action and more with the way we act: kindly, justly, patiently; recognising the importance of moral character, the significance of interpersonal relationships and the importance that emotions have in moral life. Most importantly they acknowledge that ethical

dilemmas are not always solvable. Banks and Gallagher (2009) develop Aristotle's overarching 'practical wisdom' into 'professional wisdom' as the central virtue that guides professionals to good choices. However, Armstrong (2007) acknowledges that that virtue based ethics may fail to provide guidance for action and how to address conflicts between virtues.

It is in virtue ethics that the divide between the genders may become more apparent. Tong (1998) suggests that some philosophers argue that men and women possess the same moral virtue but that women are more emotionally focused and aware of their feelings than men and that men are more likely to engage in a reasoned approach, as proposed within act-centred approaches to ethical decision making. Others, however, argue that the differences are cultural and as society did not permit or encourage women to develop reasoning and express opinion, women therefore became governed by emotion (Tong, 1998).

Within virtue ethics the agent is required to have the cognitive skills to see what is good and right in order to act in the morally right way. The agent and the act are viewed as inseparable, a complete contrast to the consequentialist approach (Tong, 1998).

Aristotle believed that an individual cannot undertake a caring act for someone unless that individual actually cares, that is, they are a caring person. A person who really cares will feel something for the objects of that care; in the case of nurses this will primarily be the patients in their care and may also extend to the patient's family or colleagues within the nursing, health and social care team (Blum, 1988).

Ethic of care: Beauchamp and Childress (2013) suggest that, for some theorists, 'care' is a virtue; however, the term 'ethics of care' is usually attributed to the work of Gilligan (1982). In her attempt to define the gendered voice she heard in her research she used the phrase 'ethics of care' to define decision making that was different from justice, principles or rules. Thus it is strongly associated with agent-centred ethical theory. It may be viewed as a virtue ethic of a specific nature; the action and the actor being judged as one. Only a morally good character is capable of a morally good act (Hawley, 2007).

The Ethic of Care, also underpinned by the work of Noddings (2003), focuses on the attention and care given to others and the relationships nurses and health care professionals build with patients and their families. Allmark (1998) highlights the fact that everyone cares but the key is what people care about and how they care about it. This focus makes it a morally good act, challenging the idea that caring is a virtue in its own right and supporting the importance of the right actor and the right act.

The health care professionals' mandate to care and the emotions of caring are central characteristics of this approach (Hawley, 2007) indicating that, in order to care and undertake caring, the actor (in this case the nurse) must really care and feel the desire to care. This is in contrast to principled approaches which expect universal principles to be applied using reason alone. The nurse-patient relationship is distinctly different to the caring relationship between a mother and her child. Both these caring relationships depend on trust; the nurse-patient relationship is a

professional caring relationship and ethical caring, and requires both effort and attention (Noddings, 2003; Hugman, 2005).

1.3d Moral action

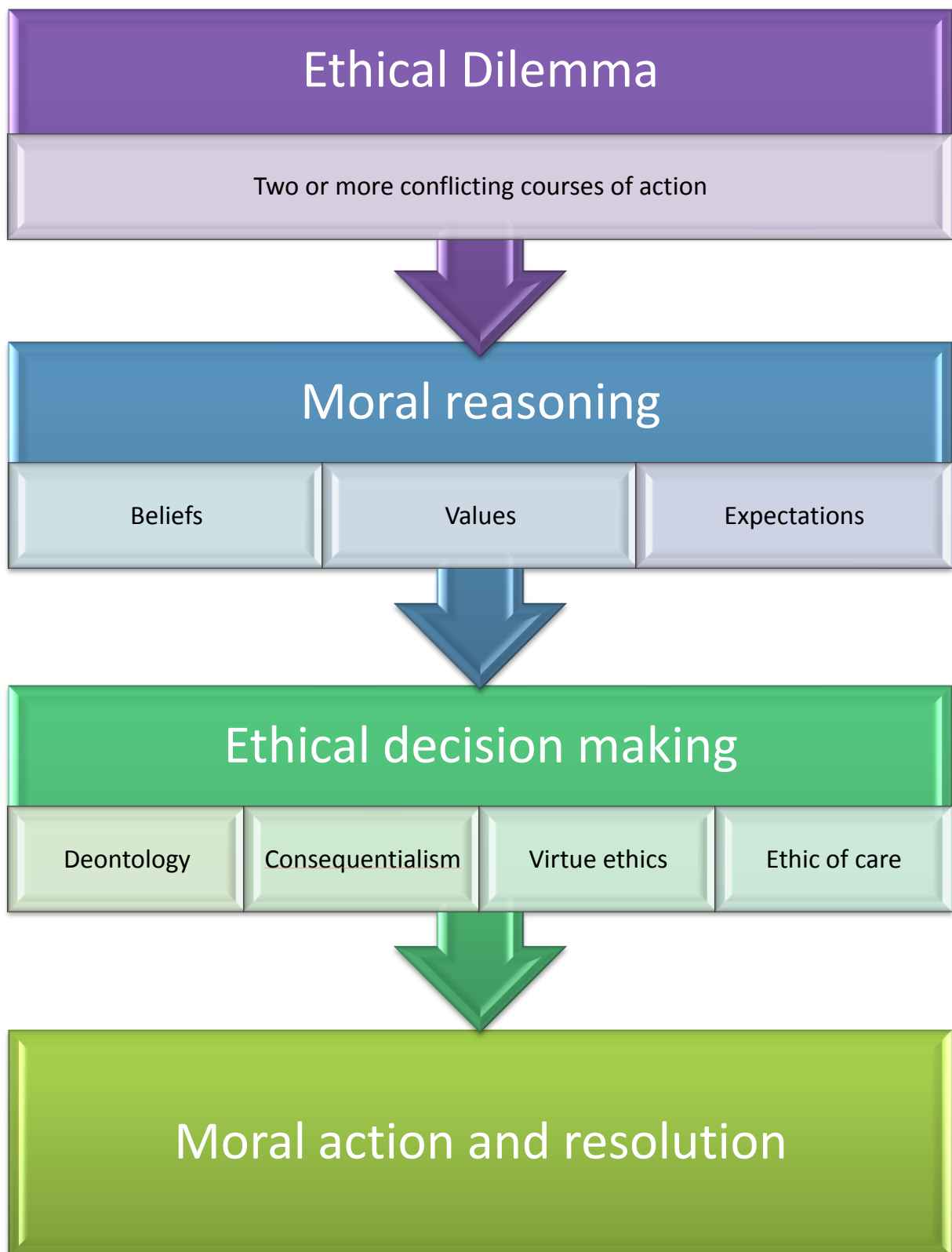
Within this theoretical framework the final stage, moral action, is informed by a process of moral reasoning and ethical decision making. This action may be in partnership with others; patients, their families and other health and social care professionals, because nurses work within multidisciplinary or interprofessional teams (NMC, 2004; Torp and Thomas, 2007; NMC, 2008). It is important to remember the debate surrounding the exact nature of a truly moral act. The question is whether an act is truly morally correct if it is simply duty motivated by what ought to be done or undertaken for personal gain. Beauchamp and Childress (2001) argue that moral virtue is a disposition to act in accordance with moral principles, suggesting that if a person performs a morally right action but his motive is improper then a moral ingredient is missing. This would indicate that resulting 'moral' action taken by the nurse or health care team is truly moral only when the motive is proper. The right action may, however, be undertaken because it is what ought to be done rather than what the nurse wants to do. The act is undertaken because it is required by law or by a contract of employment.

1.4 Summary

This introductory chapter has located the thesis within the context of resolving the ethical dilemmas nurses face in secondary health care in the UK. It has outlined a theoretical framework, based on ethical dilemmas leading to moral reasoning, which informs ethical decision making and leads to moral action. This framework was used

to guide the development of the research plan and its use is critically explored in the discussion of the research findings.

Figure 1: Theoretical framework: Resolution of ethical dilemmas in nursing practice



Chapter 2 - Literature review

2.0 Literature review

Having outlined the focus of the thesis and the theoretical framework in Chapter 1, this chapter presents an integrative review of related literature including philosophical discussion, literature reviews and empirical studies. The aim of the review is to better understand current thinking on nurses' ethical decision making in order to clarify and refine the aim and objectives of this research.

Peer reviewed journal articles make up the main source of materials used in this literature review. These are considered to be a robust source of evidence, reviewed by two or more experts in the field with a lead time which is significantly shorter than that required when publishing books (MacNee and McCabe, 2008). Care has been taken to include recent material, published within the last ten years, to ensure that the evidence is relevant to the context within which nursing is currently practiced.

Grey literature was searched using the EThOs database which provided access to recent Doctoral theses through the British Library. Grey literature also includes unpublished work such as conference proceedings, which may provide a good source of materials when performing a literature review (Parahoo, 2006).

2.1 Search Strategy

Through systematic searching of the literature the following studies and current debates were identified as pertinent for literature review; the search structure is detailed in Appendix 2.

2.1a Database selection

Electronic database searches were performed using the databases CINAHL (cumulative index nursing and other health related professions), ScienceDirect, Medline, Psycinfo, Web of Science and British Nursing Index, which provide access to peer reviewed, published material relevant to the subject (Fink, 2009). This combination of databases provides access to most English language nursing periodicals, standards of practice, government publications, research instruments and patient education material (Blackwell Synergy, 2011; CINAHL, 2011; Science Direct, 2011). During the final stages and writing up of the thesis previous searches were updated to capture any work published in the interim period.

Limits were set to ensure focused searches were undertaken to avoid unmanageable amounts of material being included in the search returns. Limits were also set to identify relevant literature for abstract review to facilitate selection for inclusion within the review process (Robson, 2002).

The limits set were:

- Written in English
- Peer reviewed
- 2000 – present
- Original articles.

A range of key words and synonyms were used for each section of the search; these were Nursing and:

- Moral reasoning / Moral issues/ Moral dilemmas
- Ethical reasoning / Ethical issues / Ethical dilemmas

- Moral / Ethical approaches
- Moral / Ethical Action.
- Moral / Ethical professional codes

Further journal searches were undertaken in the journals; Nursing Philosophy and Nursing Ethics.

Using a combination of abstract review and critical appraisal, articles were selected for use within this review (See Appendix 2).

2.1b Record keeping

Cataloguing and storage of data are essential to avoid error and duplication. All articles were carefully catalogued, entering full reference source and search strategy on to the cataloguing system. Both electronic and manual index card methods are available (Hart, 2005). A simple electronic system was mirrored by a paper file of reviewed articles, stored according to a search code. A total of 27 papers were retained for discussion within the literature review.

2.2 Critique

Once identified as having the potential to be included in the final literature review, it is important to critically read the full article to establish its quality and relevance (Polit and Beck, 2008). Comparability is an important aspect of the literature review process; articles selected must be read with purpose, in an organised manner, which will facilitate comparison of the content and the quality of the evidence (Fain, 1999; Parahoo, 2006; Cutcliffe and Ward, 2007; Polit and Beck, 2008).

Systematic recording of specific areas for consideration within the review were identified and an evaluation pro-forma generated for recording the analysis (see Appendix 2). The pro-forma used to facilitate comparability was based on Burns and Grove's (1987) model and Morrison's (1991) model; adaptations have been developed to accommodate the different types of literature within this review (see Appendix 3). The critique has been approached with some level of flexibility in order to facilitate this.

As each article was reviewed, notes were made on the evaluation pro-forma, drawing together aspects of each piece of literature. This could then be referred to at any time whilst writing up the literature review.

2.3 Results

A number of themes emerged from the literature reviewed which helped to identify what is already known about the contribution made by nurses in addressing ethical dilemmas in practice and to expose gaps. These themes were:

- a. Codes of ethics
- b. Policy
- c. Moral distress
- d. Conflict and collaboration within ethical decision making

2.3a Ethical codes

Functions of professional ethical codes include providing a vehicle for expressing the values of the professional group and guidance for decision-making and behaviour for those within the professional group (Verpeet et al., 2004). Nursing professional

codes exist at international and national levels. They provide nurses with a code of conduct; codes inform nurses how they should act, safeguarding the profession's reputation and, more importantly, protecting service users (Banks, 2003). Nurses in Britain have the Nursing and Midwifery Code of Conduct (The Code, NMC, 2008). Like other codes this comprises the rules of the profession, statements that reflect the character that nurses should possess, ethical principles and rules (Banks, 2003; NMC, 2008).

The Code (NMC 2008) is the primary source of guidance for nurses registered to practise within the UK and is intended to guide nurses' decision making and behaviour. Key aspects include:

'The people in your care must be able to trust you with their health and wellbeing' (page 2).

'Make the care of people your first concern, treating them as individuals and respecting their dignity' (page 3).

'Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community' (page 5).

'Provide a high standard of practice and care at all times' (page 6).

'Be open and honest, act with integrity and uphold the reputation of your profession' (page 7).

Each aspect of The Code (NMC, 2008) is developed further and guidance is available to support the application of The Tinto nursing practice. The Code, along with other nursing codes of ethics, provides nurses with a professional identity, support for nursing, guidance and motivation (Verpeet et al., 2004).

Each country has its own code with an overarching code provided by the International Council of Nurses (ICN) which was first established in 1953 (ICN, 2012). The ICN Code guides nurses in a number of areas, including nurses and people, nurses and practice and nurses and co-workers (ICN, 2012). Like the NMC Code (NMC, 2008) guidance is provided on the implementation of the ICN Code and each of these main sections is broken down to provide further detailed guidance to nurses. The ICN clearly states that the code of ethics is based on social values and provided as a guide for nurses' actions, thus suggesting shared values that nursing might have regardless of cultural, racial or national boundaries. The ICN code of ethics has influenced the nursing ethical codes of a number of countries in Europe, including Greece, Finland and Italy (Heikkinen et al., 2006).

Nurses' codes of ethics are regularly updated to reflect social values and changes in the context of nursing practice and nurses' roles (NMC, 2008; ICN, 2012). It is, however, very clear that a primary consideration, found at the core of all nursing codes, is the best interests of the individual. In the UK the NMC Code (NMC, 2008) is frequently reviewed and developed by the Nursing and Midwifery Council in which nurses are directly involved. There is also a period of consultation where all registered nurses are given the opportunity to comment and provide feedback on a draft version of The Code prior to a final version being adopted (NMC, 2010c).

Despite this unity, one criticism of codes of ethics is that they often contain vague statements rather than clear guidance (Lere and Gaumnitz, 2003). An exploration undertaken amongst the business community found that codes of ethics had little

impact on the decision making process and that the same decisions would have been made in the absence of a code. Reasons for this were discussed within Lere and Gaumnitz's (2003) focus groups, included the feeling that codes of ethics were common sense and participants felt they knew the difference between a right and a wrong action. Thus, they argue that whilst a code should influence actions, it may not do so unless individuals' beliefs can be changed or there are deterrents to acting outside of the code.

Whilst criticised by Lere and Gaumnitz (2003) for being too vague, oppositions to ethical codes highlighted by Banks (2003) state that using a detailed professional code may result in the practitioner becoming dependant on the code rather than making reasoned decisions and, consequently, may risk promoting moral insensitivity. Banks (2003) goes on to suggest that the general principles currently contained in these codes can only guide rather than direct and, therefore, the practitioner still needs to engage in thoughtful application of the principles it contains.

Conducting 23 focus groups, Heikkinen et al. (2006) were able to discuss the opinions of nurses from three countries about the usefulness of codes of ethics. The countries involved were Greece, where nursing is still viewed as a low status profession with limited autonomous decision-making; Finland, where women and nurses have a history of autonomous decision making; and Italy, where nursing has undergone changes within the last ten years to a position of more autonomous decision making within health care. Each country has its own culture and nursing history and it was possible to discover how these impacted on the nurses' views of ethical codes. They concluded that the conscious use of ethical codes was identified

as useful in clarifying ethical aspects of nursing and prompting nurses to think carefully about their decisions and the moral weight of their actions. The nurses viewed ethical codes as a moral guide, being effective when reflecting on ethical decisions. Conversely, the research suggested that codes were not directly referred to in situations where nurses had internalised the values and so implemented them unconsciously in their work.

Obstacles to implementing professional codes of ethics included the codes themselves, as they were viewed as abstract and generally failing to provide clear guidance (Lere and Gaumnitz, 2003; Heikkinen et al., 2006). Collaborative working, where the views and values of others - the organisation, other health care professionals, the patients and their families and health care policy - differ from those reflected in the ethical code, also proved problematic (Heikkinen et al., 2006). Conversely, Verpeet et al. (2004) identified, through analysing data collected during a series of focus groups, how ethical codes provide guidance regarding nurses' relationships with others, with patients, patients' families, other health care professionals, society in general and with each other.

The impact of the local culture, women's and nurses' status in society was seen in Heikkinen, et al.'s (2006) study to have an impact on nurses' ability to work ethically. This was also demonstrated by Donker and Andrew's (2011) study involving nurses working in Ghana. This study involved 200 registered nurses who identified times when they disagreed with decisions made by the health care team. Instances were noted where the ICN code of ethics was in conflict with cultural beliefs and norms. Aspects of care in this regard included patient autonomy, confidentiality, nurses and

co-workers and truth telling. In all of these cases it was identified that some of the Ghanaian nurses felt that it was right that these cultural and social norms should override the ICN code of ethics (Donker and Andrew, 2011). In another study exploring ethical codes of practice the issue was less concerned with cultural 'overrides', but with actual awareness and knowledge of the code itself. Verpeet et al. (2004) found that some nurses' knowledge of professional codes was limited and not used appropriately to inform ethical decision making. Belgian nurses, in their research, felt it was essential for nurses to be involved in developing ethical codes and that these should contain guidance for nurses' behaviour, moral practice, professional practice and function.

It has been established that nurses use codes of ethics and professional conduct to inform decision making and where there may be errors of judgment or poor standards of care, these codes may be used to judge nurses' conduct (Verpeet et al., 2004; Heikkinen et al., 2006). The NMC views its primary role as safeguarding the public; the Code forms part of that mechanism (NMC, 2010c). On balance, it appears that codes of ethics have an important role to play, however their usefulness as a sole guide to ethical decision making and the resolution of ethical dilemmas may be limited. Further, they may not be the primary source of guidance to nurses in practice.

2.3b Policy

Whereas professional codes of practice guide the behaviour of the individual, policy is applicable to all people within its remit. Colebatch (2009) states that National Health Policy is designed and developed by government to provide structure, goals

and guidance for health care providers, organisations and individual practitioners. Under this umbrella, local organisational policy, informed by Health Policy, provides structure at a local level, the aim of which is to ensure safe practice and direct the use of scarce resources to meet various government targets. Colebatch goes on to suggest that the development of health care policy can be difficult as it attempts to bring together the views of diverse groups of people to develop shared goals, for example, government, services users, organisational strategic objectives and health care practitioners, with all their various philosophies.

Whilst reviewing the literature retained for use here it appears to be that policy, national and local, is viewed as restrictive by nurses providing direct nursing care to patients. This is because it limits the care they are able to provide and, in some cases, is in opposition to their personal and professional values and understanding of what is in the patient's best interests or are the patient's wishes (Aroskar, et al., 2004). Nurse participants in Aroskar et al.'s study took part in a series of focus groups where they identified how national policy influenced organisational policy, which had resulted in reduced resources and was felt by them to compromise care. The nurse participants discussed issues associated with the funding of health care within the American system, suggesting that decisions about care were influenced by what was paid for rather than by the patients' needs (Aroskar, et al., 2004). Therefore, the level of health insurance patients have has a real impact on the care delivered. Whilst this is not the case in Britain, for nurses working in National Health Service hospitals, British nurses also recognised the impact of limited resources, especially staffing shortages, on patient care, resulting in them feeling angry,

frustrated and guilty and, consequently, experiencing moral distress (Oberle and Hughes, 2001; Corley, 2002).

For some nurse participants in Aroskar et al.'s (2004) study, the increase in available treatments and the focus on technical intervention rather than that described by participants as the 'ethic of care', may potentially impact negatively on the patient's experience. The nurse participants in this and other studies reviewed demonstrated the value they placed on comforting and supporting patients and families through the development of meaningful relationships built using effective communication, which requires nursing time and commitment (Oberle and Hughes, 2001; Aroskar, et al., 2004; Torjuul and Sørli, 2006).

It is clear from the literature that national and local policies can impact both directly and indirectly on patient care. They have the potential to impact on ethical decision making and the ability to deliver what may be considered to be a good standard of appropriate care. In addition, Aroskar et al. (2004) identified that policy was particularly important in ethical decision making amongst executives and nurse administrators. Decision making was predominately related to careful allocation of scarce resources and the development of policies to ensure appropriate allocation of nursing staff. The maintenance of safe staffing levels, promoting fairness by balancing patient needs whilst respecting patient choice and promoting patient autonomy, were major challenges for nurse managers in their work and are explored further in this thesis.

Limited resources and the allocation of those resources have been described as causing ethical dilemmas for nurses because this results in an inability to provide good quality patient care (Oberle and Hughes, 2001). Nurses in Torjuul and Sørli's (2006) study explained that they felt they should be everywhere at the same time and were often called away to attend to another task before completing the one that had already been undertaken. Time spent with patients who had minor problems detracted from care required by those who were seriously ill; the general feeling was that limited resources and increased demands on nurses' time in the face of changing roles had impacted negatively on standards of care. Policy was a significant factor in determining how the nurses spent their time; the participants felt that it was important that when people are admitted to hospital, nurses should be there for them and their families. Therefore, prioritising who received resources in terms of nursing time and care routinely presented ethical dilemmas for nurses. Participants also experienced challenges in maintaining patient dignity and confidentiality when patients were nursed in shared rooms; during ward rounds, during handovers and discussing patients' conditions and private lives. Finally, concern was expressed that patients might not discuss important confidential issues as patients in neighbouring beds might overhear.

Returning to Aroskar et al. (2004), changes in the focus of the nursing function were thought to impact on patient care with the blurring of professional boundaries; nurses taking on responsibility for an increasing number of technical interventions led to a lack of time being available for the development of meaningful nurse-patient relationships. In conjunction with these changes in nurses' roles, unregistered and unregulated staff were taking on aspects of care that were perceived by some

nurses to have a negative impact on the quality of care and, in some cases, to have put the patient at risk.

Aroskar et al. (2004) also identified how nurses perceived that policy changes had resulted in there being insufficient nursing staff to implement primary or team nursing, leading to reduced job satisfaction and an increase in staff turnover. The consequences of this were that nurses faced dilemmas about equity in care provision and compromised standards, which caused them moral distress. Their participants indicated that there was a lack of input from nurses in the development of local policy but that it was often nurses who faced the impact of such policies on patients and their families. This lack of involvement in policy development resulted in nurses feeling that their contribution was not valued. Finally, they identified that ethical dilemmas also occurred when organisational policies conflicted with care policies within the same hospital.

2.3c Moral distress

It is clear from analysis of professional codes governing individual nurses' behaviour and of policy directives giving structure to care delivery that nurses frequently feel unable to give optimal care. This feeling is described in the literature as 'moral distress'. Nurses' moral distress occurs when it is perceived that an acceptable solution to an ethical dilemma is not achieved. Areas which cause moral distress include organisational constraints which result in limiting the nurse's ability to undertake what is perceived to be the correct course of action (Corley, 2002). Moral distress occurs when a person's moral integrity is challenged; when there is inconsistency with what is believed to be the right thing to do and the action taken in

a given situation (Hardingham, 2004). When moral distress occurs nurses may experience loneliness and a feeling of isolation due to a lack of mechanisms to facilitate dialogue (Sørli et al., 2003).

Situations which cause moral distress amongst nurses, as identified by Kalvemark et al. (2004), include those where organisational constraints and, in some cases, legal issues, result in conflict or compromise standards of care, concluding that there is a need for structures, education and resources to help reduce moral distress amongst all health care professionals. Corley's (2002) review of the literature highlights a broader range of causes of moral distress amongst nurses. This review suggests that moral distress may occur when treatment is viewed as causing pain or harm; when suffering is prolonged; and when contextual problems associated with bureaucracy and inadequate management occur.

A number of issues that directly impact on nurses' perceived stress levels were identified by Ulrich et al. (2010). Low staffing levels were found to cause the most stress amongst nurses. The dilemmas which occurred most frequently were protecting patients' rights, autonomy, informed consent, advanced care planning, surrogate decision making, end of life decision making, breaches of confidentiality, and patients' right to privacy, all of which resulted in moral distress when a satisfactory outcome could not be found. In addition, limited staff to implement care and facilitate decision making has the potential to impact on all aspects of care.

Nurses' involvement in decision making is further highlighted in Long-Sutcliffe et al's (2011) qualitative study involving 13 semi structured interviews with registered

nurses working in critical care units in four different hospitals, which indicated that nurses have limited involvement in decisions associated with the withdrawal of treatment. However, nurses are expected to implement the plan of care and when this is contrary to what they believe is morally right, moral distress occurs. The researchers concluded that doctors, who make these treatment decisions, have a different underpinning professional philosophy which focuses on extending life, whereas it is likely that nurses may consider allowing life to end to be the appropriate course of action.

Explorations of nurses' and doctors' perceptions of ethical problems involved in end of life care indicated that nurses' concerns resulted from their lack of involvement in decision making, even though it is the nurses who are required to execute the care plan (Oberle and Hughes, 2001; Long-Sutehall et al., 2011). The lack of involvement by nurses in this type of care is supported in an examination of the ethical issues and nurses' moral distress associated with euthanasia (Dierckx de Casterle, et al., 2010).

Looking specifically at euthanasia, Dierckx de Casterle et al. (2010) identified that nurses have a crucial role in decision making, as they spend time with the patients building a trusting relationship. The importance of the involvement of the whole palliative care team in deciding to provide the treatment requested was highlighted within the interviews undertaken with participants. Although the physician makes the final decision based on the group discussion, shared decision making was viewed as essential because it is more often the nurses who have a key role in implementing the care plan and supporting the patient and their families.

Kain's (2007) examination of the literature supports the idea that nurses experience moral distress when conflict occurs between what the nurse may perceive to be the best course of action and what is possible within organisational policies, resourcing issues and different opinions on prescribed care. Responses to this distress include sorrow, guilt, frustration and anger which, if left unaddressed, may threaten nurses' self worth, the consequences of which may impact on both personal and professional relationships. Moral distress can also occur due to conflict with the health care team, particularly where there are clear differences between the priorities of nurses and doctors in relation to patient care and differences in each profession's mandate to care (Oberle and Hughes, 2001). This is explored further below.

Wolf and Zuzelo's (2007) analysis of nurses' 'never again stories' echoes concerns regarding nurses' lack of involvement in decision making and the distress they experience in association with this. This empirical research, using a qualitative approach, highlighted the participants' understanding of how failing to contribute in addressing complex ethical dilemmas, even though the constraints placed upon them were as a result of organisation policy or the hierarchal nature of health care, resulted in their distress. Through critical reflection nurse participants were able to identify if they could have acted differently and what they would do if faced with a similar situation. However, the nurses still felt that they had failed in their obligations to those in their care.

If not addressed the consequences of this moral distress for individual nurses and the nursing profession are that nurses suffer burn out. This may involve becoming desensitised to the dilemmas, as a way of avoiding the distress previously

experienced, it may also mean they may choose to leave the profession altogether (Coley, 2002; Hardingham, 2004; Ulrich et al., 2010; Palvish et al., 2011). In both cases burn out has the potential to impact negatively on patient experience.

Corley (2002) does, however, acknowledge some benefits of moral distress, suggesting that moral distress instigates a process of learning and reflection facilitating personal and professional growth through experience, resulting in the potential for future patients to receive more compassionate care. Moral distress occurs when a person's integrity is challenged; moral integrity is the connection between a person's beliefs, values and actions as a professional and as an individual (Corely, 2002). Hardingham (2004) suggests that critical reflection on values, beliefs and social influences in a given situation may help the achievement of a sound understanding of experiences in practice; through this process and socialisation into the profession the nurse may achieve moral integrity.

Nurses are expected to maintain standards of care beyond their personal motivation; a duty is placed upon them by the NMC in its Code (NMC, 2008) and by the Department of Health (DH, 2008; Francis, 2013). The importance of maintaining standards of care has recently been emphasised in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, where nurse leaders are charged with providing strong leadership to ensure the failings identified in this report do not reoccur (Francis, 2013). This report highlights that nurses did raise their concerns about standards of care but felt powerless to bring about change, a situation Corley (2002) identifies as leading to moral distress.

It would therefore appear that moral distress is a well-recognised but not fully explored phenomenon in health care which may be associated with organisational constraints as well as with dilemmas in decision making. There are clear links between the tensions leading to moral distress and the balance between moral reasoning, ethical decision-making and action outlined in the theoretical framework in Chapter 1. This will be explored further in the discussion in Chapter 10 of this thesis. A final area identified in the literature and related to moral distress is the tension between managing conflict and collaboration with ethical decision making.

2.3d Conflict and collaboration within ethical decision making

A frequent source of conflict evident within the literature is between the doctor and the nurse directly involved in patient care. This appears to occur in different aspects of ethical practice, for example within the process of decision making and in communicating with patients and their relatives. Organisational constraints and the hierarchical structures within hospitals may be contributory factors in such conflicts (Heikkinen et al., 2006; Ulrich et al., 2010).

Nurses describe 'working in between', in Varcoe et al.'s (2004) study, which used focus groups to explore the experiences of eighty seven nurses. Working 'in between' is how nurses described finding a balance between their own values, those of the patients, of other health care professionals and of the organisation, to do what is felt to be 'good', acting as moral agents. This process was described by participants as problematic and resulting in professional and personal struggle. Nurses consequentially experience conflict with a number of groups; physicians, the

organisation and its representatives (managers) and other health care professionals (Redman and Fry, 2000).

Conflict may also occur in nurses' perceptions of what is expected from their role. Hyde et al. (2005), in an analysis of nursing documentation in a multisite study undertaken in Ireland over a 5 year period, found that whilst there has been an emphasis in nursing theory on the biography of the individual and the personal experience of illness, there was little evidence in the documentation that nurses practised this; physical aspects of care appeared to take precedence over patient autonomy. It therefore appeared from the nursing documentation that 'biology' took precedence over 'biography'. This would be in line with biomedical approaches to patient care and values that have been informed by medicine and may be in conflict with perceived expectations of caring about, as well as for, the patient.

Peter et al. (2004), in a literature review of empirical studies undertaken between 1993 and 2003, concluded that much of the conflict identified resulted from nurses' perceived moral duty to promote patients' wellbeing. They and others (Storch et al., 2004) suggest that a unique relationship develops between the patient and the nurse but that this can lead to conflict with other health professionals as the nurse assumes the role of advocate, a role that is indicated within The Code (NMC, 2008).

However, some groups of nurses are less able to build on this relationship to assert their views or advocate for their patients. These include junior nurses (Peter et al., 2004) and nurses working in long-term care, (Varcoe et al., 2004). Other participants in Varcoe et al.'s (2004) study described how they chose which conflicts

to address and when not to challenge others; this may be viewed as failing to meet the potential the nurse has in promoting patient well-being.

Oberle and Hughes (2001) recognise that when conflict occurs, resulting from the nurse's inability to influence ethical decision making by doctors, nurses experienced moral distress. They suggest that the differences in nursing and medical values and, consequently, priorities, can explain some of this conflict. Doctors have, in many cases, the responsibility of deciding on treatment regimes and the nurse's responsibility is to deliver care which incorporates these regimens.

Nurses interviewed by Oberle and Hughes (2001) discussed competing values and how these were managed in situations where the patient was unable to speak for themselves. Discussions during the decision making process would include 'what the patient would want'. Conflict between doctors and nurses was described in cases where the doctor or doctors involved thought it best not to fully involve the family who might know the patient's view and values better than the team, with the doctors arguing that the family might not understand the full implications of their decision on the patient. Nurses opposed this paternalistic approach and felt that doctors often acted according to their own values and beliefs rather than respecting those of the patient.

Challenging doctors' orders or other aspects of poor care is something clearly required in The Code (NMC, 2008). However, Oberle and Hughes (2001) suggest that there is some evidence to indicate that the hierarchical structures within the organisations and the roles doctors and nurses take result in each being faced with

different ethical problems in the same circumstances. They therefore ask different questions according to their role rather than there being direct conflict between their values. Thus, it may be that it is the organisational structure and the culture of doctors' authority that place the nurse in a disempowered position when addressing morally challenging situations in practice, resulting in nurses' lack of autonomy in such cases (Liaschenko and Peter, 2004).

Nurses have been found to 'bend' the rules in order to achieve a satisfactory outcome, especially in cases where the organisation is less responsive to the need for flexibility or where there is no clear guidance or policy in place to facilitate decision making in ethically challenging situations (Redman and Fry, 2000). Redman and Fry's literature review highlighted how different types of conflicts are experienced by nurses according to their specific role. All nurses experienced some kind of conflict and 33% experienced moral distress, which they attributed to institutional constraints, making it extremely difficult, and in some cases impossible, to take the 'right' action. This is discussed further in Chapter 7.

Palvish et al. (2011), following a 70 participant descriptive qualitative critical incident study, concluded that the key to addressing ethical dilemmas associated with patient care was early identification of potential problems. It is recognised that this is more likely to occur where patients are particularly vulnerable or have multiple problems. Their results suggest that effective communication mechanisms are essential, as these promote collaboration and avoid underrating the viewpoints of others with whom the moral conflict may arise or has arisen.

Salloch and Breitsameter (2010) examined the moral conflicts in hospice care, by undertaking a qualitative study involving nurse participants in focus group discussions. They identified how nurses recognised external ethical standards and referred to the internal organisational philosophy that each patient should be valued and should not be judged by their decisions or social background. They concluded that this respect for patients' dignity is paramount in ensuring that the 'right' action is taken.

The importance of involving others within decision making is also highlighted in Vandrevalla et al's (2006) study which indicates that involving others brings a range of perspectives, recognising that it is important to involve the doctor whose knowledge and understanding of the patient's physical condition and prognosis are essential. The risks of leaving the decision to the doctor alone were associated with doctors' professional commitment to maintaining life. Furthermore, the close relationship that family members have with each other and with the patient may put them in a good position as they may know the patient's wishes (if the patient does not have capacity). However, this close relationship may also make decision making difficult for them.

Having the opportunity to contribute to the decision making process is particularly important for nurses who are charged with implementing the plan of care (Dierckx de Casterle et al., 2010). Nurse participants involved in Dierckx de Casterle et al.'s study explained the importance of the nurse's voice being heard, as it is the nurse who has a unique relationship with the patient and provides ongoing care, spending a substantial amount of time engaging with the patient, which enables them to

develop an understanding of the patient's views and expectations. Lamb and Savdalis (2011) recognise that collaborative decision making is highly valued in various aspects of patient care and decision making and that care provided for anyone with complex needs has become a multi-disciplinary activity in order to ensure the best available care for patients.

Shared decision making within the health care team, especially between the nurse and doctor, is a key contributor to patient care and is essential if good quality care is to be achieved with ethical decision making being undertaken and negotiated within the team (Botes 2000a; 2000b). Botes opposes a classical rational approach to ethical decision making, suggesting that the use of universal principles embedded in this approach is inadequate and calling for health professionals to interpret the appropriateness of the decisions taken in each individual situation. This interpretation requires moral agency to be undertaken by the health care professionals involved; recognising and respecting the views of all those involved in the negotiation and application of general principles and guidelines. Participants in these discussions must also be aware of their own values and the impact these may have on their contribution (Botes, 2000a; 2000b).

2.4 Conclusion

The themes identified from the literature review are linked, each impacting on and informing the other. Resolution of ethical dilemmas occurs within the context of professional codes and policy directives that govern individual and collective behaviour. Moral distress and the tensions between conflict and collaboration

emerge as consequences of the difficulty nurses [and other health professionals] face in attempting to achieve ethical decision making in practice.

Situations where moral distress is experienced by nurses include where care is perceived to be restricted by national and organisational policy or limited resources and when there is conflict within the health care team (Ulrich et al., 2010). Conflict occurs between nurses and other health care professionals particularly when nurses are not involved in decision making but are required to deliver a plan of care which they feel is unethical. This may be because the care delivered is contrary to the patient's wishes and value system or where treatment appears to be causing pain or prolonging suffering (Corley, 2002). The impact of moral distress for some nurses can result in burn out and moral insensitivity or in the nurse leaving the profession (Corley, 2002; Hardingham, 2004; Ulrich et al., 2010; Palvish et al., 2011). Moral distress has the potential to impact negatively on the standards of care received by patients (Ulrich et al., 2010). Furthermore, the effects may also impact negatively on professional relationships and nurses' personal relationships (Kain, 2007).

Ethical practice amongst nurses is viewed as relational in the shifting context of health care and nursing practice (Varcoe et al., 2004). Conflict of values may occur with patients, peers and managers, causing moral distress and challenge to nurses' ethical decision making (Corley et al., 2002). Effective communication is essential if solutions are to be found and appropriate decisions made in relation to ethical dilemmas that arise within a patient's plan of care (Palvish et al., 2011).

The Code (NMC, 2008) indicates that nurses must 'Make the care of people your first concern, treating them as individuals and respecting their dignity' (page 3) and 'Provide a high standard of practice and care at all times' (page 6). This indicates that nurses have a professional duty to engage in ethical decision making. Thus, codes of ethics for nurses attempt to provide the basis of professional and ethical practice. Critical discussions of prior research presented in this chapter support the argument that although these codes may appear to be the cornerstone of ethical practice they appear to provide little guidance for individual ethical dilemmas. However, Banks (2003) indicates that this approach facilitates the nurse as moral agent to make decisions based on principles rather than fixed directives.

Standards of care and ethics are viewed by Palvish et al. (2011) as inseparable, therefore, when minimum standards of care are not met, 'ethical concerns' arise. These authors go on to suggest that 'ethical concerns' are thought to be increased when a patient is particularly vulnerable and has multiple diagnoses and, in this context, nurses are both willing and able to contribute to ethical decision-making. Since the introduction of Project 2000, nurses have been educated in ethics and critical thinking skills to support the application of ethical principles, therefore acting as moral agents rather than applying strict rules (Varcoe et al., 2004).

Nurses' ability to influence policy and treatment regimens for patients when ethical dilemmas occur in practice may be affected by professional and organisational hierarchical structures. It may therefore be that nurses are inclined to make decisions based on convention and policy, (Dierckx de Casterle, et al., 2010).

Corley (2002), however, indicates that some nurses 'bend' the rules to promote patient wellbeing.

Nurses are frequently faced with ethical dilemmas in practice, however they may experience moral distress which can remain unresolved when they feel excluded from the decision making process and are uncomfortable with the outcome. The conflict that occurs is predominately between doctor and nurse, however organisational policy and the lack of resources also have an impact on standards of care and on nursing decision-making.

2.5 The aim of the study

In Chapter 1 this thesis set out to identify the values, beliefs and contextual influences that inform decision making and the contribution made by registered nurses in achieving the resolution of ethical dilemmas in nursing practice.

In Chapter 1 a theoretical framework was introduced that set out a staged approach to ethical decision making the nurse through from moral reasoning to action. This chapter has developed the context in which the theoretical framework may be applied, identifying, through the literature, professional codes and policy as well as moral distress, conflict and collaboration. There appears to be a lack of clarity regarding ethical decision making within the context of secondary care nursing practice and the need for greater understanding of the concept of moral distress within nursing. The aim and objectives of the study are therefore confirmed as:

Aim of the study:

To identify the values, beliefs and contextual influences that inform decision making and the contribution made by registered nurses in achieving the resolution of ethical dilemmas in nursing practice.

Objectives

1. Identify underpinning values and beliefs which impact on nurses' ethical decision making and moral action.
2. Critically discuss new themes which are generated from the data in the light of current literature.
3. Identify the contextual influences which impact on nurses' ethical decision making and moral action.
4. Discuss the implications of the study findings for future nursing practice.

Chapter 3 – Study Design

3.0 Study design/ Methodological justification

Qualitative exploratory research was considered the most appropriate approach for this study. A descriptive approach might result in describing the phenomena of interest and this provides the initial justification for the approach to methods within this study. However, in order to understand the full nature of the phenomena within the identified context, a broad exploratory approach was taken, encompassing tenets of an interpretative approach to data collection and analysis. (Denzin and Lincoln, 2003; Parahoo, 2006; Polit and Beck, 2008). Those tenets did not encompass issues of saturation and, therefore, sampling was not based on this and was more consistent with, for example, a 'descriptive phenomenological' methodology (Colaizzi, 1973; Mason, 2010). The processes of data analysis in this study were designed to facilitate comprehensive interpretation of the data. It was considered that selecting a single approach might result in excluding certain aspects from the analysis and interpretations (Morse and Chung, 2003). By using a flexible approach it was envisaged that the process of analysis used would facilitate interpretations that brought understanding, not only of what nurses do when addressing ethical dilemmas but why they act in this way, what it is that informs their reasoning and decision making (Denzin and Lincoln, 2008).

3.1 Data collection

Following a pilot study to determine the most appropriate data collection method, it was decided that the main study would utilise semi-structured interviews of a purposively selected sample, based on the population sampling strategy outlined later in this chapter (Gerrish and Lacey, 2006; Polit and Beck, 2008; Burns and

Grove, 2009). Field notes made during and following interviews would be used as additional data (Polit and Beck, 2008).

3.2 Pilot study

The pilot study was undertaken from January 2009 to September 2009. The findings of this resulted in some changes to the original project design and the guiding questions developed for data collection.

The pilot study was used to evaluate the selected data collection method and to check that the selected approach would result in the collection of appropriate data to inform the study (Silverman, 2010). This was a small pilot study as the nature of this project was time and resource limited. Once sufficient data had been collected to indicate any changes required in the approach and provide some indication as to the availability of data, the pilot study was concluded (Parahoo, 2006; Polit and Beck, 2008; Bowling, 2009; Burns and Grove, 2009). Three participants were involved in the pilot study. The pilot study interviews were completed using guiding questions, which were consequently amended. Flexibility regarding how to use and phrase these guiding questions varied as the focus was driven by the participant (Polit and Beck, 2008; Burns and Grove, 2009; Hennick et al., 2011). This was important as one aim of the study was to understand not only what nurses do in relation to ethical dilemmas but what it is that informs these actions or contributions.

3.2a Pilot study: Ethical approval

Ethical approval was granted by the School of Human and Health Sciences Research Ethics Panel and the Head of Department where the pilot study was

conducted. This provided access to employees within a specific academic department and facilitated the evaluation of the data collection methods. All participants were provided with the information required to gain informed consent. All data was anonymised and stored securely. It is important that where live participants are involved, informed consent is sought and confidential data is treated in line with the Data Protection Act 1998.

3.2b Pilot study: Participant recruitment

Pilot study participants were recruited from registered nurses working as lecturers within nurse education. It was important that pilot participants reflected the target population for the main study (Hennick et.al., 2011) therefore a purposive targeted approach was used. Three participants with recent experience as nurses within secondary care provision were specifically recruited.

Sample frame for the pilot study:

- Registered nurse on the NMC register.
- Have worked within the secondary care provision.
- Recruited voluntarily
- Able to provide informed consent.
- Available to participate within the specified time frame.

3.2c Pilot study: Data collection

Audio recording of semi structured interviews was used; this allowed the participant the freedom to tell their personal story within the context of their practice. It also facilitated the capturing of the full extent of their experience (Holloway and

Freshwater, 2007; Silverman, 2010). The length and direction of the interview remained participant driven; the guiding questions and prompts were only used when participants required encouragement to further explore their experiences. Each interview lasted between 30 and 45 minutes (Polit and Beck, 2008).

Guiding questions used for the pilot:

1. Can you tell me about an ethical dilemma you have faced in your recent clinical practice?
2. What exactly happened?
3. What did you do?
4. How did this make you feel?

Whilst undertaking the pilot study it became clear that this provided an opportunity for the researcher to develop interview skills, becoming familiar and more comfortable with the situation and process (Silverman, 2010). Having undertaken the pilot study researcher confidence was increased and strategies were developed to ensure participants felt comfortable (Silverman, 2010).

Data collection was conducted after obtaining informed consent. The interviews were conducted in a private office away from any interruptions. Participants were given the participant information sheet (see Appendix 4) and provided with time and opportunity to ask questions and discuss any concerns they might have prior to signing the consent form (see Appendix 5). Participants were advised that they might withdraw from the study at any time and if they wished recording to stop at any

stage in the interview they should just indicate this. All participants had access to university counselling services should this have been required.

Field notes and personal reflections were undertaken by the researcher to inform the development of the research skills associated with data collection and analysis (Holloway, 2005).

3.2d Pilot study: Data analysis

Initial descriptive data analysis of the pilot study interviews identified the broad themes detailed below. Interactional dimensions within the accounts were also identified. These were explored further within the main study.

In order to facilitate data analysis a verbatim transcript was made. The transcript was presented to the participant to ensure this was a true reflection of their personal experience. Once agreed, the thematic analysis and interactional analysis were undertaken, supported by the use of Nvivo 8 software package.

Analysis was undertaken by the primary researcher, which involved verbatim transcription in the first instance. Though this was time consuming the decision to undertake this was made as it provided an opportunity to become familiar with the data and begin analysis.

Thematic analysis was used initially as this breaks the data into separate components, facilitating comparison between transcripts and the identification of any emerging common themes (Polit and Beck, 2008). Dismantling of the data is the first

stage of analysis followed by reassembling of the themes resulting in the interpretation of the data (Hennick et al., 2011). In this case the researcher had experience of ethical dilemma resolution in this context which might have influenced the interpretation of data. Some of the findings within the pilot study did not match fully with this experience although they did reflect some previously observed incidences.

3.2e Pilot study: Findings

The main themes that emerged from the pilot data were:

1. To do 'what was best for the patient' appears to be at the forefront of the decision making process.
2. All the accounts identified autonomous decision-making.
3. There was an acknowledgment of accountability by each of the participants.

Interactional aspects included:

1. Engaging with others to find a resolution.
2. All participants acknowledged that these decisions had an impact on others, which also needed to be considered.
3. Whilst the participants acknowledged the importance of collaborative working, there appeared to be a belief that 'management', or 'the powers that be', placed constraints on their practice through policy,.

Recommendations:

1. Guiding questions required reviewing and further development

2. To continue with the main study as described above.

3.3 The Study

The study was undertaken in a single NHS Trust across two sites. This provided access to nurses working in a variety of roles, with a range of experience and levels of responsibility, within secondary care provision.

3.3a Population

In this case the total population was all registered nurses, from all fields of nursing, working within the United Kingdom within the context of secondary care provision. The Nursing and Midwifery Council in 2010 had 676,547 nurses on the register (NMC, 2010b). Nurses work in primary care, secondary care and in associated fields such as education and management. The target population was those registered nurses working in a single acute NHS Trust, which is referred to as The Trust throughout this paper, from which the sample population was drawn (Gerrish and Lacey, 2006).

3.3b Sampling strategy

Inclusion criteria

- Registered nurse on the NMC register.
- Working within secondary care provision.
- Recruited voluntarily.
- Able to provide informed consent.
- Available to participate within the specified time frame.

Purposive sampling was used to recruit the participants. It was important to ensure that there was the potential to recruit participants with a range of diverse experiences to facilitate conceptual generalisation and to strengthen the validity of the study (Gerrish and Lacey, 2006). In total, including the pilot and main study 11 participants were recruited.

Given the broad nature of the approach in this study, and that there is a longitudinal, equivocal debate in the literature of the notion of an appropriate sample range, depth and size in qualitative research, it is considered pertinent to briefly critically discuss this aspect of the design (Sandelowski 1995; Marshall 1996; Curtis et al., 2000; Mason, 2010). Much has been written on the subject of sample size in qualitative research studies, with little consensus as to whether it is an appropriate discussion per se, what constitutes a 'size, or indeed what that 'size' might mean (Curtis et al., 2000). Sandelowski (1995) has discussed that sample size may well indeed be important in qualitative research, however he also states that it rests within the area of researcher judgement and experience, the particulars of an individually designed study and the depth of the data to be collected. Authors have also attempted to provide guides as to appropriate sample sizes against particular approaches with, for example, phenomenology indicating a size of anywhere between 5 and 25 (Creswell, 1998; Mason, 2010). What is argued here, within the justified, broad exploratory approach to this study, is that the important drivers for the purposive sampling procedure detailed in this chapter were the ranges of experience, perception and depth of individual narratives rather than notions of saturation or a 'pseudo-scientific' application of 'representativeness'.

3.3c Recruitment

The planned process of recruitment was followed from within The Trust. In the first instance clinical area managers were approached in writing, including a copy of the participant information. The aim was to gain permission to visit the clinical area to talk to registered nurses who might consider participating in the study. After several meetings to introduce the study to prospective participants a number of volunteers were identified.

Participants were recruited from a variety of areas within The Trust, which included general medicine, vascular surgery, general surgery, intensive care, care of the older person and children's services. The participants had a range of professional backgrounds and experience. Some trained and worked in a single Trust, others had worked in a variety of Trusts, potentially giving them broader and different perspectives. Experience ranged from 2 years to 40 years. The sample consisted of Staff Nurses, Junior Charge Nurses and Senior Charge Nurses, all of whom worked clinically. All but one of the participants was female.

Whilst the sample frame above provided some level of purposive sampling, this did not include precise selection in relation to educational background or experience.

Participants recruited were initially assigned a code then for the purposes of presenting the findings, a pseudonym.

Table 1: Participant Profile

Participant code	Practice area	Experience	Pseudonym
P01	Medicine for the older person / acute assessment	Charge Nurse 30 years experience	Sam
P02	Medicine for the older person / acute assessment	Deputy Charge Nurse 2.5 years experience	Chris
P03	Children's Services	Charge Nurse 40 years experience	Ashley
P04	Surgery	Staff Nurse 30 years experience	Charlie
P05	Surgery	Charge Nurse 20 years experience	Brooke
P06	Surgery	Staff Nurse 2 years experience	Jordan
P07	Surgery	Staff Nurse 9 years experience	Jo
P08	Intensive care unit	Charge Nurse 10 years experience	Nicky
P09	Rehabilitation	Staff Nurse 25 years experience	Lee
P10	Acute medicine	Staff Nurse 18 years experience	Drew
P11	Care of the older person	Charge Nurse 26 years experience	Ross

3.3d Ethical considerations

As this research involved interviewing live participants and the discussion of sensitive situations relating to National Health Service patients and other National Health Service staff, it was important that appropriate ethical approval was obtained (Polit and Beck, 2008). Ethical approval from the National Research Ethics Committee and the School of Human and Health Sciences Research Ethics Panel was granted. A letter of access was provided by The Trust Research and Development Unit.

Participants were fully informed of the purpose of the study and provided with information about this prior to consenting to participate (see Appendix 6). Written informed consent was obtained from the participants prior to the interview commencing (see Appendix 7) (King and Horrocks, 2010).

One volunteer chose to withdraw following the commencement of the interview as she felt that it was difficult to discuss some of the decisions in which she was involved; this individual had approximately four years practice and worked in acute settings prior to the situation in which she was employed at the time of the interview..

All data collected was treated confidentially; each participant was allocated a reference number and all personal data kept separate from the collected audio recording and transcription. All recording and transcription files were password protected. All printed transcriptions and consent forms were stored in a locked cabinet on the University of Huddersfield premises, in a location that had restricted access.

The Trust's staff counselling service was accessible for any participant who might have experienced psychological or emotional distress following the interview. An attempt to minimise this risk was made by asking participants to identify the experiences they wished to share and discouraging them from sharing anything they were uncomfortable with. None of the participants reported having suffered any psychological distress from participating in the study.

3.3e Data collection

Data were collected from registered nurses currently practising in the context of secondary care, recruited from The Trust. There were a variety of data collection approaches available within the qualitative paradigm. The aim of these approaches is to access the rich source of data required to explore qualitative issues; these include individual perspectives and experiences (Grbich, 1999; Denzin and Lincoln, 2003; Parahoo, 2006; Polit and Beck, 2008; Bowling, 2009; Burns and Grove, 2009).

Semi structured interviews were used to capture the nurses' experience, told in their own words from a personal perspective. This was particularly useful here as this type of data provided insight into the participants' perspectives about the 'why and how' within a situation (Gerrish and Lacey, 2006; Bowling, 2009). Interviews of this nature, however, can be time consuming to undertake and to analyse (Polit and Beck, 2008; Burns and Grove, 2009). A time consuming aspect of this approach was not only the interview; on occasions more than one visit to the practice setting was required as the demands of the clinical environment can quickly change and

where an acute situation had arisen a new appointment was made to ensure that the research process did not impact negatively on service provision and patient care.

The interview process provided the opportunity to build rapport with the participant and so encourage the participant to disclose more about their experiences (King and Horrocks, 2011). Participants were put at their ease. To help achieve this the interviews undertaken were performed face to face and followed an informal path, using guiding questions to provide the interviewer with tools with which to support an engagement of conversation between participant and interviewer (Polit and Beck, 2008; Burns and Grove, 2009). Efforts were made to keep the interview process participant led, as it was important that the data collected reflected the participants' perspectives. This provided participants with the freedom to explore and focus on issues which were of importance to them within the experience they had chosen to discuss. The aim was to capture the participants' personal experiences, their interpretation of those experiences and to identify the meaning the participants had attached to the personal experiences discussed (Holloway, 2005; Gerrish and Lacey, 2006; Parahoo, 2006).

The very first stages of data analysis began during the interview, with the very first interview indicating some of the themes to be explored (Hennick et al., 2011).

The physical environment is also important when undertaking interviews. The participant and interviewer should feel physically and psychologically comfortable. If the participant feels uncomfortable this may result in limited responses to the interview questions (King and Horrocks, 2011). Interruptions and disturbances can

also result in limited data collection as the participant may lose their train of thought, as might the interviewer. It is important to ensure that sufficient time is available to put the participant at ease, obtain informed consent and allow for the participant's questions prior to commencing the interview and for possible discussion following the interview (King and Horrocks, 2011). Therefore, one and a half hours were allowed for the whole process.

In this instance participants were interviewed in their place of work as this was most convenient for them. A quiet place was identified and a 'Please do not disturb' notice was situated on the door to the room. Some instances of disturbance did occur but only when the participant was needed to attend to patient matters urgently. When working with registered nurses who have a responsibility for patient care this may be an issue, however it was acknowledged at the beginning of each interview as unavoidable.

Guiding questions used for the main study

Once the pilot study interviews were completed and the pilot data analysed, the guiding questions were amended to include further probing questions. These questions were used flexibly according to how the interview was progressing and to maintain a participant centered approach, ensuring that the content was driven by the participant (Gerrish and Lacey, 2006).

Following the use of an opening question about the participant's background and experience as a registered nurse, which was designed to help them become more

relaxed with the interview process, the following introductory open question was used.

‘Can you tell me about an ethical dilemma you have faced in your recent clinical practice, within the last three years?’

Once the participant had begun to share their experience the following questions were used as required:

1. What exactly happened?
2. How did this make you feel?
 - Why do you think you felt this way?
3. What did you do?
4. What made you act the way you did?
5. What was the final outcome?
 - Were you happy with this?

3.3f Data analysis

This research falls within the interpretive paradigm as described by Hennick et al. (2011) as the ethical dilemmas discussed occurred within the context of nursing practice which has a professional, cultural and personal dimension. The process of analysis was undertaken as planned, following verbatim transcription of the recorded narrative. The transcribed documents were repeatedly read whilst listening to the audio recordings. This was undertaken firstly to correct any transcription errors which may have occurred and secondly to ensure familiarity with the data collected. The aim of analysis in qualitative research is to repeatedly scrutinise the data to

identify meaning and bring understanding so as to recognise emerging themes and theory (Polit and Beck, 2008). Listening to the transcripts ensured that emphasis and indications of any emotion or uncertainty were appreciated and acknowledged in the analysis of the data collected (Hennick et al., 2011). The transcribed documents were then imported into Nvivo 8 for analysis.

Computerised software selection

The software was used for coding data according to emergent themes and retrieval of coded sections. Theory construction was undertaken through critical analysis undertaken by the researcher. There are benefits and disadvantages which needed to be considered when deciding to use computerised software to support the analysis of qualitative data (Polit and Beck, 2008; Riessman, 2008). Computerised software can be used to support a variety of data formats - written, audio and video data - and may also be used for coding of data during analysis, as it has been within this study. It may also be used to support theory construction (Lewins and Silver, 2007). Conceptualisation of the theoretical framework was not undertaken using computerised software.

Analysis and consequent interpretation of the collected data were undertaken using two recognised approaches:

Thematic analysis

The objective of thematic analysis is to identify themes from within the transcript considering what is being said (rather than to whom it is being said) and the purpose of the engagement, (Riessman, 2008).

Coding themes as they emerge from the data was the approach selected and used in the initial stages of data analysis, providing a description of the situations discussed and the actions taken by the nurses taking part (Silverman, 2010). Analysis involved reading the transcript several times to become familiar with the data and to identify the emergent themes (Polit and Beck, 2008). An inductive approach was undertaken as the data analysis was ongoing whilst data was being collected (Hennick et al., 2011). Themes were named by the researcher to indicate their meaning.

As more data was analysed it became apparent that subthemes could be identified. These are discussed within the results in Chapters 4 to 8. Data collection was concluded after the 11 interviews from the main and pilot studies. Data collected from pilot study participants reflect that collected within the main study. At this point the data collected from participants contained a number of common themes and it was evident that there were sufficient data to address the study aim with some level of confidence. Conducting further interviews may have resulted in redundant data and would have been an inappropriate use of participants' time (Burns and Grove, 2009).

Interactional analysis

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 made (Holloway and Freshwater, 2007).

Content analysis

One ethical dilemma from Charlie's account was selected to be viewed as a whole (see chapter 9) and the process of content analysis was undertaken; this also facilitated the examination of decision making, relationship development and the articulation of the contribution made by Charlie (Holloway and Freshwater, 2007). The accounts provided by the participants help to bring an understanding of the context and to recognise the individuals within each account. These accounts are not simply descriptions; they are filled with emotion, values and interpretation on the part of the participants (Holloway and Freshwater, 2007).

The analysis provided the opportunity to develop an understanding of the whole process and the complexity of the decisions undertaken when addressing ethical dilemmas in nursing practice. In doing so it offers a critical revision of the theoretical framework which is outlined in Chapters 9 and 10. This type of analysis allows for understanding of the participant's view of the incident as a whole (Holloway and Freshwater, 2007) rather than as separate components to be examined individually, as has been undertaken in the thematic analysis.

These accounts have the potential to help recognise the meaning of the routine activities undertaken, for the participant as much as for the researcher (Holloway and Freshwater, 2007). The sharing of an experience can act as a form of reflection, bringing new understandings to previous experiences (Holloway and Freshwater, 2007). This was particularly evident for pilot study participant Ross who stated:

‘Probably it was in hindsight, reflecting on it now which I have not done for a while probably happened correctly.’ Ross

3.3g Validity and reliability

There has been much debate regarding validity and reliability in qualitative work. Some authors prefer the terms credibility and dependability (Denzin and Lincoln, 2003), whilst others argue that the terminology should remain the same, only the processes by which this is judged should differ (Long and Johnson, 2000). The main point is that the research should evidence precautions made to ensure that the research has been rigorously performed.

Key aspects undertaken to increase rigour were:

Reflexivity

A reflective diary was kept throughout, which included key decisions; this was used to facilitate reflexivity within this research. Reflexivity within narrative research should be continuous, the researcher reflecting during each stage of the research process (Holloway and Freshwater, 2007). This reflexivity helped to recognise relationships with the participants; in this case some had been students and some worked on areas where the researcher was the educational link with the university, therefore a previous relationship already existed. Also, the recognition of personal responses to some of the incidents discussed generated comparisons with the professional experiences and values of the researcher. The researcher’s own experience had resulted in a limited personal understanding of the contribution nurses make to the addressing of ethical dilemmas in practice and, therefore, care

was taken to recognise this. The researcher's personal experience as a nurse also influenced the aim of the study.

Peer review experts in the field

The results of the study and the transcripts of interviews were discussed within supervisory sessions (Long and Johnson, 2000). Both supervisors were registered nurses and experienced researchers.

The pilot study and provisional findings were presented and discussed at a European Doctorate Students Research Conference. The abstract and a copy of the PowerPoint presentation can be viewed in Appendix 8. This provided the opportunity to discuss key aspects of the study (Long and Johnson, 2000).

The study was reviewed at key progression points through the life of the study, which included the critical review of the study design, data collection and preliminary findings by a group of internal panel members selected by the University of Huddersfield research department. This also provided the opportunity to discuss any amendment that might have contributed to improving rigour (Long and Johnson, 2000).

A keynote presentation was undertaken at the Undergraduate Student Research Conference for the Department of Health Sciences. This was attended by both academic staff and undergraduate students who were given the opportunity to question and discuss the points raised within the presentation. (see Appendix 9).

Aspects of data collection

The sampling frame was designed so that appropriate participants were recruited. The purposive approach helped to ensure the recruitment of participants from a range of backgrounds with differing types and length of experience (Gerrish and Lacey, 2006).

The audio taping of interviews for transcripts was undertaken to ensure accurate records were maintained (Polit and Beck, 2008).

3.4 Summary

In order to address the aims and objectives of the study a qualitative design has been adopted to undertake semi-structured interviews with 11 nurses from a secondary care context. Themes emerging from the analysis will be explored in Chapters 4 -9.

Chapter 4- Results

4.0 Results: Demography and Introduction to Findings

Chapter 4 presents detailed demographic information about the participants who completed the interviews and introduces the initial themes, which are fully critically presented in separate chapters.

4.1 Participant profile

The participant profile summarised in Table 1, Chapter 3, shows that the sample included nurses with a variety of different experiences. The summary does not indicate the participants' educational profile or gender; the reasons for this and the impact this has on the results are discussed further in Chapter 11, Limitations to the study. All but one participant were female; the male participant has not been identified in the Table below to help maintain the anonymity of the participants.

4.2 Results of thematic analysis

As explained in Chapter 3, thematic analysis of the interview transcripts was undertaken followed by theoretical analysis. Prior to analysis all participants were allocated a non-gender specific name. The term `charge nurse` is used for both charge nurses and ward sisters. Where direct quotes from participant transcripts are used they are presented in single spaced italic font with the participant's pseudonym alongside to indicate which account it has been taken from.

Each of the complex accounts contained several key themes and subthemes. These are discussed in detail in Chapters 5 – 8. The themes were developed throughout

the process of analysis. Analysis of the pilot data resulted in a broad number of themes:

- Feeling
- Rationale for decision-making
- Personal Responsibility
- Outcome
- Beliefs and Values
- Problem Identification
- Conflict and Collaboration
- Compromised practice
- Action
- Accountability
- Policy.

Following thematic analysis of all the interview data these initial themes were further developed into themes and sub themes. The main themes and subthemes are listed in Table 2 below.

It was evident from all the accounts that the patients' best interests were at the forefront of nurses' decision making. However, nurses identified that there were constraints on their decision-making and action as they took into account the needs of others. The impact of any decision regarding one patient's best interests on others in their care and issues in relation to national and local policy had the potential to limit resources within the context of their practice.

Table 2: Themes from the thematic analysis

Tree code	Sub code	Final Free codes
Best for the patient	Advocacy. Standards of care	Values Determination
Accountability	Autonomy Duty Actions	Problem identification
Collaboration and conflict	Nurse Manager Doctor Patient. Patient relatives. Other health care professionals	Resources Policy
Concern for others	Nurse Manager Doctor Patient. Patient relatives. Other health care professionals	Professionalism Consequences

Results for each of the main themes are discussed in the sections below:

Best for the patient: (see Chapter 5).

This section includes an examination of participants' accounts where they expressly talked about how they strove to achieve the best outcome for the patient and where they adopted the role of advocate and they explained how they strive to maintain or improve standards of patient care.

Accountability: (see Chapter 6).

Participants' accounts articulated their personal or professional accountability. Although not all participants referred directly to accountability, each participant

expressed a willingness to justify their decision to whoever wished to question or challenge it.

Professionalism was identified as influencing the way in which nurses behave; when participants felt that other nurses had not behaved in a professional manner this was seen as a cause for concern, as discussed by both Sam and Drew in their accounts.

Collaboration and conflict: (see Chapter 7)

Collaboration and conflict were identified within all the participant accounts. This helped to bring understanding to the context within which these nurses work and the importance of the relationships between themselves, the patients and their families and other health care professionals. Nurses' relationships with others appear to have a strong influence on the contribution nurses make to resolving ethical dilemmas.

Concern for others: (see Chapter 8)

Throughout the interviews participants expressed a strong duty of care to their patients. However, the analysis contains evidence that although what is best for the patient is foremost in their minds and decision making, the impact of this on other people, including other patients, patients' families and other health care professionals, is also a consideration.

Charlie's story (see Chapter 9)

This chapter presents on ethical encounter, in context, discussed by Charlie, an experienced staff nurse who was charged with selecting a patient to be transferred to a non-specialist area so that an acutely unwell individual could be admitted to the

specialist ward. In Chapter 9 themes are highlighted and some of the theory underpinning Charlie's decisions and action. The most important aspect of Chapter 9 is, however, to identify and explore where the relationships are developed and how they impact on the nurse's ability to contribute to both ethical decision-making and undertaking moral action. This contributes to a re-conceptualisation of the theoretical framework outlined in Chapter 1.

This chapter has detailed the profile of the participants and initial themes; the following Chapters 5 – 8 present the results of the thematic analysis.

Chapter 5 - Best for the patient

The participants were asked to reflect on an ethical dilemma in practice; all of them explained how the dilemma they were facing impacted on patient care and it was often this that was the driver behind the decision making and actions they took. The interest of patients was an overriding theme and clearly at the forefront of their thinking when faced with ethical dilemmas. The 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, but it's not always the best thing for the patient is it?'

Chris

Ross concluded that :

'I have had a few ethical dilemmas at the end of the day I always considered the patients was uppermost and that justified my position'

Ross

Ross and Chris demonstrated the ways in which all of the participants explained how the principle of 'best for the patient' guided them to advocate for patients and

promote patient autonomy. The next section demonstrates how they understood patient autonomy and how the nurse's role as advocate facilitates achieving what is best for the patient.

5.1. Advocacy

Advocacy influences the standards of care received by individual patients; those who are able to be autonomous can speak for themselves, but where appropriate, an advocate should be identified and empowered to influence decisions making regarding treatment and care (Hawley, 2007). Many of the participants explained how they advocated for patients and promoted patient autonomy.

Advocacy is the support for a person or cause; in this case it is patient advocacy as the nurse supports patients' wishes and assists in self-determination, promoting autonomy (Hyland, 2002). Autonomy is linked to dignity in that the ability to maintain one's dignity is influenced by the amount of power or control one has over the situation (Hyland, 2002). This is not to say that those who lack capacity to make autonomous decisions do not have moral worth [as perceived by another and felt by the individual], as such, they should be treated with dignity (Gallagher, 2004). Advocacy is not, however, a simple process of representing the patient's wishes. The patient's capacity to make decisions and the nurse's role as advocate have to be considered within the nurse's duty of care and the impact the decision and consequential actions may have on others (Hyland, 2002).

Chris's account of a complex discharge home, in which a patient's capacity to make a decision was assessed as a 'best interest decision' (MCA, 2005), illustrates the

nurse's role in advocacy. Chris felt that the patient did have capacity; the family however felt that he did not. Chris, to be sure of the patient's level of capacity and recognising that the family might know the patient better than a nurse did, decided to contact the social work team to assess the patient's capacity.

'People jumping in and making the decision for him, I didn't want that to happen that's why I pushed for a Best Interests Assessment,' Chris

Best Interests decisions have been defined within the Mental Capacity Act (MCA, 2005) as ones which take into account the patient's beliefs and values, if known, and where possible the patient must be encouraged to be involved in the decision making process. The least restrictive option is the preferred option; that which is going to cause least disruption or conflict with the patient's wishes or what his wishes would be if able to engage fully with the decision making process (MCA, 2005). In Chris's account the patient was considered to be vulnerable when in his own home and therefore re-housing was an option he and the health care team could consider. In this situation, the action undertaken by Chris promotes patient autonomy by advocating for the patient, providing information, involving social services and ensuring the patient was aware of the options. Chris ensured the patient was involved in the decision making as far as possible even though the assessment indicated that he did not have capacity to make his decisions independently in this particular situation.

'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

In an examination of the two concepts of, patient autonomy and patient advocacy Hyland (2002) suggests that advocacy is not a role that belongs uniquely to nurses.

It does, however, as demonstrated through the participant accounts, form part of the nurse's role. To advocate for an individual patient in this context includes representing them in case conferences or promoting the patient's autonomy by ensuring they have all the facts and understand the implications of their decisions. Advocating for the patient may include defending a patient's informed decision even where this may appear unwise (Hyland, 2002).

In Chris's account the patient initially wanted to go home, whereas the patient's family and the health care team felt he was vulnerable to abuse from neighbours and local youths, as there had been incidences in the past. By simply accepting the decision Chris might have failed to fulfil the duty of care that nurses and other health care professionals have (Dimond, 2008). Alternatively, as Chris expressed above, it would be equally wrong for others to take all control and make decisions for the patient without his involvement. The conflict between promoting patient autonomy and maintaining patient safety engaged Chris's 'conscience', as going home involved a risk to this patient's welfare and was potentially harmful to him and this raised concerns about his capacity

Although Chris felt the patient had capacity, he recognised that the patient did not fully understand the situation, possible outcomes and what options were available to him. Verkerk (2001) 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 Kingdom (Darzi, 2008). The risk is that those who are most vulnerable or

wary of the health and social care system fail to receive much needed care (Verkerk, 2001).

Duty of care is the duty a nurse has to protect patients from harm and promote independence; patients should be no worse off after receiving nursing care than they were beforehand (Cuthbert and Quallington, 2008). Decisions need to be made on an individual basis dependant on the patient, the situation and the level of risk. The Code (NMC, 2008) requires nurses to advocate for people in their care, supporting them to access information and services, emphasising the importance of respecting their choices and preferences by listening to their concerns (NMC, 2008). Minimising harm and risk are also addressed within The Code (NMC, 2008) requiring nurses to practise using the best available evidence and to report if a patient has been or is at risk of harm.

Chris had clearly listened to the patient and his preferences, identifying that although he appeared to have capacity and though his decisions might have appeared unwise, they were his preferences. Working with the multi disciplinary team and the patient's family, there appeared to be doubt about his capacity; therefore an independent advocate was engaged to support the patient. Collaboration is discussed further in Chapter 7.

Chris recognised personal limitations within this situation and was supporting the patient's rights and respecting the patient's choices, both of which are required of the nurse within The Code (NMC, 2008). The patient's capacity, in this case, to make decisions was compromised and his understanding of the situation was limited.

When fully supported and informed the patient chose to be re-housed, a decision he felt happy with; the risks to him had been reduced through re-housing in a safer locality.

'His daughters were happy, he was happy, I was happy, Social Services were probably happy.'
Chris

Thus, although Chris was initially unhappy with the proposed course of action, the process of negotiation, discussion and assessment of capacity led to a decision that was acceptable to all and, most importantly, respected the patient's right to make his own decision. Advocacy is understood as representing the patient's viewpoint, values and beliefs (Cuthbert and Quallington, 2008).

Advocacy can become more complicated when caring for children. In an account shared by Ashley, a children's nurse, caring for a young teenager, Ashley had to make tough decisions about how to best advocate for a patient. Ashley described how nurses need to balance disclosure, the patient's vulnerability, requests for confidentiality and the risk of jeopardising family relationships (especially the impact this will have on the child) in relation to concern for the child's welfare.

'.....you might talk to the child and try and sort of get them to 'you really need to talk to your mum about it andsometimes it works and sometimes it doesn't..... you have to make that decision, and again it comes with experience and with age.....'
Ashley

In the United Kingdom there is no single piece of legislation that covers child protection so, for any nurse working with children, not only will they need to consider if the decisions are ethically sound but also how the law impacts on this. The main piece of legislation is the Children's Act (1989) which clearly states that the child's welfare is of paramount importance. The Children's Act (1989) recognises that each

case needs to be considered individually with this in mind and to assist understanding it defines both 'harm' and 'significant harm'. The National Society for the Prevention of Cruelty to Children (NSPCC) has produced guidance for those working with children, drawing together all the legislation and guidance in a single document (NSPCC, 2012).

It was evident from Ashley's account that less experienced nurses lacked the confidence to make some of these decisions, whilst still recognising the importance of these issues. When caring for a teenager whose mother appeared to be particularly influencing her daughter, doubts were raised about the possibility that the account provided by the mother had led to unnecessary procedures being undertaken. Less experienced nurses consulted those with more experience:

'younger girls [Nurses] who were working with it found it really difficult. You know, and that's probably why I know about, because they'd come and talk to us, you know the senior staff.'
Ashley

The idea highlighted here by Ashley is that nurses are able to develop the skills required to advocate, especially in complex situations, through clinical experience (Kohnke, 1982).

Care of the dying was identified as another complex area of practice where participants viewed their role as advocate as important and necessary. Both Jo and Charlie identified instances when they attempted to advocate for patients at the end of life. Both explained how the surgical team gave instruction to administer active curative treatment, which was felt by the patients' families and the nurses caring for these patients to be futile. Jo and Charlie expressed the opinion that the care of the dying pathway should be initiated sooner to facilitate a more dignified, peaceful and

pain free death. Jo persisted with attempts to advocate for patients for some time before the care of the dying pathway was commenced.

'called the registrar and the plan was to carry on for a further 24 hours of active treatment and see from there, but as the day went on the patient continued to deteriorate her breathing, more shallow, so what I did was I got a big consultant up who decided that really the patient was for care of the dying pathway, but from start to finish when they start you know.... 7 o'clock in the morning we doing this all the way up to 4 o'clock in the afternoon.' Jo

Field notes indicated that both of these nurses felt passionate regarding the delay in commencing the care of the dying pathway and felt that had this been commenced earlier, the end of life experience for both the patient and family could have been less distressing. This was evident in the way their accounts were articulated.

Also noted was the level of concern that remained with nurse participants in relation to this issue:

'but you know for the patient I thought it wasn't fair on the patient, he should have been with it, I don't think she would have wanted to have all what she had done to her, and her daughter didn't really either. Her daughter was saying 'I just want her to be comfortable' Jo

Charlie agreed when discussing care of the dying patient concluding:

'I just feel that sometimes they're too late, do you know what I mean? And it was awful, the family were there and the man was in pain and we couldn't get on top of him, his chest was poor and we were struggling all day and we gave him everything, and I felt we'd done as much as we could but we were too little, too late.' Charlie

The comments made above by Jo and Charlie reflect the literature reviewed in Chapter 2 concerning moral distress. Nurses here have expressed how they felt about the situation where their preferred course of action was delayed and although they expressed their opinions in relation to patient care, they were still required to continue with active treatment for longer periods of time than they considered to be

appropriate (Oberle and Hughes, 2001; Dierckx de Casterle, et al., 2010; Long-Sutehall et al., 2011).

Participants working in intensive care units identified that the withholding and withdrawing of treatment presents nurses with personal and professional challenges as they strive to advocate for and provide care for the dying patient. Nurses often have to contend with conflict with the doctor who may have a different care philosophy (Halcomb et al., 2004).

When nurses feel they fall short of their responsibilities in advocating for patients and ensuring the best care provided for the patient, residual moral distress may occur (Corley, 2002). Nicky, who was trying to manage the clinical area with limited resources, highlighted the feelings experienced when managers were asking for a nurse to be sent to another area, leaving the unit understaffed.

'I felt like no-one was listening. Like I come on duty and try and you know you're patients advocate.'
Nicky

Nicky's account was full of passion for what was felt to be the right thing to do in order to maintain standards of care and the situation.

'So yes I do feel quite passionate, and that day really brought it home to me how let down I felt by my own workforce as a nursing establishment.'
Nicky

Conflict which occurred in all these cases is discussed in Chapter 7.

5.2. Standards of care

The second subtheme related to 'best for the patient' is standards of care. The importance of maintaining high standards of care, as articulated by participants in

their accounts, is also recognised in the literature. Nurses cannot maintain standards of care alone as they work within the wider context of health and social care (Maben and Griffiths, 2008). Nurses do, however, have a valuable contribution to make (Maben and Griffiths, 2008), and thus collaboration is discussed in more detail in Chapter 7.

Quantitative targets, such as reducing accident and emergency waiting times, treatment waiting times and the reduction of surgical waiting lists (DH, 2000) and treatment time-lines such as those introduced in The Cancer Plan (NHS, 2000) and The National Stroke Strategy (DH, 2005), continue to be important, however, a change of emphasis has occurred following High Quality Care for All (Darzi, 2008).

High Quality Care for All (Darzi, 2008) acknowledges the improvement in waiting times and recommends a focus on quality and the importance of improving standards of care. The importance of high quality care has been further highlighted as one of six principles of the NHS Constitution (DH, 2012); qualitative measures are now recognised as indicators of care standards.

The importance of maintaining standards of care was clearly articulated by all the participants. Charge nurse Sam explained how continued monitoring and support for the development of a particular member of staff was facilitated. This was required as the staff member was not behaving in an appropriately professional manner and not providing the standard of care that was expected by the patients, the Trust and the nurse's colleagues on the ward.

'I was dealing with that on a regular basis. 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 to and that if she had issues with that we could openly discuss them. I 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

Sam's account clearly demonstrates the efforts, energy and emotions that were involved in addressing these problems and supporting the struggling nurse to develop appropriate skills to ensure that standards of care were maintained. The importance of maintaining standards of care in the ward environment remained of utmost importance to Sam. Sam explained what was happening and the concerns that arose:

'There was a lack of professionalism about her, that existed in things, calling people 'chuck' and 'love', and referring to me as 'chuck' and things like that, and then as she gradually settled in during the coming months I'd hear the odd swear word mentioned on the corridor and things like that and a change in the nursing staff.... they behaved much differently around her than they did me,' Sam

Nurses are required to provide a high standard of care, as indicated in The Code (NMC, 2008). 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 and the dilemma I'm under is that pressure and that feeling of constant 'I wonder what she's doing today while I'm not there?', 'has she got this right, do I need to check that?' Sam

Nurses form part of the service delivery team and have a key role to play in ensuring standards of care are maintained and targets achieved (Maben and Griffiths, 2008). This can prove challenging especially when resources are limited (Ulrich et al., 2010). In Jordan's account, the loss of a nurse specialist had led to care standards being under threat and this had led Jordan to begin developing personal skills and ward resources to support patients requiring care on the ward.

'...we've not had the funding to replace her. But apparently there are not many places that have, because me and my colleague are wanting to do some more information for the amputee patients.'
Jordan

Shortages of nursing staff have been identified as one aspect of the secondary care context that causes a significant amount of stress for nurses because of the negative impact this can have on standards of care (Ulrich et al., 2010). Sam explained that developing standards of care for patients is one of the main functions of a charge nurse responsible for clinical care:

'...developing this area for the benefit of the patients and staff until I retire, so you know it isn't one thing.'
Sam

Charge Nurse Brooke described how problems related to pressure area care were highlighted as national standards and local policy led to changes in the classification of wounds. When the number of wounds of a specified classification rose on the ward above what was felt to be acceptable according to Trust policy, remedial measures were then implemented. The nurses on the ward felt this implied that patient care was below the required standard and this impacted negatively on staff morale. The account shows how Brooke worked to balance complying with local policy to reduce the occurrence of pressure ulcers on the ward with ensuring national standards were maintained and recognising the hard work undertaken by the nursing team in order to preserve staff morale.

'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'.

Brooke

Staff morale is linked to standards of care. Where staff shortages have impacted on the standards of care nurses are able to provide it has a negative impact on staff morale (Nolan et al., 1998; Adams and Bond, 2000; Day et al., 2007). Brooke identified how attempts were made to empower staff and to give them a voice, reinforcing the value placed upon their contribution to care, in an attempt to improve staff morale (Faulkner and Laschinger, 2008):

'They did a staff surveymy matron got in contact and said 'we need to send somebody to actually speak to the Chief Executive and she's organising some forums'. And initially I was asked to go but I was teaching (I do like to do a bit of teaching still), so I was actually teaching urology and couldn't go, and so they let me off but asked for staff to go on it, now I've been talking to other sisters on other wards and they're going themselves and I don't think that's the issue, I think it should be the staff members on the ward.'

Brooke

Nicky, an ICU (Intensive Care Unit) Charge Nurse, described how the Charge Nurse makes decisions based on the assessment of the clinical area in order to ensure that the standard of care delivered on the unit is of a high standard, maintaining patient safety. In this case shortages of staff on another unit had resulted in the Matron contacting Nicky and directing one of the staff nurses on ICU to be moved to a ward area where there were insufficient staff:

'I'm not going to do that just because she says so. I'm an individual with a mind of my own and they've put me in a responsible position to stand up and be an advocate for patients and that's what I'm doing.'

Nicky

In this instance Nicky was refusing to move staff to ensure patients on ICU received the standard of care they needed.

Nicky not only relied on professional judgment but justified the decision by referring to national guidelines provided by the National Institute for Health and Clinical Excellence to provide a rationale for the decision. Policy and its impact on nurses' contributions to the resolution of ethical dilemmas will be further discussed in Chapter 7.

Lee described making the decision to keep a frail elderly patient in his current location and administer what Lee described as the 'second choice drug', rather than putting the patient through the stress of travelling in an ambulance to another site.

'My thoughts behind it were I wanted to do what I felt was best for the patient.'
Lee

This had been a difficult decision as Lee had weighed up the benefits and burdens of two courses of action. One option was to administer the 'second choice' drug which might not have been as effective as the one Lee would have preferred to administer, which was not prescribed. The other course of action was to book transport, in this case an ambulance, to take the patient to the main hospital site where the doctor would be able to review the patient's medication and prescribe a drug which could potentially bring more relief than the 'second choice' drug. Neither option was considered to be ideal. When reflecting on this decision and the action taken Lee explained:

'It left me thinking had I done the best for my patient. It left me thinking did I give the patient the best I could have given her'
Lee

Nurses aim to deliver the best possible care and, as explained by Lee, this informs both decision making and the consequential actions.

Jordan, an experienced staff nurse, was concerned about how news was delivered to patients and the information they were given regarding the amputation of lower limbs. Jordan explained how the nurses on the ward were trying to change practice in order to promote patient autonomy, especially when decision making regarding treatment options. Jordan wanted to ensure that patient care was at its best, particularly psychological support, prior to making the decision to proceed with surgery, in adapting to their new body image and changes in their life style.

'You try and talk to the patient you know and explain that things are sort of there to help them if they do go ahead with the amputation and you know if you don't go ahead with the amputation you do realise what's going to happen and sometimes you can't change a patients mind and it's just a case of supporting them through that decision that they have made and trying to make them as comfortable as you can.'

Jordan

There is evidence that nurses strive to achieve high standards of care and feel that it is a priority for them as nurses. There are also numerous policy directives from the Department of Health (DH, 2008; Francis, 2013) and regulations from the Nursing and Midwifery Council which also emphasise the importance of care standards (NMC, 2008). Complaints continue to be received and reports written demonstrating that this is not always the case and, in some instances, patients and their families receive poor treatment from health care professionals and services. For example, the Care and Compassion report (Parliamentary and Health Service Ombudsman, 2011) highlighted ten cases which demonstrated how patients and their families had been let down by health care professionals. The report identified how it is often those patients who are most vulnerable who fail to receive appropriate care (Parliamentary and Health Service Ombudsman, 2011). This may be due to their complex needs,

compromised ability to communicate effectively or poor co-ordination between health care professionals and services.

Issues of poor care standards and failure to respond appropriately have recently been highlighted in the Report of the Mid Staffordshire NHS Foundation Trust.

A Public Inquiry found that failings both of the Mid Staffordshire NHS Foundation Trust as an organisation and of individuals had resulted in unacceptable standards of care for patients within the mid Staffordshire NHS Hospital Trust (Francis, 2013).

For Sam, the complaints received from patients' families and staff on the ward informed the decision to take a more serious approach to managing the nurse who had put standards of care at jeopardy.

'really wrestling with it and found it really quite difficult, but as more time went by situations worsened and worsened and complaints started coming in about her from the staff, complaints started coming in about her from relatives and patients.'
Sam

The complaints were related to standards of care and, despite Sam's best efforts to support the nurse involved to develop her practice to ensure that high quality care was received by patients on the ward, things did not improve. Finally, Sam had no choice but to refer this to a competency assessment and the nurse left the ward.

'Complaints were in relation to either standards of care or attitudes I worked through the complaints and involved her completely with them all the way, interviewed her, lots of denials.....it was just all cover-up really from her point of view, probably that she was panicking as well at that point and all the time right up to the end I supported her and always tried to help her and she'd got no idea whatsoever not one smidgen of an idea of how I felt,'
Sam

Sam's account demonstrates that putting effort into ensuring that the staff and the

team are appropriately skilled and always present themselves in an appropriately professional manner is important, however the patient takes priority and care must not be compromised.

5.3. Conclusion

The theme 'best for the patient' and the subthemes of 'advocacy' and 'standards of care' appear to be one of the most important aspects for nurses when making decisions about patient care and were felt by participants to be paramount when they were confronted with ethical dilemmas. 'Best for the patient' was the first priority every participant referred to in their account. This is also supported by The Code (NMC, 2008) and is also a major theme in the review by Lord Darzi, High Quality care for all, (Darzi, 2008) identifying that the next stage for the National Health Service is to progress from a quantity focused agenda to one which focuses on quality. Chapters 6 to 8 will now explore other themes from the data.

Chapter 6 - Accountability

6.0 Accountability

The participants did not all refer directly to accountability within their accounts. However, when analysing their interview transcripts it was possible to identify that all participants were aware of their accountability. The participants' awareness of accountability as a responsibility that may be punitive or supportive of action sheds further light on factors affecting ethical decision making. Within accountability the sub-category of nurses' autonomy emerged, which is discussed in section 6.1 below.

Two of the participants referred directly to accountability. The type of accountability was not specified by the participants. The incidents discussed fell under several types of accountability: ethical, professional, legal and employment (Caulfield, 2005)

Brooke shared an experience from early practice in which a drug error occurred. In the incident described the error was a prescription error. The prescribing doctor made the error when writing the prescription but only the nurse who administered the drug was held accountable. The drug error was reported, according to The Trust policy, and no harm came to the patient. From Brooke's perspective, the burden of responsibility appeared to fall solely on the nurse. Brooke felt it was unjust that only the nurse involved at the point of administration was held to account for the error:

'I was honest about it, yes, and I actually went through the proper process, but I just felt that the way it was handled was really negative and it was.... and I mean I know we're all accountable, it's accountability and responsibility isn't it? But some other people were responsible I felt.'
Brooke

There are processes which every prescription undergoes before administration, including the writing of the prescription, which is checked and dispensed by a

pharmacist and, on this occasion, the drug was also checked by a second nurse at the point of administration. The dilemma here is who was responsible and that, by holding only the nurse accountable, it felt unjust. Brooke recognised the nurse's accountability. However, Brooke also viewed others within this incident as having some responsibility, as not only did the doctor prescribe an incorrect dose, checks built into the process to reduce the risk of drug errors were undertaken by the pharmacist, who ensured the drug had been prescribed and checked for drug interaction. Each of these individuals belongs to a profession with a code of conduct which indicates their professional accountability for their actions. Accountability and a code of ethics are viewed as hallmarks of a profession (Hood and Leddy, 2006). This experience has influenced the way Brooke manages drug errors within the clinical area. Brooke explained the importance of ensuring that, whilst those who make errors are held to account, 'blaming' one individual is not the best way. Brooke recommended a review of the incident and that measures to reduce the risk of repeated errors should be identified and implemented. The use of professional codes as punitive measures may result in a reluctance to report errors by nursing staff, which may impact on the quality of care. Professional codes should be used to facilitate dialogue and provide a standard to work to (Esterhuizen, 1995). Brooke viewed this as part of the charge nurse's role, as the charge nurse is responsible for maintaining safety and standards of care in the clinical area. Brooke took the welfare of the ward staff seriously; this is explored further in Chapter 8.

Drew also referred directly to accountability in relation to a drug error. In Drew's account the error took place at the point of administration; the nurse who made the error was an agency nurse who did not normally work on the ward in question. The

issue for Drew was not so much the error itself but the way that the nurse who made the error acted subsequently. The agency nurse [who made the drug error] did inform the doctor and the nurse in charge of the ward at that time but refused to inform the patient:

'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 its 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

Drew explained the feelings this evoked:

'Well I felt shocked that she did not feel this was important despite being an experienced nurse even though she was from the agency and her argument was well I am from an agency and it doesn't matter. To me she [the nurse who made the error] is a registered nurse and she is accountable to the patient regardless of where she is practicing umm... So I was very frustrated by the whole thing and worried. I could not understand we had offered support for her and everything, but she seemed to totally disagree that the patient should be informed. I found her response at leaving the ward in ...well I would say it was a strange really. Umm... just to dismiss all her responsibilities having given a patient the wrong drug.'
Drew

Drew felt strongly about nurses' responsibilities and accountability to the patient. In referring to professional accountability Drew emphasised '*as a registered nurse*', indicating that the nurse had failed to fulfil her responsibilities to the patient by explaining that an error had occurred. Drew's conviction to uphold the patient's rights resulted in her fulfilling the responsibilities of the nurse who refused to discuss the error with the patient. Where there is a right, someone, in this case the administering nurse, has a duty to uphold those rights (Beauchamp and Childress, 2001). In Drew's account, for instance, the administering nurse had only partially fulfilled her duties as she had refused to inform the patient of the error. The nurse [who made the error] could be held to account to the patient, for failing to respect her

rights, to the employing organisation, as she has failed to follow The Trust medication error reporting policy fully and to the profession, as The Code (NMC, 2008) specifies that, as a registered nurse, she must be open and honest at all times. A nurse must also protect and promote the health and wellbeing of their patients. In this case the administering nurse who did not fulfil these duties was professionally accountable for her omission (NMC, 2008). Accountability may be viewed as punitive, as indicated above. The negative connotations associated with accountability emerged in the 1930s when fewer nurses worked in private homes and began to work for larger organisations. Nurses began to view the organisation in which they were now employed as accountable and the view that accountability was a disciplinary tool emerged (Hood and Leddy, 2006).

When nurses' actions are placed under scrutiny by the NMC during professional conduct cases it is The Code (NMC, 2008) which is the standard against which a nurse's conduct is judged. Accountability, however, can be empowering, as demonstrated in participants' accounts below.

Alternatively, accountability can be used to motivate. To be accountable can help to promote good practice and motivate good actions, especially where the professional boundaries are blurred (Savage & Moore, 2004). The hierarchical culture within health care can influence the decision making process; whilst it does not relieve the individual of all accountability, the position held within the hierarchy impacts on the influence and authority members of the team have in any given decision making situation (Hood and Leddy, 2006). In Drew's account below the Charge Nurse had instructed Drew to administer sedative medication to an elderly patient. The drug

was prescribed as a 'when required' medication to be administered by a registered nurse when or if the need arose. In this account Drew explained how personal responsibility and professional knowledge informed her decision making and consequential action:

'And I was responsible for looking after the patient, so I decided to make the decision not to give the drugI felt confident at that time I could justify why I was not going to give this patient the drug 'cos I didn't feel this patient needed the drug at that moment in time and that I disagreed with his [the charge nurse] reasoning I suppose if you like of why I should give the drug'. Drew

The Charge Nurse was Drew's line manager; Drew did not follow the instruction but considered her responsibility to the patient and acknowledged her accountability to the patient in declining to administer medication that was felt to be unnecessary based on Drew's own assessment of the situation.

6.1. Autonomy

Examples of nurses undertaking autonomous decisions informed by their own knowledge and understanding of the situation were described by participants. Some of the interview transcripts gave accounts of how some of the decisions made were contradictory to the judgments of other health care professionals, senior nursing staff or The Trust policy in a given situation. In each case the participant understood their rights and responsibility to act with autonomy, was able to justify the rationale for their decision and was happy to be called to account.

Sam was motivated to strive to improve standards of care on the ward by investing time and energy in the professional development of a nurse from the ward team.

'what I did was I'd set some objectives for her as well to improve on two

occasions in one year..... I very much left to do my own thing with her really, everyone was aware, but I knew that Associate Director of Nursing and the Matron trusted me to manage her and that was nice to feel that I could be trusted so I felt it was imperative that I dotted the i's and crossed the t's as I would with any member of staff on the ward going through the same thing,'
Sam

Although Sam explained how the situation was managed, he was required to make decisions about the approach used to support the staff nurse's development and what strategies to use when the situation became unacceptable. Sam felt that the senior nurses, who were also her managers, were supportive of those decisions on the whole, trusting her and respecting her autonomy as a nurse.

Ross, however, did not feel supported when asked to transfer patients into the discharge area to await hospital transport to take them home; this is an area where they are no longer classed as acutely unwell or in need of hospitalisation. When the Bed Manager, whose job it is to ensure patients flow through from accident and emergency or other admission routes swiftly to an appropriate ward base, requested that two patients be transferred to the discharge lounge to await their transport home, Ross did not feel that moving the two patients was appropriate and was able to explain why. Here Ross was demonstrating both an ability to make autonomous decisions and the preparedness to be called to account for decisions and action.

'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

'they could have sent the chief executive on the ward I would have stuck to my guns and did what I thought was best for these patients. And I know that there were two other patients that were in need of a bed but I actually had to look after the

patients that were there then. So, you know, it did make me question, even now, I feel I made the right decision'.
Ross

In charge of the Intensive Care Unit, Nicky explained the role of the senior nurse as advocate and resisted moving a staff nurse; within this account Nicky justified the decision and recorded the rationale for the decision on an incident form. Nicky was fully aware of the nurses' responsibility in relation to patient care and safety on the unit and was ready to be called to account for the decision.

Nicky explained that completing an incident form was in line with The Trust policy which advises that the form be completed whenever a clinical area is thought to be unsafe. Nicky was able to justify the decision and explained:

'I wrote down every single patient on the intensive care, the care they were getting and why they needed one to one nursing. I wrote down about NICE guidelines, quoted NICE guidelines about level 3 patients which are ventilated and should have one nurse, but yes one nurse can look after two high dependency patients but I put down the constraints about how it was very difficult to help each other then, patient moves if somebody became sick, going for blood, things like that and just dealing with the everyday running of the intensive care unit by being a nurse down, and I don't know how far that incident form got, because I later got told along the grape vine that Matron tore it up, our Matron for intensive care and said that there was nothing they could do, we had to staff the overflow ward, there was no-one else could do it, we just have to see the bigger picture'.
Nicky

Nicky presented a rationale for the decision not to move a nurse off the unit. This decision was based on sound knowledge both of the needs of the patients on the unit and the National Institute for Clinical Excellence (NICE) guidelines, which are UK guidelines and thus hold more weight than organisational guidelines in publicly funded UK hospitals (Caulfield, 2005). This indicates that Nicky acknowledged that nurses also are accountable to The Trust (employment accountability) and to those to whom they have a duty of care (professional accountability) should there be

evidence of negligence (legal accountability) and Nicky had to consider the impact on those involved and their intrinsic value as human beings (ethical accountability) (Caulfield, 2005).

Nicky fought hard to maintain safety, was 'over ruled' by a more senior nurse and was left feeling that the vulnerability of the patients on the unit had not been recognised, nor had the senior nurse been prepared to fully consider the rationale for resisting the loss of a nurse from the unit.

'I said 'yes and I've got six ventilated patients and two that aren't, two that are really quite sick still. Who's going to look after these while you take a nurse off me? What if something goes wrong on my shift? Who's going to back me up? This is my shift.' So Matron then got involved and Matron came along and demanded that I send a nurse down to the overflow ward, so I was overruled and I had to send a nurse down to the overflow ward and consequently one nurse had to look after two ventilated patients, one of which was on the haemofiltration machine, which is like the dialysis. And obviously I was in charge of the unit and was looking after a ventilated patient as well, as well as trying to support members of staff and look after the patients'.
Nicky.

Nicky felt that the ability to act autonomously is limited by the position held within the organisation. The position of Charge Nurse did not hold sufficient authority in this context to allow Nicky to act on the judgment made in relation to maintaining the safety of the unit and fulfilling a duty of care to the patients on the unit. However, each individual is responsible for their own actions and escaping accountability by claiming to be acting on the instructions of another is not seen as justifiable reasoning (Ormrod and Barlow, 2011). Applying Ormond and Barlow's (2011) interpretation, Nicky, the nurse manager who instructed the nurse to move to another ward and the nurse who moved to the other ward based on the instruction of the nurse manager were all accountable for their actions. For what each member of the team is accountable will vary depending on the situation and level of authority held

by the individual. In cases where health care staff have acted in accordance with the organisation's policy, the organisation holds some accountability with regard to the outcomes of the applications of these policies (Hood and Leddy, 2006).

Nicky's account demonstrates how accountability influences decision making but it also illustrates the limits of personal autonomy, both with regard to the position held and the context within which the nurse works (Hood and Leddy, 2006). There are incidences when an individual's autonomy is restricted in favour of that of the wider community or society (Caulfield, 2005). It is possible that, in some cases, the nurse's preferred action to achieve the best for a particular patient conflicts with the needs of others, therefore a compromise has to be found. In Nicky's situation the senior nurse had made the decision to reduce the staffing levels on the unit and was therefore accountable for both her decision and the consequences of her actions (Caulfield, 2005).

Accountability and autonomy can be seen to be inseparable; if a person acts autonomously then that person must be accountable for that decision or action (Hood and Leddy, 2006). Where a nurse has a responsibility to the patient which requires autonomous decision making, the nurse may need the authority (or need to take on the authority) to act accordingly (Hood and Leddy, 2006). This is not to imply that nurses are not accountable for omissions where restrictions limit their ability to act autonomously, for example where the nurse has no authority or when availability of resources is limited (NMC, 2008). The nurse must strive to fulfil those responsibilities as far as is possible given any limitations that may occur and needs to demonstrate that everything possible has been undertaken to meet those

responsibilities, including reporting shortcomings to a manager or person in authority (NMC, 2008).

Lee's account demonstrates how the decision to 'bend the rules' can be justified by weighing up the benefits and burdens of each option to inform the decision making process:

'My defence would be that as a nurse my code of conduct and my ethics are that I do the least harm for the patient. And to me in that situation the least harm was leaving the patient where they were in a warm comfortable bed and taking the drugs over the telephone and giving the drugs. opposed to,..... I think, causing great harm and discomfort and distress, which could be quite detrimental when they are very poorly getting cold and uncomfortable banging over bumps in roads and being taken up to [the infirmary]. Where they might have to sit about in A&E for an hour waiting to see a doctor to go down and write up a script and see them. Then wait another hour or two for an ambulance to bump them all the way back again very very late at night'.
Lee

It is evident that Lee knew that the action taken following the weighing of the benefits and burdens of each course of action fell outside of the Trust's usual policy and acknowledged that acting autonomously and outside of the organisation's policy might leave those facilitating this action fully accountable; they would not necessarily be able to look to The Trust for support through vicarious liability. In this case Lee was able to take the preferred course of action only by collaborating with others who had the authority to prescribe the required medication, facilitating Lee's administration of the drugs. Those who collaborated were also accountable for their involvement in this incident (collaboration is discussed further in Chapter 7).

Risk was very much at the forefront of Lee's mind whilst continuing with the chosen course of action. Lee identified how there was an attempt to reduce the risk to the patient.

'... and getting a second colleague to listen to try and minimise harm and risk

umm....But no I knew that you weren't totally removing the risk as opposed to, I think, causing great harm and discomfort and distress, which could be quite detrimental when they are very poorly getting cold and uncomfortable banging over bumps in roads and being taken up to [the infirmary].'
Lee

From these accounts it is possible to see that the nurse participants felt able, if not always empowered, to make autonomous decisions and were prepared to be called to account for their subsequent actions. In these situations the participants felt confident in their knowledge and understanding of the patients' needs and the situation in context. There is also indication that, whilst able to make judgments about the situations described, participants were not always able to act as they wished to. This, for some, resulted in feelings of frustration and of being undervalued and disempowered. This was the case for both Charlie and Jo who explained how, when caring for patients who were terminally ill, they recognised that the appropriate time had come to instigate the care of the dying pathway; the doctor, however, had another view. The doctor in both of these accounts continued with curative treatments for what the participants felt was too long, before commencing palliative care. Both Charlie and Jo expressed that they felt that this had made dying more stressful for both the patients and their families.

Ross, having refused a direct instruction from the bed manager, explained the feelings that this had generated:

'....in a way it gave me numerous feelings because my values and beliefs are that this is somebody that is on a higher grade than me and you should respect them. But I actually could not respect them that they had actually considered doing that to somebody that was dying. And how would they feel if that was their relative or you know. Umm.... So I had sort of mixed feelings. I lost a bit of respect for them that I had had previously. In fact I had lost a lot of respect for them and it gave me, it made me realise that suddenly in the NHS a bed had become a bed and the patients were just missing in the middle of it.'
Ross

Ross felt confident, having assessed it as inappropriate to move patients into a discharge lounge, that it was the right decision for the two patients to stay on the ward in spite of it being in direct conflict with the instructions given by a senior colleague. Ross felt uncomfortable that the situation had arisen and that there appeared to him to be no alternative other than to refuse to comply with the instructions. The fact that 'a nurse' would consider such action as acceptable appeared to make this even more difficult to accept:

'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

Ross indicated, through this account, the importance of values in nursing, the expectation that nurses, for Ross, are expected to be particularly sensitive to the needs of vulnerable people, that the National Health Service is not like other organisations and that the person [patient] should be at the centre of decision making (Benner, 1984; NMC, 2008; DH, 2012).

Nicky demonstrated how important patient safety was to her within her account and was prepared to justify her decisions:

'I'm running intensive care for that shift. I'm put in that position as leader of that shift to make decisions based on what I believe is correct, research based, clinical knowledge, patient safety.....'. Nicky

Nicky also indicated that part of the problem was that the person who was challenging her assessment of safety on the unit was a nurse, indicating that there was an expectation that, as nurses, there ought to have been some shared values and understanding of her assessment of the situation:

'I was in that position and made that decision and it was taken out of my hands because 'it doesn't matter now, we're [matron and the site manager]

overruling you. It doesn't matter that you're in that position, I don't care when you say it's unsafe'.....'.
Nicky

When explaining, in the accounts shared during the interviews, how nursing colleagues did not appear to share their values in relation to direct patient care, their duty of care and professional accountability, Nicky and Ross were passionate; both became animated, in both their verbal and nonverbal communication of the issue, while expressing the level of feeling they had had.

Professional codes of standards / ethics and, in this case, The Code (NMC, 2008) reflect the values of the professional group. Adopting these values forms part of what Benner (1984) describes as socialisation into a profession where these values become internalised by the members. Individuals become socialised into a set of cultural moral values and beliefs through exposure to the group, as these values are transmitted by members of the community and the behaviour of its members (Settelmair and Nigam, 2007).

Here Charlie explained the conversation between himself and the Sister from Radiology; the medical team wanted a scan performed but both nurses felt this was inappropriate and were prepared to advocate to prevent the discomfort the patient might experience. Undertaking the scan would not have changed the treatment plan or outcome for the patient. Both nurses recognised the importance of advocating for the patient, demonstrating their shared values in relation to facilitating a dignified death for this man, as his prognosis had already been established:

'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

This section of Charlie's account provides evidence that, in this case, both Charlie and the radiography Sister had a shared understanding of the patient's situation and opinion of what might be best for the patient.

6.2. Conclusion

Accountability and autonomous decision making were clearly expressed by the study participants. Participants explained how, when faced with difficult ethical dilemmas in practice, they were aware of their accountability. Brooke and Drew both discussed accountability in relation to drug errors, clearly demonstrating both their understanding of accountability and how it applies in a specific situation.

Other participants explained how they were able to make autonomous decisions for which they were happy to be called to account; the level of accountability may be influenced by the context of the decision or action, for example Sam had to manage an underperforming member of staff and, although supported by managers, Sam recognised the level of accountability held personally and professionally

Chris explained that it is part of the nurse's role to advocate for patients and that any decision made with or on behalf of patients must be justified, as nurses are accountable for their actions, including when they advocate or fail to advocate for patients; this is clearly identifiable in The Code (NMC, 2008)

Lee had a difficult time managing a dying patient's discomfort and recognised that

working outside Trust policy left him accountable with no security of vicarious liability from the employing Trust. In this situation Lee was seen to collaborate with colleagues, this is discussed further in Chapter 7.

Ross's experiences when discharging patients also highlight how nurses feel that advocating is an important part of their role and they feel distressed when other nurses do not share their interpretation of the situation and the values that underpin that decision. Nicky resisted moving a nurse in the team to another clinical area, as a personal assessment of the situation identified that this would reduce the staff ratio to an unsafe level, resulting in increased risk to patients on the unit. Nicky's ability to act autonomously was limited by the position held within the organisation and the nurse was moved. It is evident that the participants were not always able to act autonomously and they identified that their autonomy was limited by the position they held within the organisations, Trust policy and the resources available at the time.

How participants have worked within these constraints, collaborating with other nurses and the wider team, is further discussed in Chapter 7.

Chapter 7- Collaboration and Conflict

7.0 Collaboration and Conflict

Collaboration or conflict, in some cases both, appears in most of the accounts described by participants. Nurses do not work in isolation, within the context of secondary care nurses work as part of a multidisciplinary team. How nurses engage with other team members can be seen within these accounts. Within participant accounts, working with various people, including the patient and their family and other health care professionals, leads to situations of collaboration and conflict; the objective, however, continues to be finding the best outcome for the patient. In some accounts, such as Ross's, there was clear conflict; other accounts demonstrated how nurses collaborated with others to achieve what was viewed as the best possible outcome. In Lee's account this included almost colluding with others to work outside Trust policy.

7.1. Collaboration

Charlie effectively summed up the importance of a shared vision and working collaboratively when striving for the best outcome for the patient; here Charlie talked about caring for a patient who was dying and using the care of the dying pathway, in this case the Liverpool Care Pathway (DH, 2009):

'I think we all sing from the same hymn sheet, and I think there are areas where what we do everybody does and yes I think it works. I think we know exactly where we're going. Once we've got that we know we're not giving non-essential medications, we're giving medications to be comfortable with, we're not filling them full of fluids which just you know hang around, we are just making them comfortable, and I think that's really important'.
Charlie

For Charlie, collaboration occurred within the health care team when caring for a patient who was close to death. Charlie's account explained what each member

contributes; the physicians are able to prescribe the appropriate medication to manage the distressing symptoms which can occur when someone is close to death, physiotherapists, when required, can help with breathing difficulties and the family may know the patient's values and wishes as well as the nurses. This approach to end of life care is in line with Department of Health (DH, 2009) and National Health Service standards of care (NHS, 2011) which, Charlie felt, have brought some improvements to end of life care. However, both Charlie and Jo struggled with the reluctance of some doctors to commence the palliative plan of care, resulting in a delay in its implementation.

Chris's account demonstrated how working collaboratively helped to promote the patient's welfare after discharge from hospital. Chris's account moved beyond the health care team to include social services, as the social worker is able to access the resources required to achieve this. Chris explained that the need for social services input had arisen from working closely with the patient and his family:

'It's making that link. 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

Like Chris, Ashley worked with other agencies to ensure the best possible outcome for vulnerable individuals:

'we do have a child protection nurse that's situated on the ward, she's here Monday to Friday, so if I have any issues I go straight to her and she'll tell me whether it needs dealing with or she'll take it on board.....we work with them in that we've probably still got the child, and they take over and sort of, once the child's gone home...'

Ashley

Chris and Ashley's accounts demonstrated how nurses in secondary care pay

attention to patient welfare whilst in hospital and on discharge home. By examining Charlie's account it is possible to see how the transfer of patients within the hospital environment from one ward to another also requires nurses to work collaboratively to ensure continuity of care and the best possible outcome for patients. This is in line with their duty of care as health care professionals to their patients for both their acts and omissions; working collaboratively to plan care to prevent foreseeable harm (Caulfield, 2005; Dimond, 2008). In Charlie's case, lack of continuity of care might have resulted in an increased length of stay in hospital or emotional and psychological distress for the patient. In Chris's case, an unsafe discharge might have resulted in harm to the patient who had been assessed as vulnerable. In the secondary care context Charlie, like Chris, recognised the responsibility of the nurse beyond direct care (Dimond, 2008; 2011).

When the non-availability of beds on the specialist ward resulted in the need to transfer a patient to an alternative ward, it was Charlie's responsibility to decide which patient would be transferred and which would stay. Charlie worked collaboratively with the nursing team on the receiving ward to try to minimise the disruption to the patient's care and try to make his experience of this change and his stay in hospital as comfortable as it could be:

'I related all the history obviously to the other ward, the problems with his son and his home circumstances, the problems we'd had with the pain team was ongoing, and I mean I said to the physios 'can you make sure you go sort of morning and afternoon just so he knows we haven't forgotten him, that he hasn't been sent off somewhere where that's it we're not having anything to do with you any more'.

Charlie

Charlie ensured that the patient's needs were effectively communicated, including his progress and any plans made for discharge. Effective communication is

essential between all members of the team, especially the patient and those delivering direct care, if standards are to be maintained (Finkelman and Kenner, 2010):

'we want it also to be a good experience, you don't want them to think about that experience and think oh it was absolutely dreadful and I never want to go there, we want it to be as good experience as we can, but also I want the staff to know him and know what he's capable of and what they're up against, because I think it's difficult if you get someone who's a complex discharge, you get them from no ward, you get half a handover and then you're sort of thinking well where are we here? How far have we got? Do I need to refer to Social Worker? Has he had a home visit? Has his wheelchair been balanced because he's a bilateral amputee?' Charlie

Working collaboratively, following the loss of the specialist nurse from the team, Jordan set about developing information and support for 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

Interprofessional working is viewed as the way to achieve the best possible patient outcomes in complex situations (Johnson and Webber, 2010). Interprofessional working has been on the United Kingdom government's agenda since the late 1960s, however it gained momentum in the 1980s and by the mid 1990s was central to the National Health Service reform (Torp and Thomas, 2007). The Nursing and Midwifery Council now requires all new nursing programmes to include inter professional learning so that newly qualified registered nurses have the skills to effectively interact with and understand the roles of all the health care professionals (Longley et al., 2007).

Working with other nurses within the immediate ward team is almost a subsection of the above. For example, in addressing issues on the ward associated with the

prevention of pressure ulcers, Brooke, as Charge Nurse, explained how a member of the team was supported to develop a specialist role in order to ensure standards of care were maintained effectively:

'what I've done now is give her that day so she's supernumerary on the ward, so she hasn't particularly lost the office day but she's here doing it and she's doing all the tissue viability teaching on that day and she's doing the intentional rounding with them and she's looking at the paperwork we use and she has chances then to go to the link nurses meetings and any other meetings as well, and I make sure that there's a ward meeting on that particular day so she can do her teaching session as well, so we've actually turned it round and used it to quite a useful thing and it's also giving her a more fulfilled role so it's handing her scope of practice as well, because it's almost like once a month she's doing a specialist nurse role on the ward'.

Brooke

Brooke's approach here was to maintain standards of care by encouraging the nursing team to work together in their management of tissue viability, including the prevention and management of pressure ulcers. Brooke demonstrated the importance of this issue by charging one of the team to take a lead and ensuring there was time for any plans to be implemented. Where there is cohesion within the nursing team, which is likely to have a positive impact on the quality of patient care, nurses are found to have greater job satisfaction (Adams and Bond, 2000). The leadership style here was to lead with rather than lead over (Hood and Leddy, 2006); although the nurse who took responsibility for leading this project was nominated, as such, she did not hold a position of authority over others in the group. Nurses working within secondary care fall into two main types of teams: (1) that of the health care professionals other than nurses and the senior nurse and (2) direct care giving staff, mostly nurses and health care assistants (Cott, 1998). The team referred to within Brooke's account would fall within the second type of team made up of direct care giving nurses.

7.1a Collaboration with Patients and Families

Patients' wishes appear to be at the centre of the way nurses work and this informs their decision making. Participants recognised the contribution patients' families make in promoting this as they often have a greater knowledge and understanding of what the patients want in cases where the patients may not be able to fully engage with decision making themselves.

Ashley explained the importance of trust in the relationships nurses share with their patients. This can be problematic for children's nurses as children are not viewed as having capacity to make their own decisions:

'because we've got the trust of that child, she's trusted us with that information, she doesn't even want us to tell her mum so if we're going to go and tell the authorities.... do you see what I mean?.....Depending on how much time you've got you might talk to the child.....'

Ashley

Ashley explained that it is the time nurses spend with patients, especially with children, that helps to develop good relationships. This helps them understand the patients' wishes and work in collaboration with them and others to achieve the best possible outcome and to avoid conflict. It is the close relationship that nurses have with patients that facilitates a unique perspective that contributes to and influences the decision making associated with patient care (Storch et al., 2004; Lamb et al., 2011).

'the girls [nurses] can get, you know, quite especially on nights, if you've got a teenager you might sit and talk to her for hours'.

Ashley

Jo also identified the importance of developing appropriate relationships with

patients, recognising that this takes time but is necessary to ensure that a proper understanding of the patients' wishes is gained:

'..... we have patients for anything from 3 days to 4 months because sometimes they've social side and we get to know the patient and the family, as daft as it sounds, is sort of like our family and the patients are like our family because you get to know them really well and you get really, really close with them'.

Jo

Chris and Jordan explained the importance of working with patients' families. Chris understood how important this was when resolving issues of patients' vulnerability on discharge from hospital. Chris was able to work with the patient's daughters in finding a solution to his problem and helped them support the patient with the changes he was facing in life:

".....obviously getting his family involved helped a lot....he was, he's really close to his daughters and in fact he was really happy with the outcome as well which made it even better'.

Chris

When developing information and a support plan for patients following lower limb amputation Jordan not only involved other health care professionals but recognised how patients' families could also make a valuable contribution:

'Yes, we're going to get the families involved as well because obviously they need support as well'.

Jordan

It is important that nurses work closely with patients and their families to ensure high quality care and to support patients to stay healthy (DH, 2008, NMC, 2008).

7.1b Collaboration with Doctors

Doctors are also health care professionals and have a long history of working with nurses. The changes that have occurred in the nurse's role and positions held by nurses within the NHS have impacted on the way these two professional groups

build effective relationships (Davies, 2003). The way these two professions work together has the potential to have a significant impact on patient outcomes (Faulkner and Laschinger, 2008). Whilst this section focuses on the collaborative nature of relationships with doctors, it also illustrates how close the relationship between collaboration and conflict can become.

Jo explained that being able to engage assertively with doctors is something that has developed with experience and through the building of effective professional relationships with the medical team:

'I think that's come with getting to know the doctors, more so working over at xxxxxx because you have more time to talk to them there. I got to know the consultants a bit more and you get to know the doctors because they're all on the ward for about 6 months at a time, you get to know them slowly and I think you just get more confident and the more you're qualified and the more experience you get, the more confident you are'. Jo

Jo explained that this can, however, depend on the individual doctor:

'Some of them, there's the odd one or two that think you know 'I'm consultant, I'm the doctor and you're wrong', but usually they're pretty good and they listen to what you think and they'll take on board what you think'. Jo

Jo recognised how when nurses and doctors work together in this way, there is the potential to improve patient care (Faulkner and Laschinger, 2008).

Nicky expected support from the doctors who formed part of the team in the intensive care unit. However, on this occasion the response was less than expected. Nicky was concerned about maintaining safety on the unit and the risk to the patients if staff were moved away. The doctor's opinion was that because it related to nursing staff, it was not an issue in which he wanted to become involved. This was a disappointment for Nicky:

'I felt the other side of the coin was, I spoke to the consultant who was on for the weekend and he wasn't interested. He basically said 'well it's a nursing issue' and I said 'but it's not though is it? Because at the end of the day you're in charge of this unit for a doctor and medical point of view and we haven't got any.... I'm telling you that there's patients who are going to be left unattended and clinically if something goes wrong....' and he just said 'well it's a nursing point of view, what do you want me to do?'. I said 'well, I'd like you to back me up and say actually no you're not taking a nurse' and he wouldn't'.

Nicky

The differences in the roles which can have an impact on the way these two health professionals collaborate were further exacerbated by the organisation's hierarchical structure (Oberle and Hughes, 2001).

Ashley tried hard to help the parents of a child needing life saving surgery to understand why it was essential and to assure them that blood products would not be administered in theatre:

'In the end we had to get a consultant paediatrician and an ENT [ear nose and throat] Consultant to come in, in the night to speak to these parents, because they still wouldn't budge'.

Ashley

Unfortunately, on this occasion the doctor's attempts were unsuccessful and the case was taken to the court of protection. Under the Mental Capacity Act (2005) adults and children who have limited capacity to make autonomous decisions are provided for. Where there is a serious conflict of opinions the court of protection may be accessed in order to make the decision and ensure that the patients are appropriately represented (Dimond, 2008).

Ashley's account explained how the team struggled with a family's decision not to allow a child to undergo surgery, based on the fear that blood products would be given against their wishes and beliefs. At this time the child required surgery to avoid death. The surgeon did not think there would be a need for blood products

and, though the parents had been assured none would be administered, they did not believe this and refused to consent to the surgery.

Ashley explained how the beliefs of the child's parents were so strong that even when their own minister tried to assure them that surgery was the best option for the child, they were not happy:

'I don't know what they call them, for want of a better word – the priest of the Jehovahs Witnesses, they've probably got another name, but whatever they are, they got him in and he actually tried to persuade these parents and I can't remember how it all came about, but in the end they had to.... they took out some kind of legal

Ashley

Having engaged members of the health care team and the family's minister to try and find a resolution which they were happy with whilst trying to save the child's life, Ashley explained that the only option was to go to the court of protection:

'That's right and they overturned the parents and the child went to theatre and was intubated and everything was fine'

Ashley

Ashley felt sad that the parents did not understand. It was not that the health care team were trying to override the family's belief system. The intention was not to give blood. The family did not trust the health care team and continued to refuse to consent to the surgery.

Lee's collaboration with doctors to minimise the harm, in the form of distress and discomfort, resulted in both of these health professionals knowingly working outside Trust policy:

'as a registered nurse, you know absolutely damn fine that you should never take a drug prescription over the telephone. The alternative was to parcel the patient into an ambulance along with the prescription chart have the shipped across 'Town' so a Doctor could write on a prescription chart and look at the patient. And write them up for some drugs and ship them all the way back, but quite often we were

dealing with people who were frail who were older. For people who were elderly it would be really disruptive, dense strokes you know an awful lot of trauma to your patient to do that'.
Lee

Lee, in order to avoid the patient having to be moved to the main site for drugs prescribing, as described above, worked with the doctor who prescribed the drugs verbally over the telephone to two nurses in order for the drug to be administered. Lee's experience indicates that this was the usual custom and practice especially where patients are cared for on peripheral sites, without a duty doctor; it is the ward doctor who will sign the prescription the following morning:

'I even used to think about doctors doing it I mean doctors feel or appear to be quite blasé about it they were quite happy to do it. I used to think how do they feel prescribing a drug for a patient they have never clapped eyes on, how do they know – they are very trusting themselves'.
Lee

These two professionals worked together to achieve what they believed to be best for the patient although they both knew it conflicted with their employing Trust's policy.

7.2 Conflict

Whilst it is possible to identify collaborations, many of these accounts also recognised that developing relationships to aid ethical decision making can lead to conflict with other members of the team, patients and their families.

Doctors and nurses are seen to come into conflict about patient care, including treatment which has traditionally been viewed as the doctor's domain (Oberle and Hughes, 2001). However, nurses are required, through their code of conduct, to challenge doctors' orders where they are perceived to not be the best possible

option (NMC, 2008). Nurses are accountable, as discussed in Chapter 6, for their actions regardless of directions given by others (NMC, 2008).

7.2a Conflict with Doctors

Both Charlie and Jo explained how they experienced conflict with the medical team when caring for terminally ill patients. The conflict occurred when they were struggling to influence the doctor's decision regarding the patient's plan of treatment and care. Charlie used strong language to demonstrate the depth of feeling aroused by the decisions that had resulted in the conflict between the plan of care prescribed by the doctor and what Charlie believed to be best for the patient:

feel that you know we should have dignity in death and I don't always think we do and I don't think that's a nursing fault, I think it's a doctors fault, I think our surgeons think if they can save life if someone has a pulse then they're alive and there's no quality'.
Charlie

Jo had similar issues in relation to the care of the dying and explained how attempts to work with doctors and influence changes to the plan of care were not always successful, resulting in conflict. Jo explained why, as the nurse caring for this particular patient, it was felt that commencing the patient on the care of the dying pathway earlier would have been better than the decision taken by the doctor to keep trying curative treatment for longer:

'Yes, and I just think she just needed to be comfortable and you know spend her time with her family. We had to keep pulling the family out of the room to do all these tests and you know they needed to spend the last couple of hours with their mum. I just thought....you know it was unfair, on the relatives and on the patient'.
Jo

Historically nurses' roles were viewed in terms of supporting the work of doctors and following doctors' orders (Pugh, 1944). Substantial changes have occurred over the

decades. Nurses are now required to challenge doctors' orders (NMC, 2008) where appropriate; they are accountable for their actions and following the instructions of others does not relieve them of their accountability (NMC, 2008).

7.2b. Conflict with Patient and Family

Conflict can occur, however, when patients' or their families' expectations are not realistic:

'because sometimes you get families that you know might not be that bothered and they're just like 'well we want this', sometimes if you say it's a DNAR for instance, the family says 'well I don't want a DNAR', unfortunately it's up to the doctor, the family can't decide. Now they'll discuss it with them but if they think it's in the patient's best interest then they'll do it even if the family kick up a fuss and say 'we don't want it, or we do want it', the doctors have overall.... you know they can decide overall, not the family'.
Jo

There are a number of reasons why this occurs. Firstly, in some cases the treatment would be futile and therefore be an unjustifiable use of resources (Beauchamp and Childress, 2001). Secondly it is important to consider the patient who may be receiving futile treatment, as this has the potential to cause harm through stress and may give the patient or family false hope and unrealistic expectations (Hurst et al., 2005; Clará et al., 2006; Gallagher, 2010).

Jo explained how, when treatment options are at the health care team's disposal, they may not be made available, for example, attempts to resuscitate:

'they [doctors] do discuss it with patients if you know they understand, and to be honest with you the patients usually do understand and they're quite happy for that and a lot of patients actually say 'if anything happens I don't want any resuscitation'.
Jo

Ashely explained in depth how complex and distressing decision making can become when there is conflict between the health care team, of which the nurse is a member, and the family of a child in their care:

‘.....she was only 3 or 4 I think and she had tonsillitis, and during the night she got worse and worse and when we looked her tonsils were practically meeting in the middle, to the extent that she needed to go to theatre to be intubated, which you would think would be fairly straight forward except her parents were Jehovahs Witnesses, and they wouldn't let her go to theatre in case we gave her a blood transfusion. We explained that there was no way she was going to have a blood transfusion but they still wouldn't, and we spent a lot of time trying to persuade these parents, and they wouldn't be moved,.....but at this point we're responsible for the child... ‘
Ashley

Finally, things went to the court of protection:

‘.....they overturned the parents and the child went to theatre and was intubated and everything was fine, but apparently they had an older child who had been to theatre and had a blood transfusion, and that was why they felt so strongly about it, but I mean the doctors were prepared to swear in a court that they weren't going to give this child a transfusion’.
Ashley

Throughout this Ashley was still able to empathise with the parents' anxiety and respect that this was their belief, recognising the conflict:

'We explained that there was no way she was going to have a blood transfusion, which you know is fine, it's their beliefas a mother I can't agree, as a nurse I can't agree and as a catholic I can't agree',
Ashley

Ashley's account was filled with understanding for the family but concern for the child in the situation and real concern for the child's life. She demonstrated how strongly she felt, drawing together roles as 'mother' 'nurse' and 'catholic', thus illustrating the way in which her decision making was influenced in different ways. The family's beliefs were recognised but these were in conflict with Ashley's and those of the team and what was felt by the team should be done in the best interests of the child. This included their duty of care to the child as the first concern and respecting that

child as an individual with rights separate to those of the parents, although she had not reached the age at which capacity to consent is formally recognised.

The Mental Capacity Act (2005) has laid down guidance and regulations for those adults without capacity to make a decision in a particular situation, however, for children it is more complex and may involve several agencies. Decision making where there is conflict regarding the treatment of a child can involve a wide number of agencies as well as the child, the family and the health care team. Decisions should be made collectively and Gillick competence and Fazor's Law (Payne, 2008) are used to help determine the 'right' action. In the situation above things went to the court of protection for a final decision as the situation could not be resolved any other way.

7.2c Conflict with Nurse Managers

For the participants interviewed within this study it was this conflict that appeared to have the biggest impact on both the care delivered and the nurse participants, as they appeared to believe that, as nurses, these managers should have a shared understanding of the dilemma and should share the values that informed the participants' decisions.

Drew explained how a direct instruction from an immediate line manager was felt to be inappropriate and therefore Drew did not undertake the task as instructed:

'I was asked would I give a drug to a patient by my line manager and I didn't feel that the patient should have the drug'.
Drew

This was not an easy thing for Drew:

*'But I felt a bit threatened by my manager because he kept advising me that I should give this drug to calm the patient down so that the patient didn't climb out of bed because the patient was confused umm... and the patient had cot sides up....
.....So at the time I felt under pressure because this person was my boss and I was a very junior staff nurse Ummm.... And he was ordering me to give this drug in front of other people such as some of the medics that happened to be around the ward at the time and umm...'*
Drew

Following instruction from a nurse manager Ross explained the feelings caused by refusing to follow instructions:

'although because at one time we were equals she was now actually yes she was bed manager but she was a higher grade than me as well so umm... in a way it gave me numerous feelings because one my values and beliefs are that this is somebody that is on a higher grade than me and you should respect them. But I actually could not respect'
Ross

Nurses' roles may vary according to their position within the organisation, however, all have responsibilities to ensure that high standards of care are maintained (NMC, 2008). The context within which nurses work can have a limiting impact on the care delivered as resources may be limited (Oberle and Hughes, 2001; Colebatch, 2009). A common example identified in the literature, within the context of limited resources, is the pressure on bed occupancy within NHS Trusts (Oberle and Hughes, 2001; Sinuff et al., 2004). This is supported by the National Audit Office (NAO) who have reported that emergency department hospital attendances have risen 47% over the last 15 years with more of those attending requiring hospital admission (NAO, 2013). This can lead to conflict manifesting in a resultant ethical dilemma. In Chapter 6 Ross demonstrated her autonomy in a decision not to move two patients from the ward and remained steadfast in refusing to follow the instructions of the bed manager. Despite being pleased to have made the right decision, this did cause conflict:

'I did not care who thought I was wrong at my decision that I made and I did not move either of those two patients. And seriously did not care they could have sent the chief executive on the ward I would have stuck to my guns and did what I thought was best for those patients'
Ross

'Eventually when she rang me again, the bed manager, umm.... I actually told her exactly what I thought umm.... And she just said 'Ok ok, I'm not moving them, but she never came and apologised for the fact that she even contemplated moving them. And I did not hear anything back from anybody'. Ross

Unfortunately for Ross, although the decision made to keep the patients until they were taken home was followed through by her actions, there remained disappointment in the conflict experienced.

Lee's account was less about an individual person but explained how policy which is associated with nursing management as has resulted in the problem. Lee explained that Trust policy may at times be at odds with what the nurse views as a professional obligation, resulting in conflict:

'because of what you have to work with because of the rules and regulations and the policies and everything else so you do feel to be in an ethical dilemma really because you think your professional body and people are saying one thing but in reality your practice are saying you should do another one. Which sounds a bit confused.....I think it is an ethical dilemma if it wasn't maybe it was just a policy issue but ethically I felt pulled I felt I should have been .. and I did not I should have been ringing somebody and starting it out but my gut instinct was to say no because it was going to cause that much fuss and problem because you have worked with the system before'. Lee

Nicky had the same experience when challenging the decision to move a nurse from the intensive care unit. Nicky showed a strong sense of respect for nurse managers and was concerned that by trying to do what was felt to be best for patients in the unit, she was perceived to be obstructive:

'I really felt berated, I really felt like I was just being militant and I was being obstructive and I wasn't, so it was very difficult'. Nicky

Lee recognised that there are a number of things that may impact on what nurses are able to do for patients. These include, in some cases, patients' families, other

health care professionals, Trust policy and the available resources, whilst nurses still strive to do the best for patients:

'quite often we were dealing with people who were frail who were older. For people who were elderly it would be really disruptive, dense strokes you know an awful lot of trauma to your patient to do that. And err for years and years and years we asked our management to sort something better out'. Lee

7.3 Conclusion

Both conflict and collaboration occur when addressing ethical dilemmas in the context of secondary care. In a sense these are two ends of a single continuum; once agreement about a plan of care has been made, collaboration can occur to ensure that this is delivered effectively but conflict can arise when all parties do not agree.

The importance of team and interprofessional decision making to achieve best patient outcomes can be seen throughout participants' accounts and the importance of communicating effectively with everyone involved. Collaborative interprofessional working is essential to ensure high standards of care are delivered where possible, developing shared goals (Botes, 2000a).

Both collaboration and conflict between doctors and nurses in participants' accounts tended to relate to direct patient care, in particular in relation to the care of the dying pathway and when to commence this for patients who appear to be terminally ill. This may be explained by the differences in the perspective of care for nurses and doctors, with doctors' emphasis on treatment and cure (Torjuul and Sørli, 2006). However, the organisation's hierarchical structure may have a greater impact than

the different perspectives doctors and nurses bring to these ethical dilemmas (Oberle and Hughes, 2001).

Collaboration between other health care professionals was also identified as being important if patients were going to receive the best outcomes, both during their hospital stay and after discharge; in some cases specialist services were also involved (DH, 2000).

Collaboration with patients was identified as an essential part of getting the right plan of care in place; the building of effective relationships with patients and their families was viewed as an essential part of achieving this (NMC, 2008).

In extreme circumstances where following policy was viewed to be potentially harmful to the patient, Lee identified how nurses may risk 'bending the rules' to achieve what is seen to be the best for the patient, even when this involves colluding with other health care professionals.

Conflict has been identified within participant transcripts where team members, for a variety of reasons, held different views of what might be the best option. This, in some cases, was differences based on the values and beliefs of team members, including various health care professionals, patients and their families. Conflict may also occur where the first choice of action is obstructed by Trust policy or limited resources. For both Nicky and Ross this caused their distress and disappointment in colleagues who failed to support their preferred course of action. Concern for others,

including colleagues as well as patients and their families, is a feature of the conflict experienced and is the focus of the next chapter

Chapter 8 - Concern for Others

8.0 Concern for Others

Although the dominant theme throughout all the accounts was about striving to do what is best for the patient, including the delivery of high quality care, a smaller but significant theme was that participants also demonstrated concern for others. The concerns expressed were about the other people involved in the dilemma and the impact that any decisions made would have upon them. The following examples demonstrate how far-reaching these concerns were; they went beyond the patient's immediate family to other patients who also use health care facilities and resources and other members of the health care team. Where concerns had been raised that impacted on the health care team, participants' accounts indicated the desire to do the best they could to ensure that team members felt valued and that their best interests were also considered to be important.

Brooke explained how, when the management of pressure ulcer preventions on the ward was under scrutiny, efforts were made to make staff feel valued and maintain staff morale and she saw this as an opportunity for all the staff to improve their knowledge of tissue viability, pressure ulcer prevention, management and the latest guidance from the European Pressure Ulcer Advisory Panel (EPUA), and National Pressure Ulcer Advisory Panel (NPUA) (EPAU and NPUA, 2009; EPAU and NPUA, 2010). Brooke explained the situation and her concerns around staff morale as, at this time, they might have felt under scrutiny. Brooke appointed a nurse to take on the role of tissue viability link nurse and ensured that the nurse was given time during the working week to develop practice on the ward. Brooke was extremely concerned about the morale of all the team members and expressed that it was

important to consider this and to take measures to ensure they did not feel reprimanded but understood that good practice did exist and that the incident would provide further development opportunities:

'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. A variety of leadership styles can be effectively used within health care settings; styles which focus on relationships within the team are seen to produce better outcomes for the nursing workforce (Cummings et al., 2010). These relationships involve the patients themselves as well as other members of the team and the investment that nurse managers put into the relationships they have with their nurses will have a positive impact on the well-being of the nursing workforce and, consequently, outcomes for patients (Cummings et al., 2010):

'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

Brooke explained why effective working relationships throughout the team are so important and how a culture of care can impact on the way people feel:

'I am passionate about my job, my work and my staff and I want to look after them, and I see my role as not only a manager but also pastoral really, I'm looking after their needs as well, and that makes a stronger team and it shows that I care about them, you know within the realms of confidentiality they all come and tell me things that never goes anywhere else except you know in here between them, but also I feel that's the best way of leading people, isn't it? You know leading from the

front and showing that you actually care. I mean they could tell I was actually upset last Monday and I thought that was really touching, and a few came and gave me a hug and I thought 'oh God, that's really lovely'.
Brooke

Brooke showed how important the nursing team are and how, as Charge Nurse, she was concerned about the impact this was having on them and strove to make them feel cared about. This is important as Brooke wanted to maintain staff morale, treating team members with sensitivity to reduce any stress or loss of self esteem amongst staff members. Issues identified in the literature that impact on morale and job satisfaction amongst nurses include increased stress associated with limited resources and time constraints which negatively impacts on work place relationships (Hong et al., 2011). Similar concerns were expressed by Nicky following the request to move staff from the unit, which has been explored in Chapter 6. This had resulted from a shortage of staff which, in turn, had impacted on the relationships with both the doctor who was approached for support and the senior nurse who made the decision to move the nurse from the unit.

Sam's account of trying to resolve issues with a member of the nursing team whose behaviour on the ward fell below the required professional standard also revealed how he was concerned not only for this particular staff member but also for the other staff on whom this situation impacted. Concerns had also been raised about this staff member's competency in relation to caring for the particular types of patient on the ward, having only just joined the ward team. The nurse in question had required redeployment due to changes in service provision within The Trust. As time progressed, regardless of Sam's attempts to support this nurse, standards of care on the ward were being negatively affected as the situation impacted on other staff members, particularly unregistered health care assistants. Sam was using a

relationship focused approach to leadership (Cummings et al., 2010) to try and improve nursing outcomes and patient care.

Recognising the importance of addressing these issues, Sam continued to work with this nurse 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 Nurses) demonstrated a high level of commitment to the ward staff as well as to patients.

Whilst addressing problems and complaints associated with this, Sam continued to invest time and effort in this nurse, trying to facilitate her professional development until there was no option but to take formal procedures:

'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

Sam showed the fundamental value placed upon people. Although Sam recognised that this was a situation where things could not be changed, he continued to try:

'I put my heart and soul into guiding her along really put a lot of effort into working through, checking with her, trying to support her, and feeling a bit sorry for her really at one point because she was under a lot of pressure'. Sam

Following a serious incident Sam recognised this had to be formalised and referred to senior management and the human resources department; he recognised the impact this might have:

'I had to escalate it straight away, and I sat in the office for 20 minutes thinking what do I do here, what do I do here? I knew the consequences once that call was made and that document was filled in..... The seriousness of the incident and what I believed to be the lack of numerous things that led to it that were not done for whatever reason.
Sam

Sam clearly struggled with making this decision because of the consequences that would follow for the nurse. However, in addition to patient care, Sam was also concerned for herself and other staff on the ward:

'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

An unexpected outcome for Sam was that when this member of staff no longer worked on the ward, the team pulled together to ensure good quality care was delivered; this might have been a result of Sam's approach to leadership combined with the team's shared goals, which had not fundamentally changed.

It is evident from Sam's account that, whilst going through the process of providing support, setting targets and identifying areas for improvement with regular review meetings, Sam was concerned not only for that particular nurse. The impact it was having on quality of care on the ward and the impact it was having on the remaining team members were of equal importance. Dilemmas of this kind go beyond direct patient care and those in management positions face different dilemmas to nurses responsible only for direct patient care. Similarity in the approaches taken by nurses can, however, be recognised.

Sam demonstrated that the value placed on the individual is not person specific, she valued and was concerned about all the staff in the team and the patients in their care.

As discussed in Chapter 7, another participant, Lee, had collaborated with the doctors to access the medication required for a particularly frail male 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. Lee also demonstrated concern for all those who were involved in the dilemma, not only the patient, his family and other health professionals, which echoes the values demonstrated by Sam:

'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

Charlie's dilemma was deciding which of the equally dependent patients on the ward would be moved to provide a bed for an 'outlier', Charlie weighed up the impact on each patient and, whilst there was an acknowledgement that transferring the patient identified to move was not ideal, Charlie was also concerned about the patients

waiting to be admitted to the ward. This dilemma forms a detailed case study in Chapter 9, so is not discussed further here.

When managing patient care in the final days and hours of life, 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. Charlie explained how delays in implementing the end of life care pathway (DH, 2009, NHS, 2011) had impacted on the family as well as the patient. Charlie and Jo both recognised this in their individual accounts (see page xx)

8.1 Conclusion

It has become evident that the concern that nurses have for others is far reaching and that, whilst the patient's care and what is perceived to be best for the patient is at the forefront of the decisions, nurses do consider others, recognising the impact on those both directly and indirectly affected by the decisions and actions undertaken by them as part of their professional roles.

As in other themes examined, [best for the patient, autonomy, collaboration and conflict], professional relationships have an impact on what nurses are able to achieve for the patient and others involved. When concerned for staff morale, both Sam and Charlie used a relationship based approach to resolving the dilemma, striving to help make improving standards of care a positive experience for the nursing team (Cummings et al., 2010).

When managing the care of dying patients, nurses develop close supportive relationships with patients and their families, which results in the ability to advocate for the patient and their family when negotiating care with the health care team (Peter et al., 2004; Storch et al., 2004). The concern for their families is upheld in the accounts of both Jo and Charlie.

In summary, in this section on 'concern for others', these extracts serve to demonstrate a strongly held belief that people are important and that their welfare is the concern of nurses. This reflects Kant's proposal that humans have an intrinsic value, that each has the right to self direction and the associated principle of autonomy (Cahn and Markie, 2006).

Having completed the presentation of the thematic analysis of participant accounts in Chapters 5-8, Chapter 9 will present a single critical account in context and highlight where these themes appear and where and how the relationships developed by the participant influence ethical decision-making and the participant's ability to achieve moral action. Within Chapters 9 and 10 the theoretical framework will be critically discussed and debated within the context of these findings.

Chapter 9 – Case study

9.0 Case study

In this chapter a single case study, drawn from one ethical dilemma presented by Charlie, has been selected to facilitate theoretical analysis. Both content analysis and interactional analysis have been undertaken, looking at the dilemma and the reasoning, decision making and contextual influences within it.

Charlie, who is a staff nurse with in excess of thirty years experience, explained how, on a regular basis, nurses are required to make difficult decisions about which patients may be moved to another ward area to 'out lie'. This is when a patient is cared for on a ward that does not necessary routinely care for patients with a particular condition and where the team of doctors managing the medical or surgical aspects of the patient's treatment are not routinely available but do routinely visit. Thus, the house officer and registrar who spend time on the ward where the patient has been sent will not be familiar with the patient's situation; those who are may need to be reminded to visit to review the patient.

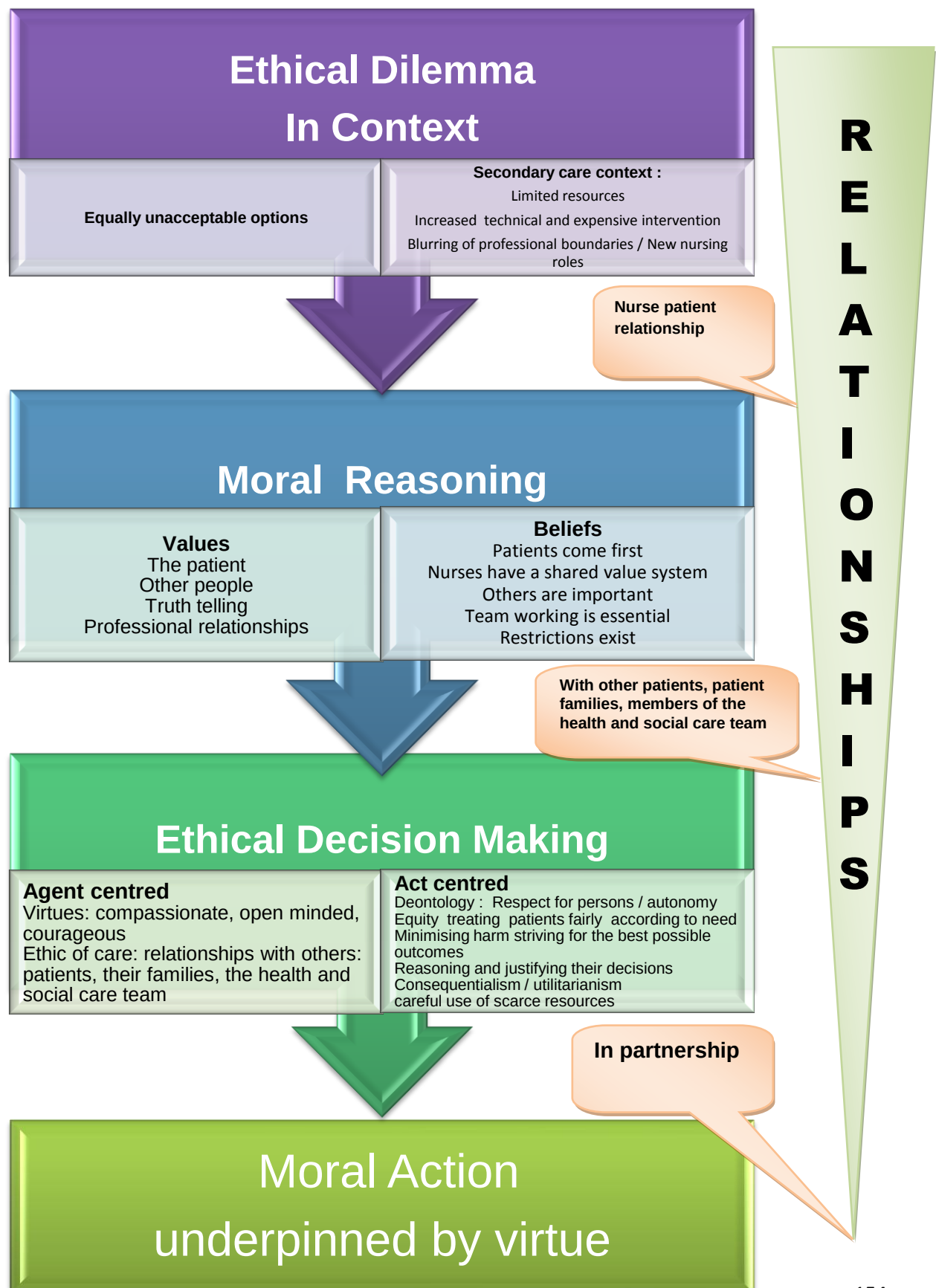
Analysis of this case study has facilitated a deeper understanding of the relationship between the themes from the research and how they work together in context. The re-conceptualised theoretical framework can be found in Figure 2, where the stages of the framework are redrawn and the element of 'relationships' added as an overarching element.

Using a diagrammatic format, each stage of the theoretical framework has been linked to Charlie's account. Analysing Charlie's account in this way has helped to

clarify the beliefs and values that underpinned the decision to move this particular patient to 'out lie' in another ward. This approach has also revealed more clearly how and when the relationships the nurses developed were crucial. The analysis leads me to believe that nurses' ability to undertake moral action, in order to do what is perceived to be the best possible outcome for the patient, is significantly facilitated through the skilful development of professional relationships

9.1 Reconceptualised Theoretical Framework.

Figure 2: Reconceptualised Theoretical Framework



Charlie's Dilemma	Relationships	Theoretical Framework Ethical Dilemma:
CHARLIE: <i>Well I think the one that immediately springs to mind is when we're asked to actually move the patient off the ward, because the patients have had some major xxxx surgery to come to us and you look round and all our patients are unwell and who do you move? I mean I look and I think – do I move the amputee who really needs the attentions of the 'specialist' physio every day? Do I move him? Do I move the gentleman that's only had a debridement of his foot, but if he goes to another ward it doesn't get the dressing done? Is he potentially going to go for another debridement? Do we move the elderly lady who's had some surgery but she's a bit confused and then you're moving her somewhere else and she becomes even more confused? And I think I find that probably the hardest, I struggle with that – who is the best to</i>	Nurse: patient Nurse: other patients	Discussing a recent incident where Charlie was required to identify a patient for moving to other ward areas to make room of a newly admitted patient. Charlie has a comprehensive understanding of the patients and begins to consider in detail the impact on the patients. Demonstrating how strongly Charlie values the patients and how important the patient experience and care is to Charlie, Charlie explains that all the people in her care are unwell, leaving Charlie with an ethical dilemma, presenting two or more available alternatives which appear equally undesirable (Hamric

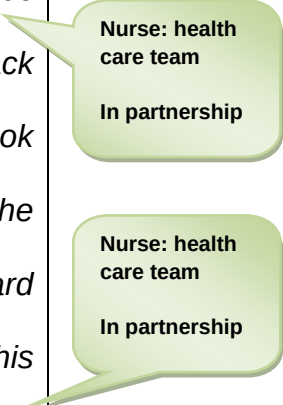
actually move?		et al., 2000; Beauchamp and Childress, 2001; Nouredine, 2001).
Charlie's Dilemma	Relationships	Moral Reasoning:
CHARLIE: <i>I've really got to go through each patient individually and sort of think who's best placed to go? Who's likely to do well? I mean sometimes it tends to be actually the amputees that get moved, mainly because they've no wounds or anything and quite often some of them can wheel themselves down to the physio department, so it tends to be them.</i> <i>But sometimes it's really.... if you've got someone.... because we are xxxxxx the type of patient we have, sometimes their wounds don't do very good so you can really struggle with 15 patients as to who's best placed to actually move, because we do have patients that are with us for months at a time, we've just recently had a gentleman died and another lady was</i>	Nurse: other patients	Charlie begins to identify the options and the unknown, unable to predict the future needs of each patient and what the impact of the move might be on each of those who Charlie may choose to move. This indicates that Charlie has already found that the consequentialist approaches to ethical decision making have limitations but may need to be utilised. Charlie wants what is best for each one of the patients, and knows that to be moved to an outlying ward is not the best for any these patients. This theme is the

<i>discharged to a nursing home, one had been with us for 6 months and the other was 7 months and the hospital does do an audit for patients that have been in for over 10 days, and for quite a long period of time we only had one patient who had actually been with us less than 10 days and we did that over a month period so it's difficult and there's so many of them, it's really, really difficult to.... I think actually we did have a gentleman fairly recently that was a bilateral amputee. He'd had an amputation perhaps about 18 months ago and he came in and had the other leg off.</i>		dominant theme from the thematic analysis of the accounts provided by the nurse participants; it is this value that nurses hold regarding patients that influences their moral reasoning and makes moving patients an ethical dilemma for Charlie. Charlie also knows that there is a patient waiting to be admitted who requires specialist care and what is best for this patient is to be admitted to Charlie's ward. From an early stage in the account provided Charlie begins to articulate the importance of the nurse patient relationship, reflecting how the nurses value the patient as an individual and the
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		responsibility felt towards the patients and their experience, as seen in the thematic analysis and indicated in The Code NMC (2008). When considering the complexity of the problem Charlie demonstrates how the situation requires multiple relationships with numerous patients simultaneously to be maintained. Balancing the interests of individual patients within the group can result in difficult situations for the nurse.
Charlie's Dilemma	Relationships	Ethical Decision Making:
CHARLIE: <i>We were struggling with him actually on the ward and it was really quite difficult to get him moving. This gentleman has quite a complex past medical history and had an awful lot of pain and his ongoing pain was very</i>		The value placed on the individual and their experience informs Charlie's initial responses to the situation, demonstrating the value Charlie places on the

<i>difficult to manage and sad to say he was actually the best patient to actually move, and it was so inappropriate to actually move a bilateral amputee and his family were quite difficult and we were struggling. He had a son, he lived with his son and the son had a problem with alcohol dependence so we're trying to sort of liaise with the son and get him home, and obviously this gentleman had no legs, had a lot of pain, he was quite an emotional man, he was prone to tears quite a lot of the time and we had to move him off and you felt really like you were abandoning him.</i> <i>We moved him to another ward, which he was fine on there, the girls on there are really good, but it was just he'd been with us so long and he'd had several admissions because he's had bypasses in the past which had become blocked and he'd come back and had ended up with the amputation</i>	Nurse: Patient Nurse: Patient's family	individual process which informs the ethical decision making and action undertaken in an attempt to resolve the problem. Charlie explains in the account provided how important the individual is and that the best interest of the patient is paramount The importance of effective professional relationships with patients, including trust, advocacy and recognising both the patient's and the nurse's values are important aspects of developing this relationship (Chadwick and Tadd, 1992). The importance of the relationships nurses develop with patients in their care
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and then the second one, so he was perhaps with us 6 or 7 admissions over the last 2 or 3 years. Charlie: He knew he'd get the support and help here, and it's difficult then like I say when you move them to a different ward. I mean he has been discharged, he was discharged about 2 or 3 weeks ago, but you know it's very, very difficult to say to someone well you're the unlucky one. And you feel it's like a lottery, you're sat there and you're the one being chosen to do something you don't really want to do. Charlie: I think the other thing that I find hard is as well, the patients get used to us and used to the ward environment and then you're moving them somewhere else and I think it's a bit like moving a child I suppose really, you're moving them along and they know us and it's then they've got to form a new relationship on that ward	Nurse: Patient Nurse: social care team In partnership Nurse: Patient Nurse: social care team In partnership In partnership	reflects Gilligan's feminist theory of moral development (Gilligan, 1982) and the ethic of care discussed by Beauchamp and Childress, (2001) and Hawley (2007). The nurse participants recognise that the development of effective relationships puts the patient at the centre of decision making and care provision and thus upholds their belief that the patient and what is 'best for the patient' is the strongest held belief, as emerged from the thematic analysis of the data collected. Charlie compares this action
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<i>you know with the staff, and I think that's quite hard as well.</i>		with that of moving a child, demonstrating the sense of responsibility of care felt by Charlie; caring in the right way about the right things (Allmark,1998). This caring relationship is the central characteristic of the ethic of care (Hawley, 2007),
Charlie's Dilemma	Relationships	Moral Action
CHARLIE: <i>'I sent one our auxiliaries with him, I said 'make sure you unpack his things, you know that he has a look around the ward, introduce him to the nurses and stuff'. I did ring the ward up and you know said 'this gentleman's been with us a long time, he's had several admissions you know, and he does know everybody, I'm not happy about moving him, he's not an ideal transfer. I said and I know from your point of view because you're colorectal, it's not an ideal patient for us to move to you, it's not an</i>	 Nurse: health care team In partnership Nurse: health care team In partnership	Charlie explains in detail the action taken once the decision had been made which patient to move. Charlie and the team worked to make sure that the man who was moved was kept informed and the move resulted in the minimal amount of disruption to his care. Charlie engaged with the nursing staff on the

<i>appropriate move, but he's the best gentleman to move. He was actually the most stable gentleman we had at that time to move, you know and I said 'he's really worried, he's quite upset', I related all the history obviously to the other ward, the problems with his son and his home circumstances, the problems we'd had with the pain team was ongoing, and I mean I said to the pain team was ongoing, and I mean I said to the physios 'can you make sure you go sort of morning and afternoon just so he knows we haven't forgotten him, that he hasn't been sent off somewhere where that's it we're not having anything to do with you anymore.</i>	 Nurse: Patient Nurse: health care team In partnership	receiving ward to explain this man's case and identify his nursing needs, ensuring that the physiotherapist knew where he was and making sure that he would be seen the next day to reassure him that he would not be forgotten, demonstrating the value placed upon the individual.
Charlie reflects	Relationships	Justifying the decision
CHARLIE: <i>Well, this gentleman had an awful lot of problems with pain and he had had throughout his admissions and he has been seen by the chronic</i>		As Charlie reflects on the way the ethical dilemma was addressed and the decision making undertaken

<i>pain team at home and obviously before surgery the acute pain team, and was seen every couple of days, because for this gentleman it was very difficult to get on top patients, particularly the amputees, the ischemic pain that they actually get in their lower limb</i> <i>is so bad prior to surgery that once they have the amputation really they are not bothered about the pain killers, they are quite happy with a couple of paracetamol, because that pain is so bad that the wound pain they get from the surgical wound is nothing by comparison to what they've as with most things, but I think that's one thing that's really important, that our patients are not in pain, and this particular gentleman we really struggled to get on top of his, so I think it was really important that they understood that we had a lot of problems and we had addressed that problem but it was still</i>		it is possible to see how the duty based ethical approaches were used to justify the decision and consequential action taken by Charlie. That most important value, 'best for the patient', expressed by all the nurse participants, remains at the centre of Charlie's account, to which ends Charlie works collaboratively with the health care team and the nurses on the ward where the patient is going. Charlie communicates with the ward team where her patient will be transferred so that they understand his
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ongoing. CHARLIE: <i>Well the thing is that he can't go home like that because he can't move, he can't get in and out of his wheelchair, he can't you know deal with activities of daily living –</i> <i>he can't wash himself, he can't move around the bed, he's got pressure ulcers. I mean this gentleman liked to go out for a smoke and quite often our amputee patients will get up and they're off the following day because they like a cigarette, but with this gentleman the pain was so bad he couldn't even get out of bed which was very, very unusual, so the pain was extremely debilitating for this man. In fact I can't think of another single person actually where it's been quite so bad as it was for this particular gentleman, and it was, as I said, an ongoing battle with it.</i>		needs in order to minimise the disruption (harm) to the patient's care and recovery, indicating that the ethical principle of non-maleficence is upheld. The team continue to try and manage the patient's pain, upholding the principle of beneficence. Charlie acknowledges that it is not ideal and goes as far as to say that moving this man felt like abandonment. Charlie takes the role of caring for the patient very strongly, so strongly that it is expressed in comparison to the duty of care one has to a child.
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CHARLIE: <i>I think it makes you feel like you've abandoned a child really, you've sort of, you've just, I feel sometimes like you know they trust us to make us aware that we are actually dealing with people, but yeah you know sometimes we're treating them like parcels because we're moving them here, there and everywhere and I try to make the experience....my thing is I like to treat people how I want to be treated and I think I would be a pain I really do, I think I would be a extremely difficult patient.</i> CHARLIE: <i>I think I would be extremely difficult, you know I would be very demanding and I like to make sure that I treat the patients the same way, so I think you know.... as I say, I just felt, it wasn't an experience that I wanted to go through really. I think you have to put it behind you and I just think, I've done this, I've done everything that I possibly can, there's nothing else that I</i>		Charlie refers to the fact that nurses are dealing with people not 'parcels', recognising the intrinsic moral value patients have as rational beings and the ethical principle of autonomy. Charlie explains the importance of treating people equally, upholding the principle of justice. Charlie returns to how it felt to move this man, comparing it to the abandonment of a child. It is therefore reasonable to understand how moral distress, as identified in the
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<i>can do, I have to move him and that's it, and you just have to put it in a box and put it away, but I don't think it's a nice feeling.</i> CHARLIE: <i>Well I suppose that the patients I've chosen to stay, obviously they're in different stages of their recovery and maybe they're not medically stable, you know maybe I've chosen them to stay, maybe they're for surgery or whatever. Obviously I've looked at all those issues before I've actually moved anyone.</i> CHARLIE: <i>No, I'm happy with that because I know I've made the right move, I know I've moved that gentleman because I've no choice, it's not a move that I'm 100% happy with but I know I've done it as it should be done you know and that's it, and you just have to cut off from it then. That's it, you've done what you can, you just have to cut off and move on,</i>		research reviewed by Corely (2002), is a consequence of some of the decisions and actions Charlie had to engage with in this situation. Charlie begins to justify what has been a difficult choice. There are targets to meet based on the availability of resources. Issues associated with minimising harm, recognising vulnerability are recognised by Charlie supported by a justification of the decision Charlie
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Charlie: <i>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, they can't use somebody who's a blubbering mess. Yeah, but I think it's something you do have to sort of.... you do have to harden yourself a little bit sometimes I think.</i>		made. This, perhaps, helps Charlie, reduce any moral distress experienced as part of the moral residue which result from any moral dilemma (Hursthouse, 1999) Charlie shows, 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.
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9.2 Conclusion

Having looked closely at Charlie's account it is possible to identify where and how crucial relationships with patients, their families and other health and social care workers helped nurses to understand the impact of their actions taken in response to ethical dilemmas. These actions aimed to help facilitate the best possible outcomes in the context of secondary care. Experienced nurses, in this case Charlie, are seen to recognise that the context may limit the possible options for all those on whom the

action may impact and that there have to be compromises made, resulting, in some cases, in moral distress. In the account above it is possible to see how Charlie recognised the dissonance between the ideal outcome and the best possible outcome achievable in the context at that time, freeing Charlie of the emotional burden of distress and possible consequences.

The overall analysis of this case study leads to a discussion, in Chapter 10, regarding the development of the concepts in the framework, greater understanding of the role played by moral distress and the exploration of relationships as central to the successful resolution of ethical dilemmas in practice.

Chapter 10 - Discussion.

It appears from the data collected and the literature reviewed in Chapter 2 that nurses face ethical dilemmas in practice and are in many cases able to contribute to the resolution of these dilemmas. In this chapter I will critically discuss key aspects of the nurse's contribution to solving these problems and the factors that influence their ability to do so, utilising the theoretical framework and incorporating the findings, policy, practice, prior research, philosophy and theoretical underpinnings.

The Reconceptualised Theoretical Framework of ethical dilemmas in context (Figure 2) illustrates the centrality of relationships to the resolution of ethical dilemmas, as it emerged from the findings in Chapters 5 to 9. This chapter will critically explore this finding in relation to current literature regarding the stages of the framework: ethical dilemmas in context; moral reasoning, ethical decision making; and moral action. Whilst discussing ethical decision making it will explore the extent to which virtue ethics are important to this relationship and the contribution this data makes to our understanding of moral distress: In doing so the discussion will locate the study's contribution to nursing knowledge.

10.1 Ethical dilemmas

As discussed in Chapter 2, ethical dilemmas are those which consist of conflicting principles resulting in equally unacceptable courses of action (Hamric et al., 2000; Nouredine, 2001; Beauchamp and Childress, 2001). Analysis of the collected data shows that it is possible to conclude that all participants were able to identify an

ethical dilemma and demonstrates that participants strongly believed that the welfare of patients is most important; this remained a theme throughout the narrative accounts (see Chapter 5). The dilemmas that occurred for these participants were described in terms of the context at that time, rather than as abstract problems to be resolved. The nurses identified their professional goal to be that their patients receive the best care available and thus the first and possibly most important relationship identified is that between the nurse and those to whom the nurse has a duty of care.

10.2 The context

Obstacles to giving the best possible care and conflicts with the nurses' personal value systems contributed to the dilemmas discussed by participants. Examples of the importance of context are provided within this thesis, which include the identification of a patient who was to be moved to a non-specialist ward where care may have been compromised or recovery delayed (see Chapter 9) and cases where perhaps the family, or even the nurses themselves, felt that the patient's decision was not one they would have recommended, as discussed by Chris (see Chapter 5). The context in which all of the narratives took place was secondary care and, as with other societies, the secondary healthcare community follows patterns of behaviour and formal and informal rules (Melia, 1987). Formal rules include those contained within each of the professional codes of conduct, the law of the country within which they practise and the policies of the organisation within which they work. Informal rules are those which have developed through custom and practice, informal hierarchies, many of which have been identified within the literature, especially the

relationship between doctors and nurses (Davies, 2003; Gunnarsdottir et al., 2009 Long- Sutehall et al., 2011).

10.2a National policy and English law

Nurse participants within this study recognised that national policy and the law impacted on professional practice generally and, in context, the nurses were able to identify where law applied to their practice and to the dilemmas they were facing. For example, the Mental Capacity Act (2005) influenced the decision to ensure a patient in the care of Chris did have capacity to make his own decision in relation to his discharge home from hospital. The Act gave Chris a structure for thinking through the dilemma and for arguing the case for reviewing capacity. Gillick competence (NSPCC, 2014) was used by Ashley in caring for children, where competence to make decisions was assessed by the nurse rather than simply accepting the parents' decision. In both these cases the law in context supported their practice.

The National Health Service in the United Kingdom has changed significantly over the last 20 years, with the introduction of the internal market (DH, 1990) the idea of working with independent providers in the NHS Plan (DH, 2000), Foundation Trusts first announced by Alan Millburn the Secretary for Health for Tony Blair's Labour Government of the time and Health Care Commissioning (RCN, 2011), to name just a few of the developments. Management styles adopted by Health Service managers, coping with limited resources, performance review and a target driven service, have been interpreted by some as a threat to the traditional public health service values (Dopson, 2009). This can be seen in the account provided by Charlie (see Chapter 9) as patients are transferred to another ward due to limited specialist

beds being available. How the 'authority' of doctors dominates the decision making and limits the nurse's ability to provide care for the dying is documented in accounts by Chris and Charlie (See Chapter 5). Ross, too, struggled with the Bed Manager's decision on how to manage limited bed availability (see Chapter 7) and Nicky was left feeling unhappy when perceiving that patient safety on the ICU was potentially compromised as senior nurses chose to reallocate nurses to another area in the hospital (see Chapter 7).

10.2b Organisational policy

Participants found that organisational policy restricted their ability to provide the 'best for the patient' in some cases, for example when Lee collaborated with a doctor to work outside of the organisation's policy and prevent a patient's transfer to another hospital for medical consultation. Ross also refused to comply with the policy for transferring patients due for discharge to the discharge lounge. Working outside of the organisation's policy may result in the employing organisation not taking vicarious liability for the consequences of the actions undertaken by those involved, which may lead to disciplinary measures or dismissal (for example: Blackpool Teaching Hospitals NHS Foundation Trust; 2014; Papworth Hospital Foundation Trust, 2014). Thus, when the participants chose, they took risks which involved a certain amount of courage, as they might have faced serious consequences regardless of the outcome for the patient. Courage, as a facet of virtue ethics, is discussed in more detail below. The participants' response to organisational policy was also influenced by their professional Code. The 'Code of Standards of Conduct, Performance and Ethics for Nurses' (NMC, 2008) was identified in the literature

review as important to nursing practice and reflects the values held by participants and the standards to which they worked. The Code (NMC, 2008) is the standard by which all nurse are judged accountable in a fitness for practice hearing (NMC, 2011).

Participants in this study did not refer to The Code (NMC, 2008) directly, although it was evident in their descriptions of their practice. It is possible that as the nurses became socialised into the profession, aspects of the code were internalised (Benner, 1984; Settelmair and Nigam, 2007). The values contained in 'The Code' became part of their professional values, for example, 'make the care of people your first concern, treating them as individuals and respecting their dignity' (NMC, 2008 p2) is evident with all participants expressing this principle in one way or another. The internalisation of these standards adds to the concept of nursing ethics and virtue ethics discussed below. Nurses, however, do not practice alone and the ability to contribute is affect by the society within which they practice (Chafey et al., 1998; Torp and Thomas, 2007).

10.2c Sociological context

Societies are made up of interconnected groups; this is reflected in the wider society within any country, community or organisation (Porter, 1998). Hospitals reflect this societal structure, without which the health service treatment and care could not be delivered. The work of Durkheim (1858 – 1917), an early sociologist, focused on the roles of social groups, for example the family, and how they contributed to the maintenance of social structure and social laws (Porter, 1998). Health care professions frequently work within small social groups in the secondary care setting; these consist of a range of professionals working in a given ward or clinical area.

Each individual member of this group is assigned to a professional group: nurses, medics, radiologists, and other therapists; in some cases this also includes members of social care professions. Participants' accounts included evidence of this particularly between nurses and doctors (Lee, Nicky and Jo), and with other professionals, as demonstrated in the accounts of Chris, Jordan, Charlie and Ross.

Weber (1864-1920) identified social groups by stratification rather than by class as understood by Karl Marx (1818-83). Weber's interpretation of social groups through stratification perhaps reflects some of the influences on the nurse's place within the social context of their professional practice (Porter, 1998). Nurses fall within the final group within Weber's theory; these are referred to as 'parties'. Parties have a shared goal which is reflected in the party agenda which results in social status. Nurses achieve this partly through the specialist knowledge and skills they achieve through a programme of education. Equally, medical doctors have achieved social status which appears to hold greater power than other professionals involved in healthcare (Dierckx de Casterle, et al., 2010). It is, however, evident that with new nursing roles, nurses show willingness to challenge doctors' decisions regarding individual patient's treatment and care, as seen in participant accounts. For example, when caring for people at the end of life, Jo and Charlie both explained that they challenged doctors' decisions about aggressive curative treatments (although they were not always successful in changing the treatment plan).

The structural purpose of societies is viewed by Parsons (1937) as having two distinct components, those which are functional and those which are instrumental.

Functional actions are those which serve to maintain equilibrium and ensure that the society meets its goals within the wider society, for example meeting the organisation's targets and the functions are those set out in the organisation's policy documents (Porter, 1998). Instrumental functions are those which are an end in themselves, such as those of providing comfort to a patient, treating individuals with compassion. Compassion can be seen in participant accounts and appears to be as important to these participants as functional aspects of their work, demonstrated by Charlie when balancing the benefits and burdens of transferring a patient to a non-specialist ward (see Chapter 9).

10.2d Power

Gender also influences the place of nurses within the context of secondary care; nursing, both historically and currently, is a profession dominated by women. Davis (1995) suggests that men can be influenced by female cultural codes and women by male cultural codes, each code valuing different characteristics; masculine social codes value autonomy, power over the world and self esteem, feminine social codes value altruism, group orientation and connectedness (Davis, 1995).

However, this is not the only power differential within the context of secondary care, as demonstrated in Johnson's (1997) theory of social judgment whereby the patient remains disempowered by the context and social structures within secondary care. Internationally, policy initiatives and the World Health Organisation (Coulter et al., 2008) indicate that power should be transferred to the patient through patient-centred care and the promotion of autonomous decision making. However, the

patient's 'extraordinary vulnerability' (as described by Sellman, 2011) through the nature of their condition, the unfamiliar environment and the power health care professionals hold through specialist knowledge, continues to perpetuate the patient's lack of power, whether actual or perceived. Within participant accounts it has been possible to see how nurses try to promote patient autonomy, for example Chris, when planning a patient's discharge (see Chapter 5) and Jordan when working with patients who have been recommended surgery to amputate a limb (see Chapter 5). However, as Charlie prepared to transfer a patient to another ward the patient had no influence in the decision to transfer, demonstrating a lack of power. Charlie did empathise with the patient's situation and strove to minimise the negative impact the move might have had, using the power held as a nurse to influence patient experiences (see Chapter 9).

Historically the nurse was portrayed as the doctor's assistant who followed 'his' directions in caring for the sick (Pugh, 1944). Nursing has been associated with the provision of intimate personal care or 'dirty work' and this has resulted in nurses' position within the multi-professional team as those who do the unspeakable tasks, which other health professionals may see as beneath them Lawler (1991). Interestingly, none of the nurse participants discussed issues associated with 'dirty work', although it is implicit in their accounts that this is part of their role. This reflects Lawler's (1991) research, which showed that some nurses believe that being able to support patients with these intimate and sometimes embarrassing aspects of care is a privileged position appreciated by those to whom they deliver this care but that nurses rarely discussed this type of work and, when they did, it was with other nurses.

It is reported that the doctor makes the final decision, particularly in relation to patient treatment (Dierckx de Casterle, 2010) but the doctor may choose to take account of the contribution made by others. When choosing to prescribe treatment to be delivered by others (often a nurse) who do not necessarily agree with the decision, this can result in moral distress for the provider of the treatment (Oberle and Hughes, 2001).

It could be concluded, therefore, that doctors have some authority over nurses, although this is not articulated in a nurse's contract of employment. The nurse's line manager is often a higher ranking nurse manager (for example: Blackpool Teaching Hospitals NHS Foundation Trust; 2014; Papworth Hospital foundation Trust, 2014). This demonstrates the doctor's position of power within this context and the limitations under which the nurse may have to work when trying to abide by The Code (NMC, 2008). The Code (NMC, 2008) clearly states that the nurse has a duty to challenge doctors' orders when there are concerns that these are not appropriate. Examples of this are seen in the accounts of both Charlie and Jo when discussing the care of patients at the end of life (see Chapter 5).

10.2e Nurses' role within the secondary care context.

Finally in this section, ethical dilemmas occurred in this study within the secondary care context. Melia (1987) notes that nurses, who view nursing as a craft, help others to do what they would normally do for themselves, striving to become competent skilled individuals. Nursing as a profession, built on nursing theory and

requiring both professional association and academic qualifications, results in an increase in the nurse's power and allows autonomous practice (Melia, 1987). This can result in conflict and challenges to some of the historically accepted hierarchies occurring, due to the new nursing roles and the blurring of professional boundaries (Oberle and Hughes, 2001; Halcomb et al., 2004). The role of the nurse has changed substantially over the last 20 years; reasons for this include the increased technological advances in health care (Storch et al., 2004). This has occurred due to the limited availability of appropriately qualified staff to undertake all the technical work, in some cases previously undertaken by medical staff. Nurses have also strived to become appropriately qualified professionals, including specialist practitioners required to meet the needs of the service (DH, 2000; DH, 2006; Darzi, 2008). This has impacted on what organisations and individual patients expect from nurses. These changes have resulted in a need to renegotiate professional boundaries and, in some cases, this can be extremely challenging; nurses refer to this as 'working in between' and explain how they choose their battles (Varcoe et al., 2004).

Melia (2004) identified, through sociological analysis, that in the intensive care unit (ICU) team members, regardless of scientific knowledge or position within the healthcare professional hierarchy, were able to contribute to the discussions during ethical decision-making, concluding that this contributed to the smooth running of the ICU and that the wider healthcare community could learn from this.

Within the context of secondary care the difference in the power attached to team members and the patient's position is difficult to justify, as all are working for the best

interests of the patients (as well as other objectives) (Sellman, 2011). The nurse is in the unique position of spending more time with patients than many of the other professionals, which may facilitate a greater understanding of the patient's perspective (Storch et al., 2004). Nurse participants interviewed for this study demonstrated how, by developing and maintaining effective relationships with patients and other professionals, they were able to empower themselves to achieve this. They influenced others and decisions made about patient care through working collaboratively to respect the patient's wishes and work in their best interests. Nurses, in some cases, needed the courage to challenge those in authority and this conflict became evident when the nurse involved felt strongly that the alternative suggested course of action was not in the best interest of the patient involved.

10.3 Moral reasoning

The initial critical discussion of moral reasoning presented in this thesis focussed on a premise that it is based on the values, beliefs and expectations of the nurse. Thematic analysis of the data collected in this study has further conceptualised the theoretical framework, as presented in Figure 2. This conceptualisation, based on the in-depth interpretative analysis presented particularly in Chapter 5, refers to the theme of 'best for the patient' and, within this, the further sub-themes of 'advocacy' and 'standards of care'.

Using Kohnke's (1982) definition of advocacy as an act of loving and caring, which is consistent with a nurse's duty of care (NMC 2008), it is argued that maintaining the highest possible standards of care for patients is a part of the role of advocate.

This is supported within the results pertaining to the accounts provided by those in the managerial position of Charge Nurse. Both Sam and Brooke talked extensively about how they worked to ensure that the standards of care provided were the best possible; both recognised that supporting and motivating staff who, for whatever reason, might have been perceived as having provided substandard care, would benefit all patients as well as the staff themselves (see Chapter 5).

Nicky and Charlie, faced with limited resources, had to consider and maintain the standards of care received by individuals and groups. In doing this these nurses were demonstrating how they advocate for the community (Caulfield, 2005, NMC 2008), in this case, the community of patients needing care; for Brooke and Sam this was primarily about standards of care and caring for the patient community. It is also evident from their accounts (see Chapter 5) that they were also concerned for the staff and, as such, were advocating in some part for the community of nurses on the ward.

The nurse participants also believed nurses have a shared value base and are likely to make similar decisions in similar circumstances, which supports the guiding principles of nursing practice (NMC 2008); this is supported in the results of the research presented (see Chapter 6).

10.3a Collaboration and relationships.

Working effectively within a team to resolve ethical dilemmas and provide nursing intervention within an accepted framework of central practice policy supports the sub-theme identified as 'moral action'. The nurse's contribution to the resolution of ethical dilemmas in the context of secondary care is facilitated through the relationships they choose to build and maintain. These relationships are identified by Peter and Liaschenko (2013) as central to morally correct culture and context and embrace the core aspects of moral agency, identities, relationships and responsibilities. Participants' accounts highlighted the importance of these relationships in achieving moral action, as discussed below.

10.3b Nurse patient relationship

The most significant factor to emerge from the data was the importance of relationships to moral reasoning and moral action.

The first and most important relationship identified within the reconceptualised theoretical framework is that between the nurse and the patient, for example, Jo and Charlie when supporting patients and their families at the end of life; Ross and Chris when discharging a patient home after a hospital stay; and Lee when negotiating care for a frail older person. Entering into this relationship both demonstrates the nurse's commitment to that individual and requires the nurse to invest in its ongoing maintenance. The idea that care given in the nurse-patient relationship is not reciprocated with a similar level of care is highlighted by Barnes (2012) and Melia (2014) who recognise that relationships in the care process are complex, particularly

where the care is provided by a paid carer. 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 down (Francis, 2013). This has resulted in a call for the recruitment of student nurses to be value based and a review of the number registered nurses within clinical areas (Nursing and Care Quality Forum, 2012).

The care of the vulnerable, frail or unwell is recognised within the Ethic of Care as involving a collective responsibility and therefore requiring nurses to maintain a number of professional relationships (Barnes, 2012), identified within the participants' accounts of both Ashley and Chris (Chapter 5). In the accounts where this collective responsibility failed to support what the participants perceived to be the most appropriate course of action, participants became dissatisfied. In some cases participants worked outside organisational policy when this had the potential to support the preferred, less harmful option, circumventing obstacles and meeting the collective responsibility, professional duty and personal decision to provide care and this was clearly demonstrated in the accounts provided by both Lee and Ross.

It has been debated that care has different meanings in different contexts (Almark, 1998; Banks and Gallagher, 2009). In this case I use the term 'care' to be something that occurs when the needs of another generate concern and compassion for that 'other', which may explain the initial desire to care (Banks and Gallagher, 2009).

However, caring in the 'right' way, about the 'right' things, as discussed by Almark (1998), as one who promotes the patient's wishes and advocates through patient empowerment can be difficult due to the barriers identified within this thesis, which include working with limited resources (Vaartio and Leino-Kilpi, 2005), understanding and respecting the beliefs and expectations of others (Banks and Gallagher, 2009; Barnes, 2012) and balancing the needs of others (In this case patients and clinical areas) (Barnes, 2012). This type of care requires energy, commitment and ability by those providing care to understand the culture of those to whom they provide care and the context within which care is provided (Banks and Gallagher, 2009). This was evident in Chris's account when caring for a vulnerable patient whose capacity to make decisions was questioned by his family. All participants referred to patients' needs and values, for example the wish perhaps not to have life prolonging treatment in the last days before death or not to have a limb amputated at the advice of a surgeon.

The 'Ethic of Care' recognises the importance of supportive relationships from a variety of contexts, for example in friendship, the family or the state. Nurses fall into the classification of those paid to provide care (Barnes, 2012). Considering the relationship when giving informal care it is evident that caring is a practical and emotional process; this may not be the case where there is an obligation to provide care through a contract of employment (for example: Blackpool Teaching Hospitals NHS Foundation Trust; 2014; Papworth Hospital Foundation Trust, 2014). Ethical relationships are recognised as essential between nurses, patients and others involved in patient care; the nurse-patient relationship is embodied in advocacy and the provision of care (Varcoe et al., 2004). It is important to recognise the risk of

coercion within these relationships and nurses are encouraged to be self aware and practice reflectively to reduce the risks of this occurring (Barnes, 2012). In Chris's account the risk of coercion is acknowledged and, to reduce this risk, Chris called in Social Services to assess and support the patient concerned in making his own decisions about his future care by presenting appropriate information about his options.

The Ethic of Care, which focuses on the importance of ethical relationships, may go some way to explaining the nurse's role as moral agent and how nurses contribute to the resolution of ethical dilemmas in the context of secondary care. It is, however, apparent from this study that it involves more; the relationships are the facilitator of understanding the dilemma and facilitating moral action.

Choosing to become a nurse and provide care, nurses engage in relationships with those who are vulnerable, or '*more-than-ordinarily vulnerable*' as Sellman (2011) defines the vulnerability of those who are in need of nursing care. Through this, nurses demonstrate that the patient is valued as an individual and that decisions made and subsequent actions taken by the nurse will be undertaken to reflect this. The findings of this study have demonstrated that nurses hold shared values which are reflected in The Code (NMC 2008). It is also evident from the data that the nurse participants demonstrated a number of virtues which impacted on their decision making and actions.

Initially participants indicated concern about a patient in a given situation; nurses are referred to as caring for patients, care however is not recognised by all as a virtue

(Allmark, 1998). The nurses interviewed demonstrated how they cared about the patient(s) in the accounts provided. Participants deliberated over what was the best course of action, weighing up the options, using knowledge gained through experience and the acquired wisdom to use that knowledge in a way to promote effective practice. Ashley explained how less experienced nurses recognised this and would call on him for guidance, demonstrating that less experienced nurses were able to recognise the ability to understand and identify appropriate responses to complex ethical dilemmas.

10.4 Ethical decision - making

What is evident from the analysis of the nurse participant accounts is that nurses use the language of consequentialism and deontology to justify some of the actions taken, however it is virtue ethics that is the dominant model used in the accounts collected in this study.

Virtues have been identified by moral theorists (Gilligan, 1982; Aristotle, 1998; Tong, 1998; Noddings, 2003) as character traits which are constant, thus defining people by their innate qualities rather than by their actions. Character traits include both virtues and vices, on a continuum where extremes are considered to be undesirable. Aristotle (1998) views some virtues as universally desirable; whilst some are considered more important or especially required in specific contexts. For nurses, virtues might include trustworthiness, honesty and loyalty (Armstrong, 2007). Open mindedness may also be a virtue in nursing (Sellman, 2011) as nurses are required to be able to understand the perspectives of others in addressing the ethical

dilemmas they face in everyday practice and considering with respect the values and beliefs of others.

Nurses are also said to need to be knowledgeable, behave accordingly and demonstrate the Chief Nurse's 6C's of Nursing, which indicate nurses should be caring, compassionate, courageous, competent, committed and communicative (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012). Whilst not all of these may be defined as separate virtues, they fit well with a virtues-based approach.

In order to manage the continuum between virtues and vices it is argued that all character traits must be mediated, as per Aristotle's (1998) median. For example, nurses need to find the right balance between being courageous or cowardly when deciding how far to defer to those who appear to have more authority when working with patients and their families. In the participants' accounts challenging and managing authority figures occurred with the matron (Nicky), the bed manager (Ross) and the doctors (Jordan), or in a foolhardy way, without regard to all those on whom the situation and resolution might impact (Charlie). All these accounts demonstrate the nurses' rationale in trying to resolve ethical dilemmas but is especially clear in Charlie's account, in Chapter 9, where the situation, decision process and resulting actions are presented as a single case study.

In order to manage the balance, or median, 'practical wisdom' is seen as an overarching virtue. For example, honesty may be seen as a desirable virtue for nurses, however the excess might involve a level of outspokenness which is

delivered without the 'reasoned qualification' provided by wisdom (Hursthouse, 1999).

Limitations to this approach are discussed comprehensively by Armstrong (2007) who recognises, as did Aristotle and others, that an excess or deficiency of character traits defined as virtues can lead to care that is not always ideal.

The nurse participants demonstrated that they were concerned about those in their care. In order to ensure that patients within this context were safe and adequately cared for, it is argued that the nurses often used the language of virtues to explain their thinking and actions. Virtues that appeared common to the role of the nurse included compassion, honesty, courage, empathy, open-mindedness and trustworthiness. Compassion and empathy were demonstrated by participants who discussed, with some insight, the situation and its impact on the patients within the dilemmas they chose to recount. Honesty appeared overtly in the accounts presented by Lee, who also had the courage to work outside the organisation's policy on oral drug prescriptions, in recognising that the second choice drug might not work to manage the patient's pain and the patient might still need to be seen by a physician. Courage was also demonstrated by Drew who chose not to give sedative medication when instructed to by a senior nurse, having the courage to stand by her own judgements, and also by Ross who did not move patients into the discharge lounge as this was regarded as inappropriate for the two particular patients within the account provided in this study.

The virtue of trustworthiness was demonstrated within participant accounts as they demonstrated how they went about achieving the best possible outcomes for the patients in the accounts.

Within virtue ethics it is recognised that to be truly virtuous one needs to have knowledge and wisdom to facilitate the appropriate application (Hursthouse, 1999). Nurse participants were able to explain why they acted as they did and were able to identify the values that underpinned the decisions which informed their actions. The wisdom, acquired through practice experience, was recognised by junior, less experienced, nurses within Ashley's account, where junior nurses sought advice and support from those with more experience.

10.5 Moral action

Within the context and concept of the major theme of moral action presented in this thesis, and supported by the results, are subthemes which have resonance with prior authority and critical debate. These are notable and receive critical discussion, and location, in this section, related to 'collaboration' (Carter 2009; Sanders 2009), 'advocacy' (Kohnke, 1982; Hyland 2002; Hawley, 2007; Cuthbert and Quallington, 2008) and 'accountability' (Savage and More, 2004; Caulfield, 2005; Ormrod and Barlow, 2011). The results presented and interpreted in this thesis 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. Having developed effective relationships with the people in their care (see 10.3b above), participants

explained how important it was to work inter-professionally to achieve the best possible outcome in the ethical dilemmas discussed.

10.5a Interprofessional working

It has been acknowledged that interprofessional teams appear to work more effectively within care of the older adult, where many of the patients have complex needs (Carter, 2009). Interprofessional working is effectively articulated by Chris, who worked with the patient, his family and a multi-professional team from both health and social care (see Chapter 5). Lee also worked collaboratively with medical staff to ensure that the patient received the medication required to treat an infection without the added trauma of moving hospital sites. As Lee explained, in some cases the doctor involved did not actually know the nurses requesting the verbal order for medication; the trust between the two professional groups is something that appears to have become part of the culture within that particular environment. 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. This was clearly articulated by both Charlie and Jo when discussing the care of a terminally ill patient, with the doctors' mandate to cure dominated by the intention to cure, the nurses in these accounts explained how they felt the correct course of action would be to maintain comfort and dignity and reduce suffering (see Chapter 6).

The nurse's role within the multi professional team is diverse and can take a number of forms depending on the situation and context; these include care giver and coordinator; autonomous practitioner; team member; team leader; and nurse

specialist (Sander, 2009). Within secondary care, situations can and do change rapidly; care often involves large numbers of people from a variety of professions, health and social care, as well as the patient and their family and carers (Carter, 2009). This thesis supports the collaborative nature of nurses working within teams to resolve ethical dilemmas and presents a theoretically underpinned understanding of collaboration which encompasses concepts of the complex relationship between embedded cultural and conflicting professional drivers (Lamb & Sevdalis, 2011; Long- Sutehall et al., 2011).

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 care (Finkelman and Kenner, 2010), improving patient outcomes (Faulkner and Laschinger, 2008) and as an objective of the National Health Service in the United Kingdom (Torp and Thomas, 2007). Working in a cohesive environment has also been shown to increase job satisfaction amongst nurses (Adams and Bond, 2000). 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 information (Hawley, 2007)

10.5b Advocacy

This section critically discusses the issue of advocacy that is related in the participants' narratives and is located within the literature in terms of definition, concern, nursing attributes and codes of practice (Caulfield, 2005; NMC, 2008).

Advocacy is not a new concept but one which has been embedded in nursing practice for many years (Abrams, 1978; Kohnke, 1982; Chadwick and Tadd, 1992). Kohnke's (1982) classic text refers to advocacy as an 'act of loving and caring' and includes providing patients with the right to information to facilitate self-determination with an emphasis on patient safety and wellbeing. Previously the view has been presented that nurses are only able to advocate if they 'care' about the patient and failure to care would result in advocacy being a purely mechanical process (Vaartio and Leino-Kilpi, 2004). It is argued, however, that advocacy is not straightforward; not all nurses are able to advocate effectively and it is suggested it can be learnt, developed and applied in practice (Kohnke, 1982). Ashley explained how less experienced nurses would come for advice and to discuss complex cases in order to benefit from the experience and knowledge held by those who had been practising for many years, in Ashley's case in excess of 30 years. Empirical work undertaken by Chafey et al., (1998) identified that nurses can advocate effectively although, at times, conflict can occur between nurses and other health professionals, resulting in a significant amount of stress within this role.

Advocacy appears to consist of providing information to support patients' autonomous decision-making and, where capacity is compromised; the activities associated with advocacy include protecting the patient's rights and those of safeguarding (Kohnke, 1982; Vaartio and Leino-Kilpi, 2004). Kohnke postulated, and is supported by this thesis, that to be a competent advocate nurses require special attributes; the advocate must have a sound understanding of their own values and beliefs to allow them to recognise those of the patient without necessarily sharing them (Kohnke, 1982); the advocate needs to be open-minded to facilitate

effective listening to understand the patient's wishes, open-mindedness also ensures that the nurse can present information objectively to the patient without the nurse's personal values affecting the information provided (Kohnke, 1982). Nurses, over time, develop some of this through the process of reflection, as suggested and recommended by Schön (1987) and Johns (1995) as a way of developing practice. The idea that reflection is crucial to the development of personal and professional practice and standards of care is further discussed by Hargreaves (2013) to emphasize the importance of interprofessional, shared reflection to appropriately develop collaboration in the development of supportive practice to achieve high standards of patient care.

It could be argued that the model of nurse advocacy has changed little from that defined by Abrans (1978) as one who ensures that the patient receives a high standard of care. However, advocacy can be viewed as passive; one who accepts the patient's viewpoint and decisions and delivers care that is available in the current context of organizational policy and philosophy (Hawley, 2007). In this thesis it is further suggested that the active advocate will deliver care based on professional standards and what the individual believes is the morally right action. This is supported in the accounts provided here by Ross, who refused to follow policy and move patients who she felt would suffer as a consequence of a move to the discharge lounge and by Lee, who 'bent' the rules to ensure the patient received the drugs required for treatment of an infection without the trauma of transfer to another hospital. This adds to the critical debate that advocacy, within a framework of moral action, is constituted by the nurse's sense of what the morality of the action is in their

view, even when convention or 'societal' (practice) rules state that this would be deemed incorrect (Ulrich et al., 2010).

In their critique of different models of nurse advocacy Chadwick and Tadd (1992) emphasised that nurses should possess the attributes and knowledge with which to advocate appropriately and recognised the powerful position of the nurse in the role of advocate, particularly where patients are vulnerable through their lack of understating of the situation or due to the nature of their condition, whether acute or long-term. Chadwick and Tadd (1992) construct a strong argument against the nurse as advocate, suggesting that an independent advocate is better placed to take on the role of patient advocate, emphasising that the nurse's duty of care to others results in the nurse being unable to advocate wholly and impartially for the patient due to the conflict of interests this presents.

Another barrier to effective patient advocacy by the nurse is due to the potential conflict within the multidisciplinary team (Chadwick and Tadd, 1992; Melia, 2014). However, as nurses spend more time and develop closer relationships with the patients, others argue that nurses make appropriate patient advocates (Storch et al., 2004). As discussed in this study by Jordan, such conflict may result from nurses supplying information to patients that others, for example health professionals and family, may prefer them not to have (Kohnke, 1982).

To some extent the nurse is required to act as an advocate for the community; this community could be a ward or unit, as in Nicky's account of the struggle to keep all

the registered nurses on the intensive care unit rather than releasing one to work in another clinical area and for Charlie, who was trying to balance the needs of the patients on the ward and those waiting to be admitted. For Jordan it involved trying to develop best practice, promoting the wellbeing of all potential patients recommended to undergo a limb amputation, supporting Barnes' (2012) presentation of advocacy. These accounts demonstrate that attributes required to be an effective advocate include the ability to communicate appropriately with patients to ensure that their needs and wishes are fully understood and open-mindedness in order to remain non-judgmental about the decisions and wishes of others which may not match the nurse's personal values or may appear foolish in some way (Hawely, 2007).

10.5c Accountability

Accountability also threaded through the nurse participant narratives collected for this study; this was demonstrated through their awareness of consequences of actions and their willingness to stand by their decisions. This supports the work of Hood and Leddy (2006) which conceptualised perceptions of accountability in terms of punishment or as an empowering process. The concept of accountability was strongly held by all participants and recognised as punitive and empowering, seen clearly in the account provided by Ross when challenging the instruction to move patients off the ward in preparation for discharge, when Ross had considered this not to be in the best interests of these particular patients. Ross was clear that the decision to keep the patients on the ward was correct and justifiable, whilst acknowledging that having refused to do as the Bed Manager asked resulted in a feeling of unease. Accountability for the participants involved justifying their position;

based on these findings it can be argued that accountability is complex for the nurse whilst the empowering aspects help nurses function as autonomous practitioners. The nurse's position within the context of a hospital setting can prove demanding and may leave the nurse feeling uncomfortable when challenging the views of other health professionals, who may perceive themselves as more knowledgeable or powerful than the nurse (Caulfield, 2005; Hood and Leddy, 2006).

The decision to act is not something these nurses do in all cases; the decision to act courageously to support the patient's 'best interest' is informed by compassion, meaning the ability to recognise the vulnerability of another and advocate for them as needed. It is possible to see from the participants' accounts that the patients within the incidents discussed are those who are more vulnerable, for example those who are dying and are disempowered by their condition. Charlie and Chris (see Chapter 5) both explained how sometimes there is a need to discuss palliative care rather than aggressive treatment, when patients are nearing death. Palliative care may be what the patient would want at this time. The relationships nurses develop with patients and patients' families place them in an appropriate position to begin to understand their expectations, through discussions over the care period (Storch et al., 2004).

10.5d Relationships

The participants explained how they managed working effectively in the hospital setting, as far as they could, by developing trusting professional relationships within the team. In this study such relationships are presented as significant in the understanding of ethical decision making, however, there were times when the

participants felt let down or disappointed by others when their perspective on the situation differed from those in a position to take away the nurse's ability to act autonomously. Participants in this study gave examples of when this was effective and when it was not as they would have hoped. Positive experiences are discussed under 'Collaboration' in Chapter 7 and these less positive experiences in Chapter 7 under the heading 'Conflict'. Where conflict occurred this had the potential to impact on the nurses' experience of moral 'residue', as discussed below.

Notwithstanding the limitations of professional relationships described by the participants, what has been demonstrated in this study is that ethical relationships are crucial to facilitating the nurse's contribution to meeting patients' needs and addressing ethical dilemmas in the context of secondary care. In addition, this relationship, whilst initially appearing to have ethics of care at its heart, is strengthened by the cultivation and use of the virtues of compassion, honesty, courage, empathy, open-mindedness and trustworthiness (Hursthouse, 1999; Armstrong 2007; Hawley, 2007; Selman, 2011; Barnes 2012; Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012).

10.6 Moral residue

Hursthouse (1999) divides moral dilemmas into 'resolvable' and 'irresolvable' dilemmas and indicates both may result in moral residue or some kind of remainder (Hardingham, 2004). This is apparent even when one moral principle clearly overrides another, for example when Drew was instructed to administer sedation to a patient and when Lee took verbal instructions to administer patient medication. Both

recognised they had engaged in a morally right action, however, they had worked outside custom and practice in Drew's case and organisational policy in Lee's case. Moral residue is descriptive of the way they felt in these circumstances (Chapter 7).

Moral distress is delineated within prior literature (Oberle & Hughes, 2001; Aroskar, et. al., 2004; Hardington, 2004; Kalvemmark, et al., 2004; Kain, 2007; Rodney, 2013; Musto et al., 2014) and the participant accounts collected for use in this study. Moral distress is discussed earlier, in Chapter 2, where I highlight how moral distress was experienced by nurses expected to deliver care that they did not agree with or felt the patient might not want. This was narrated by both Jo and Charlie, where dying patients were considered to have received aggressive treatment that was considered by the patients' families and the nursing team to be futile and possibly prolonging patient suffering.

Moral distress has also been identified when nurses find they are not able to deliver the standard of care they feel is best for the patient, due to the context in which they are working, including limited resources (Oberle and Hughes, 2001; Colebatch, 2009). This was evident in Nicky's account, where nursing staff were moved from the intensive care unit to provide care on another ward that was short of qualified nursing staff (see Chapter 6). Such circumstances left Nicky and the team susceptible to experiencing moral distress or residue if unresolved; this can have a cumulative or crescendo effect and may result in the individual nurse reaching breaking point (Epstein and Delgado, 2010)

It could be argued that moral distress appears to be a consequence of the decision to invest oneself, as a nurse, in caring relationships with patients and respectful relationships with others such as colleagues and relatives. Nurses choose their profession and invest energy and emotion in these relationships. This can be seen in each of the participant accounts as they explain how they considered the patient's best interest first and foremost. Charlie acknowledged the importance of the relationships and explained how much information was shared with the nurses reviewing a patient transferred to a new area to help new relationships to develop effectively. Drew, although uncomfortable, felt a responsibility to advocate for the patient and protect him from being unnecessarily sedated. Lee took risks working outside the organisation's policy to ensure that the patients received high quality care. In each of these examples nurses put their professional standing with colleagues at risk in considering the patient's needs, a price only Lee acknowledged explicitly, all the other participants acknowledged this when showing they were ready to be called to account. These dilemmas were resolved; however it is evident that, as indicated, nurses did experience some moral distress. The participants expressed the following emotional responses to the situations they chose to discuss and these included:

'I was very frustrated by the whole thing'.

Drew

'it makes you feel like you've abandoned a child really, you've sort of, you've just, I feel sometimes like you know they trust us to make us aware that we are actually dealing with people'

Charlie

'I feel torn between two decisions to be made – there is something uncomfortable and you are thinking have I done the right thing or haven't I done the right thing'.

Lee

‘.....really felt berated, I really felt like I was just being militant and I was being obstructive and I wasn’t, so it was very difficult’.
Nicky

Moral distress may have serious consequences for the individual, those who come into contact with the health services as a user or carer and the nursing profession. Musto et al. (2014) identified that nurses may contribute to the maintenance of the organisational structures that limit their contribution by, for example, engaging in the belittling of junior staff and failing to appropriately support nurse managers. As a consequence of moral distress nurses can become ‘burnt out’, desensitised to the situations that have resulted in the moral distress, as a way of coping and, in some cases, nurses may leave the profession altogether, which leads to a loss of valuable resources in experienced personnel (Corley, 2002; Hardingham, 2004; Ulrich et al., 2010; Palvish et al., 2011).

Nurses may also contribute to their moral distress by not taking the opportunity to respond appropriately, thereby failing to recognise the positive aspects of moral distress and the potential for change (Musto et al., 2014). Participants with extended years of experience, Charlie and Ashley, demonstrated how they were able to manage moral distress and rationalise the differences between the ideal and reality using reflection in and on action (Schön, 1987).

Recent work has resulted in the understanding that the negative impact of moral distress is not the only result (Hardingham, 2004; Laabs, 2007). Moral distress can be empowering and it has been suggested by Hardingham, (2004) that it may be the catalyst for practice development. Nurses may use reflection on the event which has

caused feelings of unease or distress to help them identify the causes and ways to change practice or build an ethical organisational culture. This would then have the potential to develop practice and improve both the patient's experience and standards of care (Holloway and Freshwater, 2007).

'I feel if we didn't have challenges like this it would be.... I don't think we'd ever develop, but also I think we'd become very complacent and think 'oh everything's fine on here....'
Ross

Irresolvable dilemmas are those in which the agent has a choice of actions and each is unacceptable (Hursthouse, 1999). Chapter 9 indicates how Charlie addressed what could be seen as an irresolvable dilemma as the move was not in 'that' patient's best interest but the best interests of 'another'. Charlie, however, found a way to manage the moral residue, recognising the dissonance and accepting that any resulting impact on the patient being moved was minimised through effective interprofessional working and maintained through effective working ethical relationships. This prevented Charlie from experiencing the potential negative consequences of moral distress. Perhaps what was expressed by Charlie is moral dissonance rather than distress. The ideal 'gold standard' which Charlie and other participants would like to deliver is not always attainable; this may be due to restrictions which are to some extent outside of their control (Ulrich et al., 2010).

In addition to validating some aspects of earlier work on moral distress and moral residue, the findings in this study contribute new insights. They reinforce the possibility that moral distress may be a catalyst for action, rather than be an inevitably negative experience and that moral residue, mediated by reflection in and on action, can positively improve decision making.

10.7 Conclusion

It is observed from the findings that the nurses working in the secondary care setting recognised the moral issues within their daily practice. The nurse participants demonstrated how they attempted to meet the needs of the patients within their care and how they developed effective relationships with patients, their families and other health care professionals to facilitate the best possible outcome for these patients within the context of secondary care. Aristotle's virtue ethics best explain how nurses view and respond to the dilemmas they face in secondary care, however, because of the context, there is some reference to utility as nurses only have access to limited resources. Participants approached dilemmas compassionately, with the patient's well being at the forefront and approached their role flexibly, with an open-mind, in order to achieve the 'best possible' outcome. This, on occasion, required the nurses to have sufficient courage to challenge those in more powerful positions than themselves. Their ability to achieve the desired outcome could be based on ethical relationships fostered by nurses with patients, their families and other health and social care professionals. In maintaining these relationships it appears that nurses are able to undertake moral action as depicted in the (re) conceptualised theoretical framework in Figure 2.

Challenges occurred for these participants when they found themselves in conflict with other health professionals and the organisation's policies, or lacked the resources to ensure best practice was achieved. When nurses were unable to negotiate a satisfactory outcome, some experienced moral distress or moral residue. The participants Ashley and Charlie, both of whom had approximately 30 years nursing experience, appeared to have developed ways of mediating this distress and

using it positively, by acknowledging the moral dissonance which occurs when what may be hoped for is not achieved and recognising that there are limits to what is achievable within the context they are working.

Nurses in these accounts achieved moral agency, resulting in moral action, through the relationships they developed. The virtues possessed by individual nurses may explain why they chose to engage in these relationships as they did and to act as moral agents.

Chapter 11 - Conclusions

11.0 Introduction

Chapter Eleven reviews the aims and objectives, demonstrating that they have been met and highlighting the contribution to nursing knowledge which has been identified within this thesis. Limitations of the study are acknowledged and recommendations are made for nursing practice. Further research into nursing values and ethical decision making, including the moral distress experienced by nurses, is suggested. A comprehensive reflection on the process identifies the journey experienced and my growth in research skills and insight into the subject of ethical dilemmas in nursing practice.

This research had the aim to *identify the values, beliefs and contextual influences that inform decision making and the contribution made by registered nurses in achieving the resolution of ethical dilemmas in nursing practice*. Throughout the thesis four objectives have been addressed:

5. *To identify underpinning values and beliefs which impact on nurses' ethical decision making and moral action.*
6. *To critically discuss new themes which are generated from the data in the light of current literature.*
7. *To identify the contextual influences which impact on nurses' ethical decision making and moral action.*
8. *To discuss the implications of the study findings for future nursing practice.*

Through a review of the literature in Chapter 2, aspects of ethical decision making were identified. Analysis of the collected data (Chapters 4 to 9) developed thematic understanding; this included the nurses' desire to do 'what is best for the patient' (Hawley, 2007; Darzi, 2008; Maben and Griffin, 2008); accountability (Caulfield, 2005; Hood and Leddy, 2006; NMC, 2008); collaboration (Botes 2000a; DH, 2008; NMC, 2008; Johnson and Webber, 2010); and conflict (Oberle and Hughes, 2001; Torjuul and Sørli, 2006; NMC, 2008), which has the potential to result in moral distress (Corely 2002; Gallagher, 2010) and concern for others (Cummings et al., 2010).

Content and interactional analysis was undertaken to inform the contextual influences and how findings of the thematic analysis informed what the nurses contributed when faced with ethical dilemmas. Through this detailed exploration of the data the theoretical framework presented in Chapter 1 has been explored, leading to a re-conceptualisation in Chapter 9.

Analysis of the data collected from nurse participants demonstrated that by developing and maintaining effective therapeutic relationships with patients and their families, nurses perceived that they were in a good position to understand the patients' wishes and needs and, in some cases, the wishes and needs of the family. Other health care professionals may also do this; it is, however, the extensive time that nurses spend with patients during their hospitalisation that places nurses in this position (Peter et al., 2004; Storch et al., 2004). The nurse's relationship with the patient and their family places the nurse in an appropriate and perhaps unique position to promote patient autonomy and, when required, to act as a patient

advocate. This makes the nurse's contribution to addressing ethical decisions an important aspect of inter-professional working.

It is apparent in the findings that nurses make complex decisions in the practice setting, though they may not always be able to act according to their wishes. Whilst nurses have both a wish and a professional responsibility to advocate for patients in their care, there are a number of constraints and other people who need to be considered; compromise is then required. This is illustrated by the narration detailed in Charlie's case in Chapter 9.

11.1 Contribution to nursing knowledge.

11.1a The findings of this study offer an in depth qualitative exploration of the decision making processes used by nurses in secondary care when attempting to resolve ethical dilemmas. The emergent themes add to our understanding of the ways in which acting in the patient's best interests or putting the patient first affects nurses' decision making.

11.1b The conceptual framework outlined in Chapter 1 suggested ethical approaches that might guide nurses' thinking. The findings suggest that the concepts within virtue ethics, in particular courage and honesty, may be significant attributes for nurses to develop. In addition, the findings suggest a re-conceptualisation of the framework (see Chapter 9) to include the centrality of relationships.

The fundamental importance of professional relationships emerges from the data and, whilst relationships with patients are the initial priority, it is essential to have

highly developed interpersonal skills, including communication, to enable nurses to build and maintain professional relationships with a variety of people. The dilemmas shared by participants demonstrate that the nurse needs to negotiate, share communicate and collaborate with many other people in order to try to get what they see as the best outcome for their patient

11.1c Moral distress was identified within the literature in Chapter 2 and this, as well as moral 'residue', is evident in the participants' narration of their experiences.

Corely (2002) offers a framework for understanding moral distress that gains some validation from the participant accounts. They shared their experiences of how they tried to maintain the patient at the centre of care in line with their moral values, their education, their professional code and policy recommendations from The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and Compassion in Practice (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012), as well as working in the context of service-led health care provision limited by the available resources and the requirements to meet government-set targets. Moral distress continues to be a problem for both nurses and other members of the health care profession. Gallagher (2010) recognises that staff shortages, failed attempts to advocate and the developments in delivering care are the main causes of moral distress, all of which are supported in participants' accounts in this study. Gallagher discusses three cases highlighting the need for nurses to show moral courage; this was demonstrated in the accounts of Ross and Drew where they needed to highlight failures in care standards.

However, the findings also add to the suggestion by Hardingham (2004) that moral distress could also be a catalyst for guiding decision making. In particular, in their accounts Charlie and Ashley show how they used reflection in and on action to channel their 'distress', using it to guide action. Rather than conceptualising moral distress and its residue as a 'negative' outcome of ethical dilemmas, it may be better understood when embraced as a guide to action throughout the decision making process.

11.2 Limitations of the study

It is essential to recognise the limitations of any research study; without insight into limitations the researcher or interpretation of the research presented may be over optimistic (Polit and Beck 2008; Burns and Grove, 2009). For the interpretation of the research findings to be realistic and therefore believable, the limitations have been identified:

1. Data has been gathered from nurses working within a single Trust and the organisation culture may impact on what nurses do; organisational culture may vary from one NHS Trust to another. Those working within that Trust, especially those who have lived in the geographical locality, may reflect the values of the local culture internal to the practice setting rather than the population of registered nurses working in Britain and this therefore may affect the transferability of the findings (Burns and Grove, 2009).
2. The issue of sample size within qualitative research was critically discussed in Chapter 3 of this thesis. Despite asserting that the range of the narratives and the quality of the data from the 11 participants is sufficient, this is worthy

of inclusion as a limitation. The judgement to stop at 11 participants was based on the researcher's experience in the field of enquiry, the context of the sample setting and the depth of data collected. As the interviews undertaken provided sufficient data to meet the study aims and objectives, it was considered satisfactory. However on reflection, it could be that in future further explorations and expansions of this thesis' contribution, a wider and larger sample would be required to establish representative perceptions in the nursing profession.

3. The participants were all self selected and therefore may have had a disposition that recognised the importance of ethical dilemmas and an awareness of the nurse role in their resolution (Polit and Beck,. 2008).
4. The researcher's own experience as a Registered Nurse may have had an influence on the interpretations of the data collected (Parahoo, 2006; Polit and Beck, 2008).

11.3 Recommendations

11.3a Recommendations for nursing practice

Having completed this exploratory study, it is evident that whilst nurses do have a role in resolving ethical dilemmas in practice, there are still a number of outstanding areas to be addressed to ensure that this is maximised.

Based on the analysis of the participants' narrative accounts, those nurses interviewed had a value system which is reflected in the NMC (2008) Code and the

patients' experience was their primary priority when faced with ethical dilemmas. It is therefore important that nurses are aware of The Code (NMC, 2008) and consider if the professional values within it reflect their personal values, because where there is conflict nurses may struggle to manage the moral distress that they may experience.

Nurses need to be able to communicate effectively to develop and maintain the professional relationships required to achieve effective advocacy. The case study presented in Chapter 9 and the conceptualised theoretical framework (Figure 2) highlight the importance of the relationships nurses had with others in the contribution these nurses made in addressing ethical dilemmas. It is therefore important that nurses have the opportunity to develop advanced interpersonal skills.

Nurses need to be able to influence both micro and macro decision making within health care organisations. Nurses need to begin to take every opportunity to contribute to the development of national and organisational policies which inform their daily nursing practice and the management of organisational resources. Nurses therefore require the courage and the self confidence to engage with others at all levels of healthcare organisations and policy makers.

Participants demonstrated the ability to engage in complex decision making by considering a number of different issues simultaneously. This included the impact of the dilemma and the options available to them. In order to do this they applied ethical principles, weighing the benefits and burdens to each person of each option within the dilemma. Student nurses will therefore need to be appropriately prepared with the skills to address such complex dilemmas once they have been accepted onto a

nursing degree programme. They will also need to develop the self confidence to contribute effectively and the courage to challenge others appropriately when the situation requires it.

11.3b Recommendations for further research.

Nursing values and ethical decision making

Participants involved in this study were Senior Charge Nurses, Charge Nurses or Staff Nurses working on a ward or department. Further research using a case study is planned; a Senior Nurse with strategic level responsibilities within the organisation will be interviewed using the same semi-structured interview process. Agreement in principle has been granted and ethical approval is being sought.

Further research studies could to be undertaken within the UK primary care sector and internationally, involving staff in both primary and secondary care settings, to establish if the nursing values identified in this study are shared globally and across care settings.

11.3c Moral dissonance.

A key theme that has emerged is that of moral distress; Corely (2002) presented a model of moral distress based on a review of the literature, recommending that further research be undertaken. It is evident from the findings in this thesis that whilst nurses did find ways of contributing to the resolution of these dilemmas, they also highlighted the distress or discomfort they experienced when they felt that the best possible outcome for the patient was not achieved or when they came into conflict with others in the context of meeting their duty of care. The changes in NHS

provision have resulted in an increased risk of nurses experiencing moral distress as services become driven by policy and organisational productivity objectives. The increased demands placed on limited resources due to the increased number of treatment options available and increased demand for care provision have been highlighted in Chapter 7 of this thesis.

Moral dissonance has been identified within this study and in recent literature (Cronqvist et al., 2006; Fairchild, 2010). It appears that, in some cases, experienced nurses are able to recognise the dissonance between the ideal outcome and what is achievable with the context of their practice, thus limiting the moral distress experienced and the potential negative impact.

Research is therefore required in order to:

- Identify ways to ensure the nursing voice is heard and respected at all levels within the organisation from macro-level organisational policy making and ways of delivering care to micro level decisions associated with individual patient treatment, care and ethical decisions in practice; this may help to reduce the moral distress experienced by nurses.
- Identify strategies to help nurses address any residual moral distress, to avoid any negative consequences.
- Identify how experienced nurses are able to recognise and accept moral dissonance, using this as a catalyst, and so limit the moral distress experienced and improve outcomes.

11.4 Dissemination of results.

This thesis will be available through the University of Huddersfield repository which provides open access to the full text. All participants have received information on how to access this so they are able to see how their accounts have contributed to the findings of this research.

A minimum of two papers will be submitted to appropriate journals to facilitate further dissemination. One will be a scholarly publication and the other will be aimed at reaching nurses in clinical practice.

Abstracts will be submitted to nursing conferences, the RCN research conference and the International Philosophy of Nursing conference, as these two attract different audiences, both of whom may have an interest the study findings.

11.5 Reflection

A reflection of the process from the conception of the research aim to the writing of the thesis has been undertaken. Gibbs (1988) reflective cycle was used to facilitate this reflective process.

11.5a What happened?

Framing my Ideas

In the initial stages I was aware of the topic I wanted to explore, having spent approximately 20 years working in acute medicine and older people's services. I was aware of the changes in health care provision and the increase in treatment options available since my initial enrolment on the nurse register as an enrolled nurse. These

changes had resulted in the need for nurses to make more and more complex decisions, the most challenging of these were ethical in nature.

I had also been teaching ethics to undergraduate preregistration nursing students for 2 years; many of my students struggled to see how this would help them in their practice as registered nurses. Ethical decision making was recognised in the 'big' questions, 'life and death situations', and some students perceived that doctors made the important decisions and that nurses were only involved in the care that had been prescribed. When exploring this further with students it became apparent that students had observed nurses working in environments where, day-to-day, they were faced with ethical decisions, however this had not been articulated to the students and they had not recognised it.

The literature review

A literature review was undertaken to discover the current understanding of the topic and a theoretical framework was developed to help with the understanding of the concept of ethical dilemmas in nursing practice.

A further detailed search of the literature was undertaken and emergent themes were identified. I had to be disciplined in both protecting time to undertake this and in recording and storing the literature retrieved.

A proforma was used (see Appendix 3) to record the main findings from the critical review of each piece of literature retrieved. This had been developed whilst undertaking a Master's degree. The need to develop this modified proforma was to

enable different types of evidence used to be within the review of the current literature. A wide variety of evidence is used as, within ethics, both philosophical development of theories and empirical work have been undertaken.

Ethical approval

Ethical approval was sought and obtained from both the University of Huddersfield and the National Research Ethics Committee for the NHS. To obtain approval extensive documentation and a full explanation of the proposed study were required. I also attended the meeting of the committee to respond to questions regarding the study. Following approval, permission to access participants from The Trust was sought and granted.

Progression monitoring

Progression monitoring was also required at key stages, at the end of years two and three of the programme, as this was a part time PhD. Progression monitoring at the end of year two required a written submission which was reviewed and feedback provided on further development of the study.

Progression monitoring at the end of year three required both written submission and oral presentation, to which members of the university staff and their postgraduate research students were invited, and at which they could ask questions together with the university appointed reviewers.

The pilot study

The pilot study was undertaken prior to the progression point at the end of year 3 and involved staff from the university. Initial interviews were shorter than I had hoped they would be, however, with experience my interviewing skills improved and I was able to engage with the voluntary participants sufficiently to obtain rich data which was later used to inform both the pilot study findings and the main study findings (reflection was undertaken after each interview to facilitate this). Interviews were audio recorded; it took a little time to get to grips with the MP3 recorder but once I had practised a number of times this proved to be a suitable way of collecting the narrative accounts provided by participants. I transcribed the pilot interviews, which took at least a whole day each.

Once transcribed, the analysis could be undertaken and, for the pilot data, only a thematic analysis was undertaken, using the software package NVIVO 8. It was the first time I had used this type of package and, again, this was challenging at first but as I became more practiced I was able to code the data more efficiently.

European Doctorate Students Research Conference

Findings from the pilot study were presented at the European Doctorate Students Research Conference in September 2010. This involved travelling to Berlin where the conference took place and meeting other doctoral students from across Europe. I was able to discuss my work with others in a similar position to myself in the context of undertaking doctoral studies. We compared our work in terms of topics, research methods, expectations of our supervisors and institutions and the final oral examination process.

The study

Once NREC's approval had been gained and a letter of access provided by the research and development department of The Trust received, I was able to begin recruiting participants from The Trust. The recruitment of participants involved visiting wards and departments, speaking to the ward or department manager where possible or the nurse in charge on that day, leaving a letter with them to explain the research to be undertaken and a copy of the participant information sheet. I followed this up with further telephone contact to arrange a time when I could visit and talk to any registered nurses who might be interested in taking part. Nine participants were recruited from a variety of areas. All were interviewed; one participant stopped the interview and decided not to continue.

I reassured the participant that this was not a problem, the tape was stopped and I asked the participant if there was anything I could do for her or if she felt she wanted to access counselling. The participant wanted to contribute to the study but did not want to continue with the interview. A long discussion about her experiences then took place; this included how the participant felt about the nurse's involvement, or in some cases lack of inclusion in the decision making process, whilst having to provide the care prescribed as a result of the decision. The participant was feeling better and was happy for me to use my reflections and account of our conversation as part of the final thesis.

Transcription of these interviews was undertaken by an audio typist as the time involved was thought to be better spent reading and re-reading the transcripts whilst listening to the recordings to facilitate in-depth knowledge of the interviews so to

facilitate data analysis. Data analysis was undertaken using NVIVO 8 to code data; thematic content and interactional analysis were undertaken.

Student conference

A keynote presentation was undertaken as part of the student research conference held annually at the university as the theme was ethics in clinical practice (see Appendix 9).

Final writing of the thesis

Completing the writing of the thesis was difficult and took a substantial length of time with numerous drafts being discussed with supervisors. Sections of this had been undertaken as the research progressed, however sections required revisiting and developing for the final thesis.

11.5b What were you thinking and feeling?

Framing my ideas

In the initial stages I was excited that, having wanted to undertake research in this field for many years, I was now embarking on this journey. At the same time, however, there were feelings of anxiety, of 'would my work make the grade?'

I knew that this was an opportunity to research what I wanted and that I might never have this luxury again; I wanted to make the most of this.

I hoped that this work would inform my role as Senior Lecturer and help me to inspire others to practise ethically as student nurses and as registered nurses, in whatever area they ultimately practised.

The literature review

I was familiar with this aspect of the research process as I had undertaken a literature review for a recently awarded master's degree. I was, however, surprised at the limited range of empirical work I found into what I considered to be an essential part of nursing practice, aspects of which have recently been further identified as such by Francis (2013).

Ethical approval

I was fully aware of the requirement of the School ethics panel as I had been on the ethics panel for two years by this time and was not concerned about the process; I understood the importance of the role of the ethics panel and how feedback from the panel could help to further develop the proposed research.

Progression monitoring

Whilst I recognise the importance of progression monitoring I felt that the extensive form filling that this seemed to involve took me away from making the progress I wanted with the research, particularly at the end of year one.

Monitoring at the end of year three was even more time consuming and my previous frustrations re-emerged, however once I had completed the written submission and prepared my oral presentation I began to see my work as a whole and was able to

recognise the progress I had made. I found this motivating and helpful in forward planning for the next 12 months.

The oral presentation was to a group of about 20 people and, although I was used to teaching large groups of students, I remained anxious about this and felt vulnerable at having to share my work with anyone other than my academic supervisory team. I felt relieved and happy when this was over as it appeared to go well; the written feedback, however, was provided on a form and was minimal. I felt disappointed as I had hoped for constructive comments to help me question my work and develop it further.

The pilot study

The pilot study was difficult as I was not confident that I would retrieve the data I was looking for with the semi-structured interview questions I had developed. My anxiety showed and knowing some of the participants for some time perhaps made me more so, rather than making the process easier. My confidence increased with each interview and the questions were modified as appropriate.

Initially I thought the data I was collecting would be insufficient and lacking depth as many, but not all, of these accounts reflected my own experiences. However, as I thematically analysed this data it soon became apparent that I had collected some valuable data, with some participants expressing similar thoughts, feelings and responses within the very different dilemmas they had faced.

European Doctorate Students Research Conference

Attending this conference presented me with more than the challenge of presenting my work. Unfamiliar with foreign travel and having never travelled abroad alone I was filled with apprehension; managing to overcome some of these perceived boundaries proved to be a positive experience and confidence building.

Meeting with others also studying at doctorate level was enlightening and others showed interest in my work and I in the work of others. Confidence in our work, and our ability in discussing this with others, further developed over the weekend.

The study

Entering environments (although they were in a hospital and I am familiar with the hospital environment) in which I had never worked or knew anyone was difficult and I was a little concerned about it. I did, however, have a colleague who worked in The Trust and kindly came with me to meet the ward and department managers. Once I had made the initial contact I felt more confident in contacting and meeting with the managers and prospective participants.

Meeting and engaging with the participants was very rewarding; I felt like a nurse again for the first time in a number of years, it reminded me of why I do the job I do and the important role nurses play in the lives of others, especially when they are vulnerable. I felt that I was able to very quickly build a rapport with participants.

Engaging with the data and undertaking the analysis was rewarding and reminded me why, firstly, I had decided to become a nurse and, again, how important this aspect of professional nursing practice is.

Final writing of the thesis

This felt like the final endurance test, having had some episodes of ill health during this time I was determined this was not going to stop me completing this thesis. The support at this stage from both supervisors and colleagues was more than I could have asked for and my appreciation of this cannot be expressed sufficiently.

11.5c What was good about the experience?

The good things about this experience are the people I have met, the things I have learned and knowing what it is I need to do next.

The people who have supported me on this journey have proved to be the most valuable resource available to me both professionally and personally; valuing my work; discussing aspects of this and helping me increase the breadth of perspectives from which I viewed things; supporting me to free up time to spend on the research and writing of this thesis; an giving me space to rest and reflect when I needed it; believing in me and my work when I did not; helping me to find my way through.

I have learned that, with hard work, commitment and the support of others, I can develop new skills to further develop my research and contribute to the way nurses act and are perceived by others. I have also learned that although I struggle with

written English, it should not stop me from contributing in this way, as help is always available.

I have, right at the end of this first stage of my journey, discovered it is possible to make time for research. As the deadline approaches for the submission and each draft requires more work than I had initially expected, I have found the time.

What was bad about the experience?

I was not able to make the time I wanted to complete this work and sometimes I felt it would take forever; it has drawn me away from other things, such as meetings with friends and family. I have, however, now found I am able to do this.

I felt that in the effort to support my progress with this study I had been excluded from other opportunities to develop professionally and that, whilst I had hoped that it would bring me closer to the research community at the university, it has served as an obstacle.

11.5d What sense can you make of the situation?

The situation is one that many people go through and I do not think it is possible to explain what it is about to someone who has not been there. I know that the support of others and having friends on the same journey have been a great help to me, as indicated above.

- The rapport quickly developed with participants was, I think, because as I am also a nurse, the participants felt at ease. As suggested in Chapter 6, there is

a perceived shared value system amongst nurses and, therefore, the understanding that there would be a shared understanding of their dilemmas.

I recognise it is something that I both wanted and needed to do both personally and professionally and I now believe that I am in a better position to continue developing as a researcher and make a contribution to understanding ethical practice and reveal the voice of nurses working in the context of the changing health care system.

What else could have been done?

Progression monitoring

I should have followed up the oral presentation and made an appointment for further feedback from the internal reviewers of my work than was available on the feedback form issued by the university. This would have given me the opportunity to recognise areas that could have been developed to strengthen the work and possibly increase my confidence in this work.

European Doctorate Students Research Conference

I could have maintained contact with those I met at the conference. I could have submitted abstracts to other conferences as my work progressed

The study

Data could have been collected from nurses working in other geographical locations, Trusts or organisations providing secondary care. This may have strengthened the findings of this study (Polit and Beck, 2008) as it has not been possible to exclude that the values exhibited by the participants were not influenced by the organisation

within which they were working. Participants did, however, have different backgrounds and had worked in other organisations.

If it arose again what would you do?

I would undertake this as a full time course of study rather than a part-time one; I think that I would have enjoyed it more than I have. As a full time student I would have been more able to main the momentum, gained a richer understanding of the topic and the participants' experiences and probably felt part of the research community within the university. I did not feel part of either the postgraduate research community or the postgraduate student community, as a part-time student and a full-time senior lecturer in the same institution, with the majority of my time taken up with teaching and administrative work rather than balancing the two effectively.

With regard to the research process, I do not think I would do things any differently in respect of data collection and data analysis. For the literature review I would manage my time differently and undertake this in blocks of time (several days at a time) rather than in short bursts of a single day or afternoon.

I think that I could have made more of the opportunity to network and keep in touch with the people I met at the European Doctorate Students Research Conference, and taken up the opportunity to attend more conferences to meet others working in the same field.

11.6 Summary

This thesis details an exploratory enquiry into the contribution nurses make in the resolution of ethical dilemmas in secondary care.

The purpose of the study was to identify the contribution nurses make to resolving ethical dilemmas and what it was that formed the decisions and actions associated with this. In order to establish this, a qualitative exploratory study was undertaken, using a semi structured interview process to collect data.

Chapter 1 presents the background to the study and explains that the context of secondary care has changed significantly over the last 20 years. These changes are the consequence of technical developments and the increased number of treatment options available for a variety of conditions and, consequently, the role of the nurse has changed significantly (Storch et.al., 2004).

From examination of the literature retrieved to inform the background of this study, a theoretical framework was developed (see Figure 1). The theoretical framework used in this investigation shows the process the nurse might follow when addressing dilemmas and begins with the identification of the dilemma or problem which is triggered by the nurse's moral conscience. Moral reasoning, based on the nurse's values and beliefs, informs the initial response to the situation. This is then justified through ethical decision making and followed by the moral action which the nurse has decided is the best available course of action in context.

The nurse participants demonstrated that they believed that the welfare of the patient is the most important aspect of the nurse's role; that nurses should be prepared to be accountable for their actions, promote patient autonomy; that the impact of any action on 'others' should be considered and that nurses have a shared understanding and a set of beliefs and values.

Nurses value people most of all and in the secondary care context that begins with the patient; the virtues of compassion, honesty and trustworthiness are important in developing these professional and ethical relationships which are required to facilitate best possible outcomes for patients and others who are affected by dilemmas the nurses face.

The aspect of the nurses' behaviour required in order to facilitate moral action was the importance of the professional relationships developed and maintained by nurses in achieving the preferred outcomes for the patients and facilitating the resolution of the ethical dilemmas. These relationships are with patients, families and other members of the multidisciplinary team and facilitate collaborative working in partnership to achieve moral action. Nurse participants highlighted how they work with others and emphasised their role within the collaborative working that was undertaken in each account.

Therefore, it is likely that nurses may use a combination of approaches to ethical decision making and the indications from this exploratory study are that they use a virtue based approach. The virtue based approach is complemented by the development of key ethical relationships, developed and maintained between

nurses, the patients for whom they are caring, the patients' families and other health and social care professionals involved in the interprofessional care delivered.

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Appendix 1

Literature selected for use in the development of the theoretical framework

Appendix 1: Literature selected for use in the development of the theoretical framework

Author /date	Method	Strengths	Weakness	Main point	Significance
1. Almark 1998	Discussion	Well constructed & referenced	Age	Caring about the right things in the right way.	Caring as a virtue
2. Aroskar, et. al., 2004	Qualitative Focus groups 36 RNs	N = 36 Detailed analysis	Nurse participants all had 20 years plus experience	Looks at nurses potential involvement in Policy development	How policy contributes to moral distress
3. Banks, 2003	Discussion / evaluative	In-depth evaluation of codes of ethics for social professions	Does not include nursing	Highlights some similarities limitations to these	‘ The code ‘
4. Bell 2003	Questionnaire	N=9751% response rate	No such role currently in UK	Utility nurses role	Resource allocation
5. Botes 2000a	Integrated ethical decision making – health care team	Well organised and supported		Supports health care ethics rather than biomedical or nursing Need for moral agent	Ethical decision making collaborative working esp. nurse and Dr.
6. Botes 2000b	Discussion Ethic of care V justice	Ethics of care and justice	Limits to two perspectives	Recommend that a balance between these two poles is required	
7. Clará et al 2004	Cross sectional study	N= 253 From 26 departments	Participants are surgeons	Youngest & most senior surgeons higher companion	Conflicting principle
8. Carter and Klugman 2001	Discussion	Well constructed and referenced		Philosophy of cultural engagement	Culture ,beliefs and values

Author /date	Method	Strengths	Weakness	Main point	Significance
11. Dierckx de Casterle, et. al., 2004	Discusses the contribution of two empirical studies	Both studies have Large sample size stable over time	Now 9 years old, changes in health care deliver has continued to change	Nurses use conventional methods when making ethical decisions	Challenges idea if 'best for the patient'
9. Elgar and Harding 2002	Questionnaire 5pt Likert scale	N=127+168	Medical & law students	Patient rights	Patient autonomy
10. Herbert 1997	Discussion re stroke patients & DNR decision	Recognises the decisions making	Only considers Utilitarian & deontological approaches	Considers the dilemma from a number of perspectives	Uphold the role of the nurse in the decision making process
11. Hurst et al 2005	Survey Telephone interviews	N=344 64% response rate	Participants are Physicians	Avoided conflict Looked for assistance In decision-making Sort to protect their integrity	Shared decision making
12. Jenkin and Millard 2006	Discussion / reflective approach	Considers the complexity and perspectives Well referenced	7 years old	Patients best interest	Acknowledges that some dilemmas need to be addressed quickly
13. Kain 2007	Literature review	Well documented search, well developed discussion	Care of dying babies	Moral distress during this & the impact on the Nurse	Calls for framework of primary care ethics due to increase in complex dilemmas
14. Kalvemmark, et. al., 2004	Qualitative Focus groups	N= 3 focus groups 4-7 in each 1.3 – 2 hours		Includes The need for support & structures re ethical decision making	Conclusion is nurses use conventional approach to ethical decision making
15. Martin 2004	Used policy documents to examine the language of nursing ethics	Examines both internal and external influences on the context of primary care	Primary care		

Author /date	Method	Strengths	Weakness	Main point	Significance
16. Nouredine 2001	Discussion	Nursing theory & nursing ethics	The discussion of the impact of the context is limited	Highlight nursing values	Recognises the importance of caring
17. Oberle & Hughes 2001	Qualitative, interview Thematic analysis	Drs =7 Nurses = 14	More nurses than Doctors - not justified	Dr make the decisions Nurses implement the decisions leading to moral distress	Challenged by new findings
18. Pavlish et. al., 2011	qualitative descriptive study	70 participants	No face to face contact with participant Participants recruited from ethics conference (bias)	Relates to aspects raised by participants	The nurses role in EDM Conflict
19. Redman and Fry 2000	Five studies 4 specialties	Five studies		Looking at ethical conflict described by nurses	Less ethical conflict described more moral distress and unresolved dilemmas
20. Salloch, and Breitsameter 2010	Qualitative Grounded theory	10 interviews – saturation reached	Nurses & volunteers This therefore is not based purely on nurses and does not involve the full range of people working in the hospice	Importance of being non judgmental	Conflict between the patients' wishes and values and those of the participant (nurse)
21. Tourjuul & Sørli 2006	Qualitative Phenomenological – hermeneutic interpretation	Small of 10 however in depth interviews & analysis produced rich data	Surgical nurses only	Norway Tension between nurses and the limits imposed by organizational objectives	Pt Records had documentation by nurses indicate that nurses put biology over biography

Appendix 2

Literature selected for inclusion in the literature review

Appendix 2: Literature selected for inclusion in the literature review

Author /date	Method	Strengths	Weakness	Main point	S Significance
1. Aroskar, et. al., 2004	Qualitative Focus groups 36 RNs	N = 36 Detailed analysis	Nurse participants all had 20 years plus experience	Looks at nurses potential involvement in Policy development	How policy contributes to moral distress
2. Banks, 2003	Discussion / evaluative	In-depth evaluation of codes of ethics for social professions	Does not include nursing	Highlights some similarities limitations to these.	' The code '
3. Botes 2000a	Integrated ethical decision making – health care team	Well organised and supported		Supports health care ethics rather than biomedical or nursing Need for moral agent	Ethical decision making collaborative working esp. nurse and Dr.
4. Botes 2000b	Discussion Ethic of care V justice	Ethics of care and justice	Limits to two perspectives	Recommend that a balance between these two poles id required	
5. Corely 2002	Philosophical discussion	Will structured and referenced	Does not identify how the supporting literature was selected		Proposes theory of moral distress
6. Dierckx de Casterle, et. al., 2004	Discusses the contribution of two empirical studies	Both studies have Large sample size stable over time	Now 9 years old, changes in health care deliver has continued to change	Nurses use conventional methods when making ethical decisions	Challenges idea if 'best for the patient'
7. Dierckx de Casterle, et. al., 2010	Grounded theory	N =18 registered nurses	Did not reach saturation.	Nurses contribute to the care process (good)	Decision making is taken on by senior nurse & physician.

Author /date	Method	Strengths	Weakness	Main point	Significance
8. Donker and Andrews 2011	Qualitative Anonymous self administered questionnaire	N=200	Loss of depth which may have been retrieved using other methods	Local beliefs and organisational requirements limit the application of ethical codes	Highlights how cultural values and norms influence ethical practice
9. Hardington, 2004	Discussion	Well structured Balanced discussion Reflection	Search strategy is unclear	Nurses as part of a moral community	Moral distress & relates to tension with the 'system'
10. Heikkinen, et al., 2006	Qualitative, international.	23 focus groups N= 138 participants in total Several researched	Focus groups may stifle disclosure of some 'unethical practices'	Obstacles to implementing codes	7 barriers identified Nurses MDT Patient families Organization Nursing profession Society /health policy
11. Hyde et.al., 2005	Discourse analysis	45 patient records	Patient records can be limited	Little evidence within documentation of nurses interpersonal interactional with patients and the facilitation of patient autonomy.	Highlights that record indicate that nurses put 'biology over biography'
12. Liaschenko and Peter, 2004	Discussion paper	Discusses the limitations of professional ethics	10 years old – still relevant though		Identifies the 'ethic of work' and nursing as work
13. Kain 2007	Literature review	Well documented search, well developed discussion	Care of dying babies	Moral distress during this & the impact on the Nurse	Policy / resources limiting action
14. Kalvemark, et. al., 2004	Qualitative Focus groups	N- = 3 focus groups 4-7 in each 1.3 – 2 hours		Includes The need for support & structures re ethical decision making	Conclusion is nurses use conventional approach to ethical decision making

Author /date	Method	Strengths	Weakness	Main point	Significance
15. Lamb & Sevdalis, 2011	Discussion paper	Effective discussion Well referenced current	Editorial	Increased nurse lead decision making Need for increased research.	Collaboration
16. Long- Sutehall et al., 2011	Qualitative Grounded theory N= 13	Current Semi-structured interview vignettes		Nurse involvement increases when implementing the decision	Context Collaboration
17. Oberle & Hughes, 2001	Qualitative, interview Thematic analysis	Drs =7 Nurses = 14	More nurses than Doctors - not justified	Dr make the decisions Nurses implement the decisions leading to moral distress	Challenged by new findings
18. Pavlish et. al., 2011	Qualitative descriptive study.	70 participants qualitative descriptive study	No face to face contact with participant Participants recruited from ethics conference	Relates to aspects raised by participants	The nurses role in EDM Conflict
19. Peter, et. al., 2004	Literature review Critical incident Questionnaire	18 papers	Dated	About nurses resistance to ethical action Recommendation how to address this	Nurses resist situation where there is moral conflict Lots about power
20. Redman and Fry, 2000	Five studies 4 specialties	N=164 N=97 N=118 N=91 N=470		Looking at ethical conflict described by nurses	Less ethical conflict described more moral distress and unresolved dilemmas
21. Salloch, and Breitsameter, 2010	Qualitative Grounded theory	10 interviews – saturation reached	Nurses & volunteers Not based purely on nurses / does not involve the full range of people working in the hospice	Importance of being non judgmental	Conflict been the patients' wishes and values and those of the participant (nurse)

Author /date	Method	Strengths	Weakness	Main point	Significance
22. Tourjuul & Sørli, 2006	Qualitative Phenomenological – hermeneutic interpretation	Small of 10 however in depth interviews & analysis produced rich data	Surgical nurses only	Norway Tension between nurses and the limits imposed by organizational objectives	Pt Records had documentation by nurses indicate that nurses put biology over biography
23. Vandrevalla et. al., 2006	Interpretive phenomenology Focus groups	N= 48 older people	All UK Limited acknowledgement of limitations	'patients' views on ethical decision making	Themes match some of those used by nurses
24. Ulrich, et.al., 2010	Postal survey	N= 422 returned 52% response rate	Closed questions	'Nurses face daily ethical challenges'	The need for ethical related interventions
25. Varcoe et. al., 2004	19 Focus groups	N=87	Focus groups may stifle disclosure of some less mainstream opinions	Presents a 'new' understanding of nursing ethics	Working 'in between' Away of being and action as moral agent.
26. Verpeet, et al., 2004	Qualitative 8 Focus groups	N = 50 thematic analysis audit trail maintained	Some limitations identified within the data collected	Nurses view on ethical codes	Useful for a number of reasons detailed in the paper
27. Wolf and Zuzelo, 2007	Qualitative Critical incidents	N = 20 Range of experience All nurses	No acknowledgment of limitations	Never again stories Disempowered nurses	Talks extensively about the constraints on nursing action & disempowerment

Appendix 3

Review Framework

Review Framework Proforma

	Questions	Yes / No / NA	Comments
1	The researcher		
	What is their back ground?		
2	The problem		
	Is It clearly stated?		
	Dose this give a new creative slant/ position		
	Does it relate to nursing practice / education		
3	Literature review		
	Relevant topic?		
	Is it comprehensive?		
	Is current and up-to-date material included?		
	Are classic studies cited?		
	Dose the summary accurately capture the crucial aspects of the literature and relevance to the study?		
4	The design		
	Dose the design statement convey the type of report being discussed?		
	Are theoretical frameworks discussed?		
	Are the hypotheses stated clearly?		
	Straight forward description of the plan with rationale?		
	Could other replicate the study based on information provided?		
	Are technical terms clearly defined?		
5	Data collection		
	Is the method selected discussed?		
	Is rationale provided?		
	Does it stand up to criticism?		
	Are details of sampling methods / sizes clear?		
	Are details of special instruments given? Questionnaires, interview schedules, measuring techniques		
	Is reliability and validity discussed?		
6	Ethical issues		
	Are procedures ethical?		
	Is informed consent obtained?		

	Confidentiality safeguarded?		
	Ethical clearance obtained?		
	Respect for academic property upheld/?		
7	Data analysis		
	Is the method selected appropriate for the data?		
	Is it clearly described?		
	Are the findings clearly presented?		
8	Reporting the results		
	Dose the title identify the type of study?		
	Is the abstract clear?		
	Has the researcher been honest?		
	Is non-discriminatory language used?		
9.	Discussion / argument		
	Are the results clearly discussed?		
	Are the results adequately discussed?		
	Is the argument clearly constructed		
OR	Are some aspects of the discussion / argument emphasised more than others, if so is this justified?		
10	Conclusion / recommendations		
	Are the conclusions justified		
	Are the conclusions linked to the original purpose?		
	Have new insights been uncovered?		
	Have new research questions emerged?		
	Are the recommendations feasible?		
	Are possible limitations of the study if identified?		
11	What are the strengths of t he study / paper		
12	What are the limitations of the study / paper?		

Adapted from Burns and Grove's (1987) model and Morrison's (1991)

Appendix 4

Participant information (pilot study)

What the nurse does?

A narrative approach to understanding the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice.

Information sheet

You invited to take part in a research project that is exploring the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice. Please take the time to read this leaflet through and do not hesitate to ask if there is anything that is not clear or if you would like more information. It is important that before deciding to take part you fully understand why this research is being undertaken and what it will involve.

What is the purpose of the study?

The purpose of this research is to identify how registered nurses working within secondary care provision view their personal and professional contribution to achieving the satisfactory resolution of ethical dilemmas within the context of their nursing practice.

.

Why have I been chosen and what will I have to do?

You have been chosen because you work as a registered nurse within the secondary care environment.

I would like to collect your perspective on the contribution you make within the context of your nursing practice. This will involve an individual meeting during which time we will talk about your experiences and contributions. The narrative provided by you will be recorded for transcribing at a later date prior to analysis. It is envisaged that the meeting will last approximately 30 minutes to one hour.

Can I withdraw from the study?

If you do decide to take part you are still free to withdraw at any time and without giving a reason.

Who is organising and funding the study?

The research is funded and supported by the University of Huddersfield.

The researcher is Nichola Barlow who is a part time PhD student at the University. Nichola will correspond with you at all stages of the study. Nichola will meet with you discuss your contribution and record the meeting. The transcribed data will be returned to you for verification prior to analysis.

If you require any further information about the project then please contact Nichola Barlow at the University of Huddersfield email:n.a.barlow@hud.ac.uk, or telephone 01484 473472.

You will be able to have access to the completed report once the research is finished the writing up process has been completed.

Thank you

Appendix 5

Participant consent form (pilot study)

What the nurse does?

A narrative approach to understanding the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice.

Consent to participate

Please initial the box

- | | |
|--|--------------------------|
| 1. I have read and understand the information sheet for the above study, provided. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily. | ☐ |
| 2. My participation in this study is voluntary and I understand that I am free to withdraw from the study without giving a reason. | ☐ |
| 3. I understand that the collected narrative will be recorded and on completion of the research the recordings will be destroyed along with the original questionnaire responses. | ☐ |
| 4. I understand that the original recorded narratives will not be shared with any individuals apart from the researcher, audio typist engaged to transcribe the data and the study supervisors. | ☐ |
| 5. I understand that the final report, containing anonymous quotations may be used for the publication of peer reviewed journal articles and conference presentations. | ☐ |
| 6. I agree to participate in this study. | ☐ |

Participant Name

Signature

Date

Researcher

Signature

Date

Appendix 6

Participant information

What the nurse does?

Exploring the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice.

Information sheet

You are invited to take part in a research project that is exploring the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice. Please take the time to read this leaflet through and do not hesitate to ask if there is anything that is not clear or if you would like more information. It is important that before deciding to take part you fully understand why this research is being undertaken and what it will involve.

What is the purpose of the study?

Nurses face ethical dilemmas as part of their nursing practice and it is often these that cause the greatest concern for the patient, their family and the nurse. It is therefore important that we are able to understand what, currently, registered nurses contribute to addressing these dilemmas as they occur.

Why have I been chosen and what will I have to do?

You have been chosen because you work as a registered nurse within the secondary care environment.

I would like to collect your perspective on the contribution you make within the context of your nursing practice. This will involve an individual meeting during which time we will talk about your experiences and contributions. The narrative provided by you will be recorded for transcribing at a later date prior to analysis. It is envisaged that the meeting will last approximately 30 minutes to one hour.

Can I withdraw from the study?

If you do decide to take part you are still free to withdraw at any time and without giving a reason. If I choose to withdraw from the study any data collected will be retained for use within the study.

Who is organising and funding the study?

The research is funded and supported by the University of Huddersfield.

The researcher is Nichola Barlow who is a part time PhD student at the University. Nichola will correspond with you at all stages of the study. Nichola will meet with you discuss your contribution and record the meeting. The transcribed data will be returned to you to confirm you are happy with it prior to analysis.

If you require any further information about the project then please contact Nichola Barlow at the University of Huddersfield email:n.a.barlow@hud.ac.uk, or telephone 01484 473472.

You will be able to have access to the completed report once the research is finished the writing up process has been completed.

Counselling Services

If you require support or counselling as a result of disclosing sensitive or distressing situations you may access the staff counselling services via the occupational health department

Confidentiality Anonymity of participants will be maintained throughout the study. All data collected will be treated confidentially; each participant will be allocated a reference number in order to maintain confidentiality. However disclosure may be required where unprofessional or illegal practice is identified.

Thank you

Appendix 7

Participant consent form

What the nurse does?

Exploring the nursing contribution to the resolution of ethical dilemmas in the context of nursing practice.

Consent to participate

- | | |
|---|--------------------------|
| 2. I have read and understand the information sheet for the above study provided. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily | ☐ |
| 2. My participation in this study is voluntary and I understand that I am free to withdraw from the study without giving a reason. | ☐ |
| 3. If I choose to withdraw from the study any data collected will be retained for use within the study. | ☐ |
| 4. I understand that the collected narrative will be recorded and on completion of the research the recordings will be destroyed along with the original questionnaire responses. | ☐ |
| 5. I understand that the original recorded narratives will not be shared with any individuals apart from the researcher, audio typist engaged to transcribe the data and the study supervisors. | ☐ |
| 6. I understand that the final report, containing anonymous quotations may be used for the publication of peer reviewed journal articles and conference presentations. | ☐ |
| 7. I agree to participate in this study | ☐ |

-----	-----	-----
Participant Name	Signature	Date

-----	-----	-----
Researcher	Signature	Date

Appendix 8

European Doctorate Students Research Conference,

Abstract and PowerPoint presentation



EDCNS 2010 Abstract Form
11th European Doctoral Conference in Nursing Science
Berlin, Germany, 17 - 18th September 2010

Title

What the Nurse does

Exploring the nurses contribution to the resolution of ethical dilemmas in secondary care - the pilot study

Authors

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Abstract

Introduction

Nurses face ethical dilemmas as part of their nursing practice and it is often these that cause the greatest concern for the patient, their family and the nurse (Storch 2004, DH,1999.) . It is therefore important that we are able to understand what, currently, registered nurses contribute to addressing these dilemmas as they occur.

Aim of the study

Nurses face ethical dilemmas as part of their nursing practice and it is often these that cause the greatest concern for the patient, their family and the nurse. It is therefore important that we are able to understand what, currently, registered nurses contribute to addressing these dilemmas as they occur

Methods

This is a qualitative study using audio recording of semistructured interview to collect narrative data from participants (Polit and Beck 2006). A two phased analysis was undertaken firstly a thematic approach was used followed by a narrative analysis designed to examine the cultural dimensions within the clinical setting (Burns and Grove 2001).

Results

This pilot study using a sample of three participants revealed was undertaken to allow the testing of the questions used in the interviews. This also allowed the researcher to develop the skills required for undertaking data collection using this method.

Three themes emerged from the data:

- Authority – Organisational
- Nurse – physician relationship
- ‘Best for the patient’

Discussion incl. Conclusion

Participants identified and discussed conflicts that have arisen between the organisational objectives, procedures or protocol and that which was thought to be ‘best for the patient’. Non of the participant discussed how they had established what was ‘best for the patient’ although this, for participants two and three, become a dominant objective in their accounts

Practical relevance

As a researcher this pilot study highlighted the importance of developing the appropriate interviewing skills required for data collection and appropriate wording of questions to illicit the required data from participants prior to undertaking the main study.

Research implications

The results of the data analysis have identified three key areas identified by registered nurses in relation to ethical dilemmas where further research would be beneficial

References

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- Storch, J. L. (2004) *towards a moral horizon. Nursing Ethics for Leadership and Practice*, Toronto Pearson.
- Department of Health (DOH) (1999) *Making a difference. Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London Department of Health Publications.

WHAT THE NURSE DOES: A PILOT STUDY

Nichola Barlow
BHSc MSc

Aim of the study

- ▣ To identify the values, principles and contextual influences which inform the contribution and influence the action taken by registered nurses in achieving the resolution of ethical dilemmas in nursing practice.

Study Objectives

- ▣ Identify the contextual influences which impact on the nurses ethical decision making and moral action.
- ▣ Identify underpinning beliefs and values which impact on the nurses ethical decision making and moral action.
- ▣ Critically analyse these beliefs values and contextual influences in the light of current thinking.
- ▣ Discuss new themes which are generated from the data collected.

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3

The literature

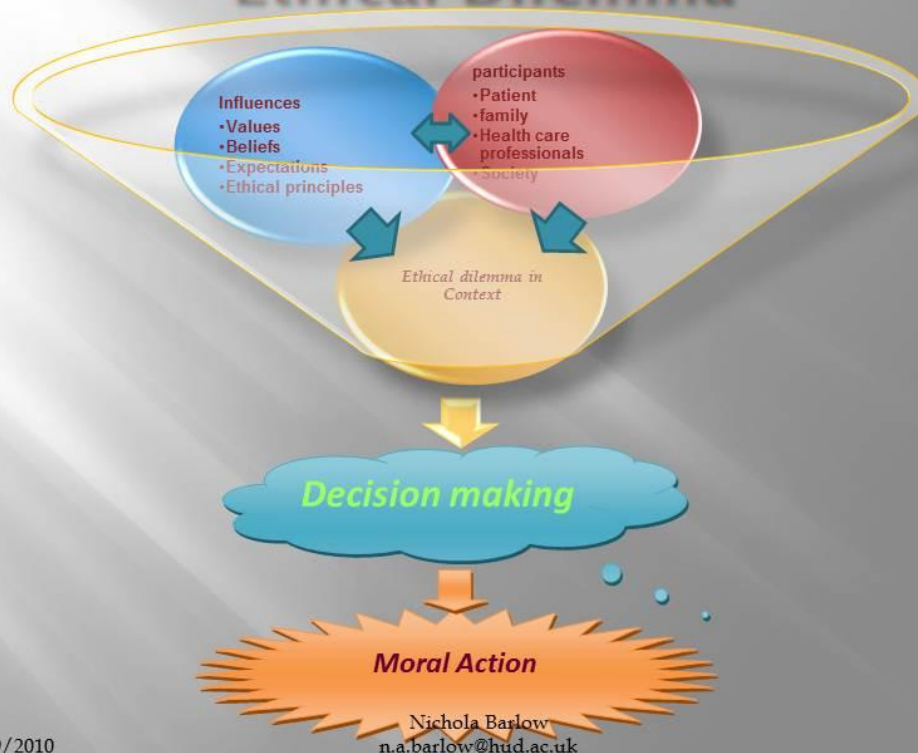
- ▣ Nurses must advocate for those patients who are vulnerable (NMC 2004)
- ▣ The increasing number of complex and expensive options at the disposal of health professionals has increased the frequency and emphasis of these decisions (Storch, 2004).
- ▣ There is a requirement placed on the team to consider the person at the centre of care provided, whilst considering broader issues associated with the availability of resources within organisational and political objectives (Padgett, 1998).

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4

Conceptual Framework: Ethical Dilemma



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5

Methodology: Sample strategy

▣ Sample frame

- Registered nurse on the NMC register.
- Have worked within the secondary care provision.
- Is recruited voluntarily
- Is able to provide informed consent.
- Is available to participate within the specified time frame.

▪ Ethical approval

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6

Data collection:

Semi structured interview

▣ Guiding questions:

1. Can you tell me about an ethical dilemma you have faced in your recent clinical practice?
2. What exactly happened?
3. What did you do?
4. How did this make you feel?

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7

Amended Guiding Questions

1. Can you tell me about an ethical dilemma you have faced in your recent clinical practice, **within the last three years?**
2. What exactly happened?
3. How did this make you feel?
 - **Why do you think you felt this way?**
4. What did you do?
5. **What made you act the way you did?**
6. **What was the final outcome?**
 - **Were you happy with this?**

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8

Analysis

- ▣ **NVIVO 8**
- ▣ **Thematic analysis**
 - *Was used to identify emerging themes within the narrative as described by Riessmen (2008).*
- ▣ **Sociocultural analysis**
 - Was used to place the contribution in the context of nursing practice and examine how the culture within that practice area has impacted on the contribution made (Grbich, 2007).

Findings

Problem identification

All participants were able to identify and articulate the problems they had chosen to share

'But it was an ethical dilemma as to did I parcel up the patient put them through probably about two hours of discomfort in a cold ambulance in the middle of winter to go to the other side of Town' (P2)

'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.'
(P3)

Findings: Themes

Best for the patient

'So I felt in a way that I got some satisfaction from - that I had stuck to my decision which I believe was best for the patient.' (P1)

'Had I done the best for my patient? It left me thinking did I give the patient the best I could have given her ...' (P2)

'you have got to consider what you are going to do to that patient.'..... at the end of the day always considered the patients was uppermost and that justified my position.' (P3).

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11

Findings: Themes

Concern for others

Within each account the participants demonstrated a concern for others as well as the patient.

'I don't think she could cope with the situation.....we had offered support for her ..' (P1)

'I even used to think about Doctors doing it'. (P2)

'I think you try to be fair and you give, you rationalise your resources fairly and spread them out evenly.' (P2)

'You know there was no consideration about that poor man, about his relatives about how they might feelI know that there were two other patients that were in need of a bed' (P3)

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12

Findings: Themes

Acting Autonomously

'with what I know about this drug and the effect it would have on the patient and having considered for and against me giving the drug I felt I could justify why I didn't give the drug' (P1)

'So I rang her and told her that no I was not going to accept these patients I was not moving them. So I told them I was not moving them and that I would not have any beds..... I did not move either of them. I stuck to my guns and I did not move either of them,.....' (P2)

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13

Findings: Themes

Engaging with others

Senior & junior nurses

'we had some discussions about why the patient should be made aware and I offered to take this responsibility off her or support her with this ' (P1)

Medical team and family

Participant two explains how she engages with the medical team and family members to ensure her patients receive the correct medication with minimum disruption

Senior Nurses and peers

Participant three explains how she engages with a variety of using staff whilst arranging patient discharges

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14

Findings: Themes

Conflict

Whilst all participants identified conflict within the accounts Given.

There was much less conflict identified between nurses and patients than between nurses and organisational objectives, interpreted by participant two as those which resulted in conflict between practice verses the professional obligations.

'feel to be in an ethical dilemma really because you think your professional body and people are saying one thing but in reality your practice are saying you should do another one.' (P2)

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15

Findings: Themes

Conflict

'such as some of the medics that happened to be around the ward at the time ' (p1)

'But none of the other sisters supported me on it. They never showed any support they were very quiet' (P3)

Non of the participants indicated any type of conflict between the patients expectations and their own objectives.

Participant two provided an example of conflicting expectations between the relatives and the nurse about the care of a patient.

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16

Findings: Themes

Feelings

Threatened and under pressure

Boss

Bed manager

Fear

Regarding the situation

Frustrated

Felt that *'wings were clipped'* by policy (P2)

At the actions of another

Confident – able to justify action taken

Uncomfortable – when care felt compromised

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17

Findings: Themes

Shared values

1. To do 'what was best for the patient' appears to be at the forefront of the decision making process.
2. There appears to be a belief that 'management' 'the powers that be' place constraints on their practice through policy.
3. All the accounts identified autonomous decision-making
4. There is an acknowledgment of accountability within each account.
5. All participants acknowledged that these decisions have an impact on others which needs to be considered

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18

Findings: Themes

Shared values

5. Only Participant two identified where she thought these beliefs and values originated. She acknowledged the influence of her family background, the culture within which she lived, and that of her profession.

However participants one and two both did indicate they had expectations of other nurses in relation to a shared value base to inform decisions associated with their nursing practice.

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19

Findings :Sociocultural

Organisational

Hierarchy of management

'I was asked would I give a drug to a patient by my line manager and I didn't feel that the patient should have the drug' (P1)

'because at one time we were equals she was now actually yes she was bed manager but she was a higher grade than me'. (P3)

Policy

'because of what you have to work with because of the rules and regulations and the policies'. (P2)

Interprofessional

Doctors and Nurses

'I even used to think about Doctors doing it I mean Doctors prescribing a drug for a patient they have never clapped eyes on, how do they know - they are very trusting themselves.they did not know my capabilities and could not trust my capabilities they did not know me.' (P2)

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20

Recommendations

- ▣ Use guiding questions as developed above.
- ▣ Employ a flexible approach to interview
- ▣ Ensure remains participant lead
- ▣ Continue with main study to identify further themes or contextual influences on decision making.
- ▣ Update current literature review based on these findings.

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Appendix 9

Under graduate student research conference Department of Health Sciences

PowerPoint presentation

The Contribution Registered Nurses Make in the Resolution of Ethical Dilemmas'

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Academic supervisors:
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Aim of the study:

- ⌘ To identify the beliefs, values, principles and contextual influences which inform the decision making and the contribution made by registered nurses in achieving the resolution of ethical dilemmas.

Objectives:

- ⌘ Identify underpinning beliefs and values which impact on nurses' ethical decision making and moral action.
- ⌘ Identify the contextual influences which impact on nurses' ethical decision making and moral action.
- ⌘ Critically discuss new themes which are generated from the data in light of current literature.

Context,

- ⌘ Secondary care (Acute care) provision.
- ⌘ The context in which these nurses practice is complex.
- ⌘ Demand and options for treatment and care for people with health problems, has increased.
- ⌘ Policy directives have led to changing expectations from patients, (DH, 2001; DH, 2006).

Background,

- ⌘ The increasing number of complex and expensive options at the disposal of health professionals, resulting from technical developments, has increased the frequency and emphasis of these decisions (Storch et al., 2004; Hugman, 2005).

Background

- ⌘ Benner (1984) recognised the development of individual nurses' reasoned decision making and competence through the various stages of their professional development.
- ⌘ There is a need for nurses to behave in an ethical manner, considering the professional relationships they build with others in the course of their nursing practice (Chadwick and Todd, 1992).

Background

- ⌘ New requirements for professional practice have resulted in the move of nurse education into Higher Education Institutions, commencing with project 2000 (Ramprogus, 1995) and now to an all graduate profession (NMC, 2004; NMC 2010).
- ⌘ Medical and Bio ethics have traditionally informed practice.
- ⌘ Johnson (1997), Gilligan (1982) and Armstrong (2007) highlight the limitations of obligation based approaches to moral reasoning and ethical decision making in the context of nursing practice.

Theoretical framework, Resolution of Ethical dilemmas



Methodological approach,

- ⌘ A flexible approach has been selected to facilitate interpretations that bring understanding, not only to what nurses do when addressing ethical dilemmas, but why they act in this way: what it is that informs their reasoning and decision making (Denzin and Lincoln, 2008).
- ⌘ Therefore an exploratory approach is considered to be the most appropriate (Denzin and Lincoln, 2003; Parahoo, 2006; Polit and Beck, 2008).

Study design,

- ⌘ This is a qualitative exploratory study, utilising semi-structured interviews in a purposively selected sample, (Gerrish and Lacey, 2006; Polit and Beck, 2008; Burns and Grove, 2009).
- ⌘ Analysis : Thematic and Theoretical.

Ethical Considerations,

- ⌘ Ethical approval from the NREC and SREP has been granted.
- ⌘ Participants will be fully informed prior to consenting to participate.
- ⌘ All data collected will be treated confidentially (Data Protection Act, 1998).
- ⌘ NHS Trust staff counselling services are available to any participant who may have experience psychological or emotional distress following the interview.

Population,

- ⌘ The Nursing and Midwifery Council currently have 676,547 nurses on the register (NMC, 2008).
- ⌘ Nurses work not only in primary and secondary care, but also in associated fields, such as education' research and management.
- ⌘ The target population are those registered nurses working in a single acute NHS trust,, from which the sample population will be drawn (Gerrish and Lacey, 2006).

Sampling strategy,

Inclusion criteria

- ⌘ Registered nurse on the NMC register.
- ⌘ Working within the secondary care provision.
- ⌘ Is recruited voluntarily.
- ⌘ Is able to provide informed consent.
- ⌘ Is available to participate within the specified time frame.

Recruitment,

- ⌘ Clinical area managers across The Trust will be approached in writing, to gain permission to visit the clinical area to talk to registered nurses who may consider participating in the study.
- ⌘ The aim is to recruit participants from a number of different clinical areas and with varied clinical experience.

Data collection,

- ⌘ Semi structured interviews were used to capture the nurses' experience told in their own words from a personal perspective.
- ⌘ This data collection method provides insight into the participants' perspective, about the 'why and how' within a situation (Gerrish and Lacey, 2006; Bowling, 2009).

Guiding questions,

1. Can you tell me about an ethical dilemma you have faced in your recent clinical practice, within the last three years?
2. What exactly happened?
3. How did this make you feel?
 - i. Why do you think you felt this way?
4. What did you do?
5. What made you act the way you did?
6. What was the final outcome?
 - i. Were you happy with this?

Data analysis,

- ⌘ A verbatim transcription of the recorded interview, will be imported into NVivo 8 for thematic analysis (Denzin and Lincoln, 2008; Riessman, 2008).
- ⌘ The themes that emerge from the transcripts will be coded in preparation for interpretation.
- ⌘ The researcher's own experience as a Registered Nurse may have an influence on the interpretations (Denzin and Lincoln, 2008; Polit and Beck, 2008; Parahoo, 2009).

Data analysis,

- ⌘ Theoretical analysis will also be undertake.
- ⌘ This process will involve examining the data in light of the current understanding of ethical theories to establish what the nursing contribution is and what informs the consequential actions of the nurse.

Pilot study,

- ⌘ Ethical approval
 - × SREP
- ⌘ Sampling strategy
 - × Reflected the main study
- ⌘ Data collection
 - × Semi-structured interview
- ⌘ Data analysis
 - × Thematic

Themes:

- ⌘ To do 'what was best for the patient'
- ⌘ Autonomous decision-making.
- ⌘ Accountability
- ⌘ Collaborative working
- ⌘ Impact on others
- ⌘ Policy / management

Recommendations

1. Guiding questions have been amended as detailed above.
2. Continue with the main study as described above.

The main study Participant Profile

Participant code	Practice area	Experience	pseudonym
P01	Medicine for the older person / acute assessment	Charge Nurse. 30 years	Pat
P02	Medicine for the older person / acute assessment	Junior Charge Nurse. 2.5 years	Chris
P03	Children's unit	Charge Nurse. 40 years experience	Ashley
P04	Surgery	Staff Nurse 30 years experience	Charlie
P05	Surgery	Charge Nurse. 20 years experience	Brooke
P06	Surgery	Staff Nurse 9 years experience	Jo
P07	Surgery	Staff Nurse 2 years experience	Alex
P08	Intensive care unit	ICU Sister 10 years experience	Nick
PS01	Rehabilitation	Staff Nurse 25 years experience	Kim
PS02	Acute medicine	Staff Nurse 18 years experience	Lee
PS03	Care of the older person	Senior Sister 26 years experience	Ross

The main study Topics

- ⌘ Bed-end handover
- ⌘ Disclosure of information within a family
- ⌘ End of life
- ⌘ Discharge & and outlying of patients
- ⌘ Managing competency issues with the nursing team
- ⌘ Standards of Care
- ⌘ Wellbeing of others

Analysis & results Themes



Best for the patient

- This is the dominant themes throughout all the interviews
- Advocacy



Conflict and collaboration

- Conflict with managers, doctors or other colleagues
- Healthcare team
- Engaging with others to find a resolution.
 - Patients, relatives colleagues

Analysis & results

Themes



Policy

- There appears to be a belief that 'management', 'the powers that be' place constraints on their practice through policy, whilst acknowledging the importance of collaborative working.



Accountability

- There is an acknowledgment of accountability
- All the accounts identified autonomous decision-making.
- Weighing the needs of others.

Theoretical analysis

⌘ Charlie's story

Any Questions

Thank you

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