
Problematic Ethical Experiences: Stories from Nursing Practice

by Amy Marie Haddad

If nursing is to develop a science which promotes health and well-being for clients and professionals alike who encounter ethical problems, then a rigorous body of knowledge concerning ethics and values is needed. However, there are as yet few empirical studies which identify systematically the ethical problems faced by registered nurses. Although it is important for experts in ethics to provide their views on the most pressing ethical problems in nursing today, the perspectives of nurses in the "trenches" provide a clarity and insight missing from the normative views of experts. This paper will emphasize the voices of staff nurses from a variety of clinical settings regarding their concerns about ethical problems.

*Because the story of our life
becomes our life*

*Because each of us tells
the same story
but tells it differently*

*and none of us tells it
the same way twice
and though we listen only
haphazardly, with one ear,
we will begin our story
with the word and*

—Lisel Mueller, "Why We Tell Stories"

Ethical concerns are almost inseparable from nursing concerns about the quality of patient care. This is true regardless of the context of nursing practice: a critical care unit, a patient's home or an extended care facility. Nurses have reflected on their roles and responsibilities in a variety of settings and situations, including nursing home dilemmas (Lund, 1989); AIDS and confidentiality (Kirkman and Bell, 1989); ethical decision making and the severely ill newborn (Martin, 1989); and ethical issues in home care (Haddad, 1992).

If nursing is to develop a science which promotes health and well-being for patients and professionals alike, then a rigorous body of knowledge concerning ethics and values is needed. There has been considerable research in the area of moral reasoning and nursing (Ketefian, 1989). However, there are as yet few empirical studies which systematically identify the ethical problems registered nurses face. Although it is important for experts in ethics to provide their perspectives on pressing ethical problems in nursing, nurses in the proverbial "trenches" can

offer an insight and realism that is missing from the normative views of experts. This study was designed for nurses to tell their stories and share their perspectives about what counts as an ethical problem and how they see their duty.

The primary purpose of this article is to present the findings of a study that describes how practicing, registered nurses (N=352) view ethical problems. The article focuses specifically on the nurses' responses to an open-ended question that asked them to share a problematic ethical experience and how it was resolved. The narrative responses to this question are categorized according to major ethical theme. Finally, areas for further research and inquiry are proposed.

Background and Methodology

The aim of this research study was to describe ethical problems from the perspective of practicing, registered nurses. By examining specific ethical incidents in the clinical experience of individual nurses, a more complete picture of the most common ethical problems in nursing can be pieced together.

A probability sample of 1,400 registered nurses was drawn from nurses who were licensed in New York (Middle Atlantic), Tennessee (East South Central), Illinois (East North Central), and California

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(Pacific). Each was sent a survey questionnaire, a letter explaining the purpose of the survey and a postage-return-guaranteed envelope. A follow-up reminder letter was sent one week after the original mailing to encourage participation.

The instrument for the study was a 52-item questionnaire that looked at issues in three major categories: (1) educational preparation; (2) factors influ-

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encing ethical decision making; and (3) perceptions regarding the degree of difficulty and incidence of moral problems in clinical practice. The final item on the questionnaire was open-ended and read as follows: "Please share a short written description on the back of this page of a problematic ethical dilemma that impressed you the most during your professional career and how it was resolved."

The results of the entire study are published elsewhere (Haddad, 1989). The present article will focus on the narratives or stories the nurses wrote in response to the final item on the questionnaire.

Results

Of the 1,400 surveys distributed, 352 were usable for a 25 percent return rate. Eighty-six were from New York, 90 from Illinois, 72 from Tennessee, and 104 from California. Three hundred thirty of the respondents were female and 21 were male. Those in the sample ranged from 22 to 70 years (mean = 40.35) and in years of clinical experience from less than a year to 42 years (mean = 13.07). This corresponds closely to the median age of registered nurses in the United States (median = 39.0) (U.S. Department of Health and Human Services, 1990).

Twenty-four percent of the nurses indicated that an associate degree was their highest level of completed education. The remaining respondents reported the following levels of completed education: 28.2 percent diploma, 28.5 percent B.S.N., 8 percent bachelor's degree (not in nursing), 5.1 percent M.S.N., and 4.8 percent master's degree (not in nursing). The educational preparation of the respon-

dents corresponds closely to the national distribution for associate degree (28.3 percent) and B.S.N. (22.2 percent), but not for the diploma graduate (48.7 percent).

Forty-nine percent of the nurses identified their job position as staff nurse. The majority worked in hospitals (64.8 percent). The national profile for place of employment is 67.9 percent in hospitals, 7.7 percent in ambulatory care settings and the remaining in areas such as extended care and community health (U.S. Department of Health and Human Services, 1990).

Response to Request for Narratives

Of the 352 subjects, 200 (56.8 percent) wrote a response to the request for a short written description of a problematic ethical dilemma that impressed them most during their professional careers and how it was resolved.

The narrative responses were organized into six descriptive categories of ethical problems. The cases were generally complex and often involved more than one problem. However, major themes were identified and classified into the following categories: (a) patient's right to know diagnosis and refuse treatment; (b) quality of life issues including decisions to resuscitate terminally ill patients; (c) truth telling and informed consent; (d) difficulty in working with physicians; (e) standards of care; (f) allocation of resources. The distribution of cases is illustrated in Table 1.

Table 1
Distribution of Narrative Responses by Descriptive Categories (N=200)

Category	Frequency	Percent
Patient's right to know diagnosis and refuse treatment	39	19.5
Quality of life issues and DNR of terminally ill	57	28.5
Truth telling and informed consent	21	10.5
Difficulty with physicians	34	17.0
Standards of care	40	20.0
Allocation of resources	9	4.5

Cases dealing with quality of life issues and resuscitation of the terminally ill were most frequently cited, followed by issues related to the patient's right to know his or her diagnosis and participate in decision making, including refusing treatment.

Although there was considerable overlap of ethical themes in the stories the nurses told, the following responses serve as the "cleanest" examples of the six descriptive categories; that is, the story deals with one ethical problem rather than several. The nurses' stories are transcribed verbatim with lapses in grammar, spelling and punctuation intact. The reader is urged to let the story itself be the discovery (Coles, 1989). What is interesting in reading these stories is the unfolding of a lived life, the sharing of the personal perspective of a nurse regarding what she or he identified as the ethical problem that impressed her or him the most and how she or he resolved it.

Patient's Right to Know Diagnosis and Refuse Treatment

A terminally ill patient with metastatic cancer refused to be intubated or given CPR was moved into our medical ICU. He was started on a Regitine drip for increased bowel sounds and an alpha effect. Pt. was quiet and stoic, but asked family to let him die (he only spoke Spanish). After a few days he had a respiratory arrest, was intubated at the Doctor's orders and was on life support until it was turned off per patient's family. Patient had become comatose and unresponsive.

1. *We have an Ethics Committee but only Doctors are on it.*
2. *We are a 300+ bed teaching hospital.*
3. *We are a welfare/county hospital.*
4. *Many of our patients are non-English speaking and have little or no health knowledge.*
5. *Many times the young doctors unintentionally do not allow patients or their families many choices, i.e. allow them a dignified death (out of the ICU). They often stress what we can do, not always the inevitability of death.*

Quality of Life Issues and DNR of Terminally Ill Patients

A 29-year-old man was dying of leukemia. He was in a great deal of pain and in the morning he greeted his doctors on rounds with "Let's get this show on the road." The doctors ordered me to dispense them a dose of Dilaudid large enough to kill the patient. They drew up the dose and injected it themselves. I signed out the dose but did not chart it as given. I've often wondered if this was the way to handle the medication sign out and administration, but I've never questioned that it was the merciful and therefore the right thing to do.

Also, I HATE keeping people alive with NG tubes and Osmolite/Ensure feedings. I wouldn't let them do it with my mother and I've asked my children not to let them do it to me. (LET THEM DO IT TO ME! The words are interesting.)

Truth Telling and Informed Consent

On several occasions patients have had test, biopsy or surgery. The family will approach the Dr. afterwards saying if it's cancer don't tell patient. To me, this is wrong. The patient signs his/her permit for the procedure and this is between the patient and his/her doctor. I feel that the patient above all other—family, spouse—should know what is going on and no one else unless the patient desires that they know. This I have trouble dealing with.

But in each case, the patient's doctor gives the family a little time to deal with news and tells them the patient will need to know and questions will be asked by the patient that Dr. will have to answer. So usually a day or two later, the patient is informed.

The nurses felt trapped in caring for a patient who rejected his treatment and fought all the way.

I know if I were the patient I would expect my doctor to tell me what findings there are; then when I wanted others to know, they would be informed.

Difficulty Working with Physicians

I witnessed a physician round in the intensive care unit late one night on the 11-7 shift as he went back through the chart and entered a note which was placed between other attending physicians' notes throughout the previous week which would indicate he visited the patient each day when we nursing staff knew that he had not seen the patient in one week even though he had been frequently paged and his office notified.

What worried me about this particular situation is other nurses and physicians knew about this and nothing was said or done by the physicians or nursing supervisors. I was told it was "medical politics."

Standards of Care

Cost-efficient cuts in nutritional supplement for extended care residents resulted in across the board decrease in weights and health. Many residents nearly subsisted solely on the former supplement, and after the change de-

creased health status resulted in weight loss, decubitus, and even refusal of the new formula despite not eating substantially when spoon fed. This change bothered me because there were visible changes in residents' health status and because it was to save money for administration. There had been documentation to show majority of residents' refusal of new formula.

Allocation of Resources

Another issue is with nursing cut-backs and shortages. Many units including critical care are not adequately staffed or almost completely staffed with new, inexperienced personnel. This is an unsafe practice. I don't think a courtroom would accept that the nurses were too busy or short-staffed. This worries me.

Comparison with Previous Research

The predominant themes in the present study are comparable to those identified in other empirical studies of the types of ethical problems in nursing. Tierney (1978) identified many different moral dilemmas but three occurred most frequently: (1) Care of terminally ill patients; (2) Whether or not to resuscitate particular kinds of patients following cardiac arrest; and (3) Whether or not patients and/or relatives should be told the truth about diagnosis. Similarly, Murphy found that 49 percent of 800 cases reported by nurses dealt with truth telling. The right to refuse treatment and the prolongation of life ranked as the second and third most prevalent categories of ethical dilemmas in practice (Murphy, 1984).

The present study contrasts with these findings in the area of truth telling. Truth telling and informed consent issues represented only 10.5 percent of the cases in the study. This difference may be due to improvements in medical technologies which allow more people than ever before to survive for long periods of time with extremely limited physical and mental capacities. According to the present study, quality of life issues and life-sustaining treatment of the irreversibly comatose or terminally ill is the most frequently cited ethical dilemma faced by nurses.

One study noted that physicians were frequently the cause of ethical problems in nursing practice (Applegate, 1981). Similarly, the findings indicate that difficulty with physicians is a source of ethical problems in clinical nursing practice.

Discussion

The findings indicate a considerable overlap of issues in a single problematic situation. For exam-

ple, the following narrative encompasses issues of the patient's right to know prognosis and refuse treatment, difficulty in dealing with physicians, and standards of care.

I used to work in a 12 bed general ICU in a 180 bed community hospital. One of the cardiologists was very difficult to work with—he had no respect for nurses and had been reprimanded several times for being verbally abusive to them. He had an elderly patient with end-stage emphysema who was on a vent and had requested many times to be taken off and had extubated himself several times. The doctor refused to wean him from the vent or realistically speak to the family about the man's conditions and wants. Unfortunately, it was solved by the man arresting and dying, but the nurses felt trapped in caring for a patient who rejected and fought all the way.

When asked to decide the dominant ethical theme in this response, there is justifiable difficulty because this requires an ordering of priorities. The respondents were not asked to rank ethical problems in order of difficulty. Furthermore, there is an underlying theme in this story. The nurse is speaking eloquently to the problem of moral distress—when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984). The nurse in this case, and to a degree the nurses in all the cases cited previously, are prevented from doing what they have decided is right. Many of the nurses shared their frustration at not being able to do what they knew was right.

Nurses' stories reveal that ethical problems leave an imprint on the mind and the soul.

How a nurse arrives at the decision of what is morally right is beyond the scope of this study. It appears, however, that several of the respondents are using projection to determine what is right for the patient. For example, "I wouldn't let them do it with my mother and I've asked my children not to let them do it to me," and "I know if I were the patient I would expect my doctor to tell me what findings there are; then when I wanted others to know, they would be informed." Projection is a defense mechanism. It is the unconscious attribution of one's motivations, desires and values to others. However, projection is not the most desirable method of determining what is ethically correct.

People involved in the decision tend to assume that everyone wants what is best for the patient which is (through projection) "the same thing I want" (Sal-laday and Haddad, 1986).

The nurses often voiced fears about harming a patient or feeling ashamed of themselves in regard to compromising their ethical principles, as in the following story.

A 93-year-old woman in previously excellent health for her age walked in to the ER c/o chest pain. On a monitor, pt. showed frequent PVC's and block ectopics. In a few moments, her heart stopped. Over the next two hours, the pt. was defibrillated eight times, given jillions of respiratory/cardiac drugs and dragged back from the edge repeatedly. Unfortunately, she continued to live and was placed on a ventilator. Over the next 24 hours, this poor woman was subjected to a temporary pacer, a permanent pacer placement eight hours later, and a femoral embolectomy three hours after that (her artery having occluded from repeated sticks for ABG's).

In the last dreadful day of her life, this patient was burned, battered, pinched, stuck, choked, cut, and silenced with a trach tube (she couldn't even moan). This was one of the worst series of event I ever witnessed (over two 12 hour shifts). This last siege against her trying to die hurt her body, did violence to her spirit, and gouged her estate. Unfortunately, this is only one of any number of similar episodes.

The nursing work environment must change to support nurses' authority in ethical decision making.

The words that this nurse chose to express her frustration and perhaps guilt regarding the treatment of this patient are revealing. They are violent, aggressive words that run counter to the mandate of care in nursing practice.

Qualitative analysis of ethical problems from clinical practice could also focus on events that are so morally outrageous that those involved see the world, or in this case nursing practice, differently. The identification of reasons for these "airplane crashes" in ethics is far simpler, more definitive, and less costly in time, money and personnel than the global approach of observing day-to-day practice for the occurrence of factors that impair ethical judgment.

Several respondents noted this type of ethical event from their clinical practice. The following two

examples illustrate the gravity and tragedy of these events.

The last fifteen years of my nursing career were spent in a large geriatric facility. I supervised the care of 42 patients by aides and was responsible for dispensing all medications and treatment.

One small woman who had been receiving an I.M. diuretic twice weekly had this increased to daily by our chief-of-staff. When the patient developed severe arm pains immediately following each injection, I requested that the dose be reduced. The doctor refused. I discussed the problem with the RN's on 3-11 and 11-7 and both felt that the daily I.M.'s were detrimental. However, since bringing this reaction to the physician's attention several times and with the same refusal, I continued to administer the daily dosage. Attempts to have our nursing director intervene also brought negative results.

Consequently, only death resolved this patient problem. Seeing this little lady writhe in pain has haunted me for years. Had I to do over, I would have charted but withheld the drug.

Ethical events such as these do seem to "haunt" the nurse. The nurse respondents were able to describe in great detail the pain endured by both the patient and themselves. The emotional baggage that accompanies the telling of these stories is evident in the following.

I was asked to do nothing to prolong or shorten the life of a 4-5-month-old fetus once it was delivered into a surgical pail. The mother was single, had attempted suicide, and had attempted illegal abortion at least two times. At the time of the delivery, she was bleeding heavily and the legs of the fetus were partially expelled from the uterus. The physician was the chief of staff, a man I had seen make difficult ethical decisions with which I had agreed in the past.

At birth, the fetus was emaciated and unresponsive with an Apgar of 2 and 3. I baptized the child. It was a boy. The pail was covered with a surgical towel and left in the utility room. I checked it from time to time and I noticed he moved around a little in the pail. About two and a half hours after his birth, the boy died. The mother left the hospital six hours after her delivery. I cried. I am crying now as I write this.

Of particular interest for further exploration are those ethical events that caused such a drastic change in how the nurse viewed her or his practice that she or he left the profession completely.

Implications for Nursing Practice

Highly stressed, inexperienced nurses are expected simultaneously to develop competence in clinical skills, interpersonal communication, and resolving

ethical problems. Formal education focuses heavily on the first two but seems to leave the latter to on-the-job training or trial and error. Nurses' stories reveal that ethical problems leave an imprint on the mind and soul. This study provided a legitimate outlet for the "telling" of these stories. Several nurses wrote a personal note at the end of their narrative thanking the investigator for the opportunity of sharing. What occasions, formal or informal, exist in clinical settings for nurses to share their concerns in this fashion?

In their stories, nurses placed considerable importance on relationships. They did not see ethics as merely an exercise in resolving difficult problems. Rather, the stories point to the responsibilities and relationships that comprise the moral life of nurses. An ethic of caring is tied to an understanding of relationships in concrete circumstances rather than abstraction or universalization, and expressed best as an "activity of care" rather than a set of principles (Gilligan, 1982). Considerable debate revolves around the implications of an ethic of caring for nursing (see H. Nelson and N. Noddings, 1992). Further qualitative analysis of nurses' stories may provide insight into how an ethic of care works in decision making.

Two important procedural questions arise from this study: (1) How can we support staff nurses in making ethical decisions? A source of support could be a nursing ethics committee which provides education, guidance and a forum for discussion (Edwards and Haddad, 1988). (2) What authority do we assign nurses making ethical decisions? It is clear that support by administration or people in powerful positions is essential for effective ethical decision making. Because we do not make ethical decisions independently or in isolation, what counts as useful and desirable virtues will depend partly on the social, economic and institutional circumstances in which the actors live and work (Baier, 1987). Therefore, returning to the problem of moral distress, the nursing work environment must change to support nurses' authority in ethical decision making from a clinical case level to institutional policy and procedure development. Nurses must have confidence that decisions made at the bedside will be supported by nursing administration.

Implications for Further Research

Qualitative research would help discover what nurses themselves see as solutions to the moral problems identified in clinical nursing practice. What are the contexts and consequences of ethical decision making in nursing? Who embraces the challenge? Who avoids it? What makes them different? These kinds of questions need to be answered. The answers seem to lie in the stories nurses tell about their experi-

ences with patients. In all their various forms, styles and settings, these stories from clinical practice provide an opportunity to share experiences and reassure us that others have faced similar difficulties.

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