REGISTERED AND ENROLLED NURSES' EXPERIENCES OF ETHICAL ISSUES IN NURSING PRACTICE

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Key words: ethics, human rights, ethical issues, nursing

ABSTRACT

Research aims:

To explore and describe registered and enrolled nurses' experiences of ethics and human rights issues in nursing practice in the Australian State of Victoria.

Method:

Descriptive survey of 398 Victorian nurses using the Ethical Issues Scale (EIS) survey questionnaire.

Major findings:

The most frequent and most disturbing ethical issues reported by the nurses surveyed included: protecting patients' rights and human dignity, providing care with possible risk to their own health, informed consent, staffing patterns that limited patient access to nursing care, the use of physical/chemical restraints, prolonging the dying process with inappropriate measures, working with unethical/impaired colleagues, caring for patients/families who are misinformed, not considering a patient's quality of life, poor working conditions.

Conclusions:

Nurses in Victoria frequently experience disturbing ethical issues in nursing practice that warrant focussed attention by health service managers, educators and policy makers.

INTRODUCTION

Nurses at all levels and areas of practice experience a range of ethical issues during the course of their day-to-day work. Over the past three decades there has emerged an impressive international scholarship on nursing ethics offering comprehensive philosophical critiques of the kinds of issues nurses face and the processes that might be best used for dealing with them. The degree to which nurses are involved in ethical issues in the work place, how effectively they have been able to deal with them, and the extent to which their formal education has prepared them to deal effectively with ethical and human rights issues encountered during the course of their work has not, however, been systematically explored or enumerated either in Australia or, with rare exception, elsewhere.

Method

Following ethics approval being obtained from the RMIT University Human Research Ethics Committee, a representative sample of 2329 (3%) nurses registered in divisions 1, 2, and 3 of the register of the Nurses' Board of Victoria (NBV) was drawn randomly from the NBV database. A copy of the questionnaire together with a letter of invitation to participate and a consent form were distributed by mail to each nurse on the randomly selected list. Three hundred and ninety eight completed questionnaires were returned (response rate =17%). The majority of respondents were female (92%) and employed part-time (55.3%). On average, the respondents were 41.4 years of age (±10.2 years), had 19.8 years of nursing experience (±10.5 years), and had been in their current position 5.4 years (±5.6 years). The main areas of practice identified were: aged care/gerontology (12.3%); acute care (8.8%); psychiatric/mental health nursing (6%); and, critical care (5.3%). Over 50% of respondents held a graduate degree/diploma in nursing.

Questionnaire

An anonymous self-administered survey tool, the *Ethical Issues Scale (EIS) survey questionnaire*, originally developed, piloted and validated by Damrosch and Fry (1993) through contractual agreement with the Maryland Nurses' Association (USA), was used for this study. Before being distributed to the Victorian population, the tool was piloted using a snowball sample of 40 nurses registered in Victoria. The purpose of the pilot was to ensure 'cultural fit' with Australian nomenclature and the classification of nursing positions and areas of work. The pilot confirmed a strong 'fit' with the use of nomenclature with only minor amendments being made. Proposed amendments were confirmed with the tool's authors and approved. None of the amendments affected the validity of the tool. Some examples of the amendments made are: 'Consulted with the nurses association' (expanded to include 'org/union eg. Australian Nursing Federation, Royal College of Nursing, Australia'); position classifications expanded to include classifications endorsed by the Australian Nursing Federation.

Data analysis

Data analysis was undertaken using the SPSS statistical package. Descriptive statistical analyses were performed on the data relating to questions based on three major areas. The aim of these analyses was to summarise nurses' responses on a number of issues within these major areas. These were:

- ethical issues in nursing practice: the analysis of the data relating to questions in this area focussed on finding out what issues in their practice disturbed them the most and how they dealt with them.
- suitability of education: responses to questions in this area were analysed to document nurses' existing knowledge and level of their education, together with potential for educational opportunities in relation to perceived learning needs.
- workplace support: in this area, the focus of the analysis was to summarise responses to questions based on the adequacy of workplace resources in dealing with ethical issues.

An *Involvement* score was derived for each respondent based on responses to questions on ethics and human rights concerns in their nursing practice. This score quantified their level of involvement on these issues in the workplace. Two Sample T-Tests were used to determine whether significant differences existed among various subgroups in the sample on the *Involvement* score. Multiple regression analysis was used to quantify the influence of the nurses' knowledge of ethical issues, their perceived need for ethics education in the workplace and the adequacy of resources to deal with ethics and human rights issues in the workplace on the Involvement score.

Additional comments written on the questionnaires by respondents were analysed using the qualitative research techniques of content and thematic analysis (Patton 2002).

RESULTS

Ethical issues of most concern

The five most frequently cited ethical issues reported by the nurses surveyed were:

1. Protecting patients' rights and human dignity;
2. Providing care with possible risk to your health (eg. TB, HIV, violence);
3. Respecting/not respecting informed consent to treatment;
4. Staffing patterns that limit patient access to nursing care; and,
5. Use/non use of physical/chemical restraints.

A combined analysis of reports revealed the following as being the most personally disturbing issues faced by the nurses surveyed:

- Staffing patterns that limited patient access to nursing care;
- Prolonging the dying process with inappropriate measures;
- Working with an unethical/incompetent/impaired colleague;
- Caring for patients/families who are uninformed /misinformed;
- Providing care with possible health risk; and,
- Not considering a patient's quality of life.

Almost one quarter (23.9%) of the nurses surveyed reported having direct involvement in an ethical and/or human right issue between one-to-five times per year; 20.4% reported being directly involved in an ethical and/or human rights issue between one-to-four times per week. Only 5% reported that they were never involved in an ethics or human rights issue in the past 12 months.

Dealing with ethical issues

When confronted with an ethical or human rights issue, the nurses surveyed reported that they were most likely to handle these issues through discussions with nursing peers (86.9%), and nursing leadership (70.4%). Only 47% of nurses surveyed reported they would discuss the issue with the patient's doctor, and only 41% indicated they would discuss the issue with another professional. Less than 5% reported they would make a decision without consulting anyone. The nurses reported they were unlikely to consult with the patient's family, and only 2.3% indicated they would consult an ethics committee for advice (noting, however, that only 38.4% reported knowing they had an ethics committee at their places of employment).

Education

Approximately 80% of the nurses surveyed reported having ethics content integrated into regular nursing courses within their curricula. Although 88% of nurses reported they were moderately to extremely knowledgeable about ethics/human rights in nursing practice, almost 74% believed they had a need for more education on ethical issues. Only 7% felt only a 'slight or little need' for such education.

The six most frequently chosen educational topics that the majority of nurses (80%) identified as being helpful were:

- patients' rights;
- quality of life;
- being an advocate for patients' rights and autonomy;
- professional issues;
- ethical decision-making; and,
- risks to their health.

In contrast, educational topics addressing emerging technologies and organ transplants were rated by the nurses as not very helpful.

Adequacy of workplace resources

Only 8.3% of the nurses surveyed believed that their places of employment provided adequate resources to help them to deal with ethics and human rights issues in their nursing practice. In contrast 28.4% of nurses believed their work place resources were only slightly adequate, and 10.6% rated their work places' resources as totally inadequate. Only 38.4% of the nurses surveyed said they had an ethics committee at their places of employment, with more than a third (34.7%) reporting that they did not know whether they had an ethics committee at work. Of the 153 nurses reporting a workplace ethics committee, 92.4% reported that it had included nurses and 63.7% knew how to access these committees when they needed to do so. Approximately 10% accessed their work place ethics committees in the past year, and close to 73% wanted to have more information about their workplace ethics committees.

Involvement in ethical issues

A comparison of subgroups via t-tests in the sample surveyed found no significant difference in regard to their involvement in ethical issues. This would suggest that the nurses working in the various areas identified came across ethics or human rights issues at about the same frequency in their practice. There was, however, a significant influence ($p<0.01$) on the nurses' general knowledge of ethics and human rights by their responses to the frequency of their involvement in ethical and human rights issues in practice quantified by the Involvement score. There was also a significant relationship ($p<0.01$) between their need for ethics education (Need) and the Involvement score. Resources exerted a significant negative influence ($p<0.01$) on the Involvement score. Knowledge, however, was shown to exert a bigger influence on the Involvement score than did Need.

Other issues

A thematic analysis of the comments of 82 (22%) respondents revealed three key areas requiring attention: poor working conditions; the need for further and ongoing education on nursing and health care ethics; and, the need for improved attention to be given to ethical issues in nursing not otherwise addressed in nursing domains. Poor working conditions were described as including: poor management; poor communication among staff; nurses having to work in under-resourced conditions (especially aged care); violence in the workplace (bullying and abuse by other staff and patients); and, feeling 'undervalued' and disrespected (especially by attendant medical staff). The need for further and continuing education was identified and deemed necessary in order to: facilitate the nurse's role/empower nurses as 'patient advocates'; improve interdisciplinary ethical decision making; improve knowledge of emerging issues; and, to meet the needs of care givers and care recipients. Other specific ethical issues identified as needing attention included: informed consent (especially with children and older adults); family involvement in decision making; end of life decision making; nurses' rights; reporting unethical and/or incompetent colleagues; and, confidentiality /privacy issues in telephone counselling.

DISCUSSION

This study has sought to ascertain what nurses experience as problematic ethical issues in nursing practice and how they have dealt with these issues. The findings of this study support overseas research suggesting that what concerns nurses most are not the so-called 'big' or 'exotic' issues of bioethics, such as abortion, euthanasia, organ transplantation, and reproductive technology which, significantly, were identified as being of least interest to the nurses surveyed. Rather, what is of most pressing concern to registered nurses (and the issues that cause them the most distress) are the frequently occurring issues of: protecting patients' rights and human dignity, caring for patients in under-resourced health care services (including staffing patterns that limit patient access to nursing care/managed care polices that threaten quality care), informed consent (including patient autonomy and family involvement in decision-making), providing care with possible risk to the nurses' own health (eg. TB, HIV, violence, poor working conditions), ethical decision making, ethical issues at the end stages of life (eg. prolonging the dying process using inappropriate means, not considering the patient's quality of life), working with an unethical, incompetent, or impaired colleague, and the use/non use of physical/chemical restraints.

It is significant that less than 50% of the nurses surveyed indicated they would consult either the patient's doctor or other professionals for assistance to deal with ethical issues. Just why this is so is a matter for speculation. Historically, the medical profession and others have not been supportive of nursing ethics or respectful of the legitimate concerns nurses have had about ethical issues in nursing and health care domains (Johnstone 1999, 1994). Although nursing ethics is now recognised as a distinct and legitimate field of inquiry in its own right, nurses still lack the legitimate authority they need to match their responsibilities as ethical practitioners. Nurses are still in a position of legitimated subordination to the medical profession (Johnstone 1994) and there continues to be some suggestion in the nursing literature (and even in the findings of this survey) that nurses don't feel respected or valued by their medical colleagues. As two respondents to this survey commented:

'I am [a] professional who believes that I am a patient advocate. Having my judgment called into question and being patronized by the medical profession annoys me –especially when I am right and they are wrong. There is no recognition of my contribution to the safety and welfare [of patients]' (QR:020).

'The biggest issue for me is constant conflict over medical dominance in childbirth and blatant disregard for women's rights to choose. Hospital administration offers no support at all to midwives who try to protect women's rights and in fact punish staff members who defy doctors in the process of helping women to get what they want. This is the biggest source of job dissatisfaction and is directly resulting in staff shortages. I would like to see hospital administrators educated about patient rights to be fearful of constantly ignoring them to keep the doctors happy eg. denial of waterbirth; forced inductions; misinformed consent to caesarean section; denial of choice in caregiver' (QR:204).

Past experiences of not having their views and practice valued or respected by medical colleagues may be one reason why the nurses responding to this survey were reluctant to consult with medical colleagues for assistance when dealing with ethical issues. Another reason may be that the ethical issues confronting the nurses may have directly concerned medical staff and the medical treatment of patients and as such, not matters easily addressed by nurses or from a nursing perspective. In such instances, it is understandable that nurses might prefer to seek advice and assistance from a nursing peer or a nurse manager before taking the matter further or raising it with a medical colleague.

It remains less clear why only 41% of the nurses surveyed would seek assistance from another professional to help deal with ethical issues, and why less than 5% of the nurses surveyed reported that they would make a decision without consulting anyone. Possible explanations include a lack of confidence in the ethics expertise/experience of other professionals. Alternatively, the nurses surveyed might have felt competent to deal with the situations they faced and genuinely did not need to consult with a third party for assistance.

It is significant that only 2.3% of the nurses surveyed indicated they would consult an ethics committee for advice. A key reason for this may lie in the relatively recent history of the establishment of institutional ethics committees (IEC) in Australia. Over the two decades, there has been a proliferation of IEC established in Australian health care agencies (McNeill 1993, 2001). Today, most IEC are concerned primarily with research ethics and granting approval for human research. Of those that are concerned with clinical ethics, most play only an educative or policy-making role, not an advisory role (McNeill 2001).

Characteristically, at least during the early years of IEC in Australia, nurse representation was either non-existent, tokenistic or disproportionate (ie in regards to medical staff representation), making it very difficult for nurses to have any significant or 'real' influence on the proceedings of these committees (Johnstone 1999, 1998). Although nurse representation on IEC has improved in recent years (of the 38.4% of nurses who indicated they had access to workplace ethics committees, 92.4% indicated that these committees included nurses as members), IEC may still be difficult to access. Reasons for this may include: the nature and purpose of the committee (eg. research ethics versus clinical ethics), rules governing who has access to the committee, composition (eg. may be dominated by management), issues of confidentiality and the processes involved for advising on ethical issues. It may also be that the nurses surveyed had little confidence in their IEC to provide the kind of assistance they needed in a timely and useful manner.

Finally, it is significant that the nurses surveyed indicated they would be unlikely to consult with the patient's family when dealing with ethical issues. This reluctance may be due to a number of factors, including: a reluctance to burden family members with the problem; a reluctance to involve the family in what is essentially a confidential matter involving the patient; and, a fear of provoking a complaint and possible litigation associated with the complaint. The issue of family involvement in patient care and ethical decision-making is one that has yet to be comprehensively addressed in the nursing ethics literature.

Ethics education

The issues identified by respondents are among the most commonly discussed in nursing education forums (both formal and informal, eg. workshops, seminars, conferences, award courses) and the nursing literature (too numerous to list here). Further support of the findings of this study is found in the strong correlation that exists between the issues identified by the Victorian nurses surveyed and the issues identified by the nurses surveyed

Table 1: Victorian Study and New England Study: A comparison of the findings

Base data	Victorian study	New England study
Sample size/response rate	N=398 (17%)	N=2090 (28.8%)
Gender ratio	92% female	94.4% female
Employment EFTS	55.3% part-time	35.5% part-time
Average age	41.4 years (±10.2 years)	44.4 years (±9.4 years)
Average years of nursing experience	9.8 years (±10.5 years)	19.2 years (±10.3 years)
Years in present position	5.4 years (±5.6 years)	7.6 years (±7 years)
Percentage of university/ college graduate degrees/diplomas	50.0%	55.0%
Top clinical areas of practice	Aged care/gerontology (12.3%) Acute care (8.8%) Psych/mental health (6.0%) Critical care (5.3%)	Aged care/gerontology (7.4%) Psych/mental health (6.9%) Paediatrics (6.6%) Critical care (6.3%)
Five most frequently reported ethical and/or human rights issues	1. Protecting patients' rights and human dignity. 2. Providing care with possible risk to your health (eg. TB, HIV, violence). 3. Respecting/not respecting informed consent to treatment. 4. Staffing patterns that limit patient access to nursing care. 5. Use/non-use of physical/chemical restraints.	1. Protecting patients' rights and human dignity. 2. Respecting/not respecting informed consent to treatment. 3. Providing care with possible risk to your health (eg. TB, HIV, violence). 4. Use/non-use of physical/chemical restraints. 5. Staffing patterns that limit patient access to nursing care.
Most personally disturbing issues	1. Staffing patterns that limited patient access to nursing care. 2. Prolonging the dying process with inappropriate measures. 3. Working with an unethical/incompetent/impaired colleague. 4. Caring for patients/families who are uninformed /misinformed. 5. Providing care with possible health risk. 6. Not considering a patient's quality of life.	1. Staffing patterns that limited patient access to nursing care. 2. Prolonging the dying process with inappropriate measures. 3. Not considering a patient's quality of life. 4. Implementing managed care policies threatening quality of care. 5. Working with an unethical/incompetent /impaired colleague. 6. [Not cited]
Least personally disturbing issues	1. Protecting the rights of patients as research subjects. 2. Procuring organs/tissues for transplantation.	1. Procuring organs/tissues for transplantation. 2. Protecting the rights of patients as research subjects. 3. Determining when death occurs.
Frequency of encountering ethical issues: *1-5 times/per year* *Never involved over past 12 months*	 23.9% 5.0%	 39.6% 6.8%
Dealing with ethical issues by discussing with: - Nursing peers - Nursing leadership - Patient's doctor - Other professional - Ethics committee Not discussed with anyone	 86.9% 70.4% 47.0% 41.2% 2.3% 4.5%	 83.8% 66.5% 58.8% 60.1% 13.3% 6.2%
Knowledgeable about ethics Have little or no knowledge about ethics	88.0% 12.0%	92.0% 7.0%
Need for further ethics education	74.0%	59.0%
Previous ethics education, content integrated into curricula	80.0%	58.0%
Topics most helpful	1. Patients' rights. 2. Quality of life. 3. Being an advocate for patients' rights and autonomy. 4. Professional issues. 5. Ethical decision-making. 6. Risks to their health.	1. Being an advocate for patients' rights and autonomy. 2. Professional issues. 3. Patients' rights. 4. Resource allocation and access to care. 5. Content/interpretation of ethical codes Ethical decision-making.

Base data	Victorian study	New England study
Topics least helpful	1. Emerging technologies. 2. Organ transplants.	1. Reproductive technologies. 2. Genetic testing. 3. Organ transplants.
Workplace resources for dealing with ethical issues: - very adequate - slightly adequate - totally inadequate	 8.3% 39.0% 10.6%	 11.6% 24.0% 12.3%
Access to ethics committee: - ethics committees exist at workplace - don't know' if ethics committee exists at work - ethics committee exists & includes nurse membership - nurses accessing ethics committee in past year - desire for more information on workplace ethics committees	 38.4% 34.7% 92.4% 10.0% 73.0%	 56.8% 16.3% 95.6% 19.0% 53.0%

in other countries such as The Netherlands (van der Arend and Remmers-van den Hurk 1999), Israel (Wagner and Ronen 1996) and, of particular relevance to this study, New England where the EIS tool used in the Victorian study was first developed and used (Fry and Riley 2000; Fry and Currier 1999, 2000; Fry and Duffy 2000, 2001; Mahoney 2000; Redman and Fry 2000). See table 1.

The relationship between nurses' knowledge and their involvement in ethical and human rights issues in practice is particularly noteworthy. As has been discussed elsewhere (Johnstone 1999, 1998), the ethics education of nurses (and their associated improved knowledge of ethical and human rights issues in practice) can paradoxically compound the frequency and intensity of ethical and human rights issues experienced by nurses in practice. There are at least two reasons for this:

- ethics education is known to result in nurses experiencing a 'Gestalt shift' in their moral perceptions resulting in their identifying ethical issues in places of work more readily than they did prior to their learning; and,
- the level of ethics education among nurses is often higher than that undertaken by allied health workers which sometimes means that nurses may identify ethical issues in practice that their co-workers either do not regard as ethical issues or recognise as ethical issues but lack the moral knowledge and skill for dealing with them; in either case, this can result in distressing moral disagreements (Johnstone 1998, p.80).

Workplace resources

The inadequacy of workplace resources to help nurses deal with ethics and human rights issues has not been systematically identified before, although the 'unethics' of poor working conditions and the implications of unethical organisational culture on nurses capacity to provide moral care is receiving increasing attention in the nursing and related literature (Johnstone 2002). Arguably a more pressing issue facing nurses is that, while the nursing profession has 'institutionalised' ethical motivation in its organisations, the organisations in which nurses work have not (Johnstone 1998, pp. 80-82; 2002). Organisations, like individuals, are morally accountable and responsible entities. This accountability and responsibility includes an organisation's quality assurance of moral standards, policies and practices. Organisations, like individuals, must also behave ethically and be made to account when they fail to do so (Johnstone 2004). Nurses are part of the organisations in which they work. Thus, when nurses are made to account for their moral actions and/or inactions, so too must the organisations in which they work. This is an important consideration in the effective prevention and resolution of moral problems in work-related contexts. It is imperative that work-related environments are supportive of ethical nursing practice, and that organisations actively create what Curtin (1993) calls 'moral space' for nurses to practice ethically.

Institutions and organisations can support nurses in dealing with ethical and human rights issues in the following ways, namely, by:

- formulating and articulating, through democratic processes, ethical standards of conduct (for example, in the form of an organisational code of ethics, position statements and policies);
- facilitating repeated, regular and effective communication of ethical standards and policies through printed information, stakeholder access to resource people, and role modelling of ethical conduct (for example, managers need to not only *manage ethical problems well* but to *manage ethically* the problems they have to deal with as managers);
- supporting the establishment of institutional ethics committees and other forums (for example, nursing ethics forums/committees) for the purposes of enabling the discussion of ethical issues in a 'safe place' outside of the usual hierarchy of power and authority characteristic of institutions;
- supporting 'moral quality assurance' programs and the monitoring of 'moral performance indicators' (as

Scofield [1992, p.310] points out, 'impairment need not be fatal to anyone's personal or professional life. The *failure to monitor impairment*, however, is fatal to maintaining a real accountability and integrity [emphasis added]); and,

- rewarding moral conduct; this can include: 'praise, recognition, action on suggestions, responsiveness, setting examples, making positive examples of people for desired ethical actions' (adapted from Derry 1991, pp.121-136; Johnstone 1999, pp. 436-438).

Limitations

The poor response rate (17%) of this study is a major imitation and one that prevents it from being generalised to the total population of nurses registered or enrolled in the State of Victoria or elsewhere in Australia. Reminder letters were sent out to prospective participants near the specified timeline for the return of the completed questionnaires. This strategy, however, had little impact on improving the response rate. Despite this limitation, the findings of the study can nevertheless be generalised to like populations. For example, as stated previously, responses and findings of the study correlate strongly with the 1999 study (n=2090) reported by Duffy and Currier (1999) for Fry and Riley (1999) (see table 1).

CONCLUSION

Nurses in Victoria frequently experience disturbing ethical issues in nursing practice that warrant focussed attention by health service managers, educators and policy makers. Although the findings of this study cannot be broadly generalised they nevertheless highlight the need for a critical examination of the:

1. accredited ethics education programs for nurses and whether these are effective in terms of assisting nurses to achieve the stated and agreed ethical competencies expected of registered and enrolled nurses with respect to professional and ethical nursing practice;
2. ethics and human rights content of both undergraduate and postgraduate nursing curricula and whether nursing curricula address the issues that are of most concern and are of most relevance to nursing practice - such as those identified by this study; and,
3. the nature and availability of continuing education/ professional development programs on ethics and human rights for nurses, and whether these address the issues that are of most concern and are most relevance to nursing practice, particularly in regard to:
   - facilitating the nurse's role/empowering nurses as 'patient advocates';
   - improving interdisciplinary ethical decision making;
   - improving knowledge of emerging issues;
   - meeting the needs of care givers and care recipients;
   - specific ethical issues identified as needing attention, eg.:
     - informed consent (especially with children and older adults);
     - family involvement in decision making;
     - end of life decision making;
     - nurses' rights;
     - reporting unethical and/or incompetent colleagues; and,
     - confidentiality and privacy issues in telephone counselling; and,
4. poor working conditions, violence in the workplace, and disrespect of nurses as professionals by other allied health workers as fundamental ethical issues relevant to the profession and practice of nursing.

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