Nurses’ Responses to Ethical Challenges in Oncology Practice: An Ethnographic Study

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Oncology nurses encounter increasingly complex ethical challenges in clinical practice. This ethnographic study explored 30 oncology nurses’ descriptions of ethical situations and 12 key informants’ perspectives on factors that influence the development of ethically difficult situations. Nurses described the goals of preventing patient suffering and injury, being honest with patients, and contributing meaningfully to patient improvement and stated goals. Nurses experienced six primary challenges in meeting their goals: being the eyes and arms of patient suffering, experiencing the precariousness of competing obligations, navigating the intricacies of hope and honesty, managing the urgency caused by waiting, straining to find time, and weighing risks of speaking up in hierarchal structures. Nurse actions included addressing concerns, creating other avenues, murmuring to one another, staying silent, and looking away. Several factors influenced nurses’ responses to ethical challenges. Results imply a contextual model of moral action that reveals a need for altering practice environments in addition to improving nurses’ ethics skills. Nurses are very aware of their moral responsibilities in ethically difficult situations and need work environments conducive to interprofessional collaboration and open dialogue.

Moral Complexity in Clinical Practice

When caring for patients with life-altering and life-threatening disease, oncology nurses confront many challenges ranging from complex and fragmented healthcare systems, continuous research advances, multiple treatment choices, and helping patients and families adapt, all while considering the moral dimensions of care and articulating ethical concerns. Researchers have suggested that oncology nurses frequently encounter ethically difficult situations (Ferrell, 2006; Raines, 2000; Shepard, 2010), experience more moral distress than other nurses (Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008), and confront ethical issues such as value conflicts with pain management, resource use, informed consent, and end-of-life decisions (Cohen & Erickson, 2006; Raines, 2000; Shepard, 2010). According to some researchers, healthcare providers (including nurses) report increasing pressure from administrators, colleagues, patients, and families to provide life-extending treatments (Chen, 2007; Hamric & Blackhall, 2007; Morris & Dracup, 2008). Too often, structural problems such as inadequate interprofessional communication and collaboration result in mounting moral distress (Ulrich, Hamric, & Grady, 2010), which lead to patient safety concerns and quality-of-care issues (Campbell & Cornett, 2002; Maiden, Georges, & Connelly, 2011). This article describes an ethnographic study that explored the experiences of oncology nurses and other key players (e.g., clinical ethicists, oncologists) in ethically difficult clinical situations. The results yielded deeper understandings about ethical challenges that nurses encounter and factors that impact their response.
Gastmans, & Dierckx de Casterlé, 2010). Complex clinical situations often create moral uncertainty or pose moral dilemmas. Moral uncertainty is a situation in which one is unsure whether an ethical dilemma exists or not; it also applies to situations when a person is unsure about what principles or values apply in an ethical conflict (Jameton, 1984). A moral dilemma is an experience that arises when two or more ethical principles (e.g., autonomy, beneficence, nonmaleficence, justice) or values conflict. More than one principle applies, and good reasoning can support mutually inconsistent courses of action. Although very difficult, violating one of the principles is inevitable (Jameton, 1984).

Those uncomfortable experiences can contribute to moral distress and residue. Moral distress is a response when people believe they know the morally right course of action, but constraints make pursuing that course impossible (Jameton, 1984, 1993). Initial distress involves feelings of frustration, anger, and anxiety that a person experiences when faced with institutional obstacles and conflict with others about values. Reactive distress is a response when people do not act on their initial distress; it usually results in feelings of worthlessness and, if chronic, can lead to burnout. Crescendo effect is the accumulating impact of multiple episodes of moral distress over time (Epstein & Hamric, 2009), and moral residue is the lingering effect of moral distress (Hardingham, 2004). Moral distress and residue potentially threaten nurses’ moral integrity, a sense of wholeness and self-worth that results from having congruence between clearly defined values and actions (Hardingham, 2004).

Ethical decision-making models have been proposed, most of which are step-by-step guides to help practitioners make ethical choices (Cohen & Erickson, 2006). However, many models focus on individual patient situations and overlook the ethical climate in which those situations occur. Ethical climate is largely based on the nature of relationships within an organization and relates to both responsibilities and power (Chambliss, 1996; Hardingham, 2004). Climate also reflects a collection of individuals’ values and beliefs about what comprises good clinical practice. For example, what nurses believe to be good clinical practice in a clinical situation may differ from physicians’ beliefs. The beliefs and values that guide clinical practice often are unexamined and unstated, and yet, ironically, are assumed to be shared by everyone.

Nurses, in their unique and constant position at the patient’s bedside, are the hub of those multiple relationships and intersecting values and beliefs. As a result, nurses not only are positioned to understand their own moral appraisals, but also to assess others’ appraisals. Describing nurses’ in-between position as one of strength, Hamric (2001) asserted that nurses have numerous opportunities to advocate from the middle. However, Chambliss (1996) claimed that nurses’ moral voices often are subsumed within powerful medical, administrative, or family structures. Because nursing practice is a morally relevant profession with its own code of ethics (see Figure 1), nurses cannot abandon ethical obligations. Depending on individual characteristics and work environments, nurses choose whether or not to vocalize their appraisals and act. Avoiding conflict, some nurses silence their own moral appraisal of a situation (Goethals et al., 2010; Pavlish, Brown-Saltzman, Hersh, Shirk, & Rouanke, 2011) or disengage from situations (Gutierrez, 2005). Others experience enough moral distress that they leave their positions or the nursing profession altogether (Bowles & Candela, 2005; Elpern, Covert, & Kleinpell, 2005; Hart, 2005; Pendry, 2007; Schluter, Winch, Holzhauser, & Henderson, 2008). To support nurses in meeting their ethical obligations, Goethals et al. (2010) called for qualitative research on nurses’ ethical experiences and actions. Information about challenges that nurses experience and actions during ethically difficult situations is important in designing work environments that prevent moral distress and improve patient safety and care quality.

Methods

Aiming to make explicit what is implicit within a culture or organization, ethnography applies data collection methods to understand how people interact and relate to one another and how they derive meaning from their experiences (Speziale, 2007). The University of California, Los Angeles Office for the Protection of Human Subjects approved the current study. Researchers explored perceptions and beliefs regarding practices employed in ethically difficult situations during six focus groups with 30 oncology nurses recruited from local Oncology Nursing Society chapters in southern California. The researchers collected information on specific examples of ethical conflicts during the focus groups and paid particular attention.
to how conflicts developed and what nurses experienced. In addition, the researchers interviewed 12 key informants (five clinical ethicists, three nurse executives and managers, one nurse in a bioethics center, one oncology clinical nurse specialist, and two physician oncologists) from five southwestern and two midwestern U.S. hospitals and medical centers. In the key informant interviews, the researchers asked about organizational and system factors that seem to contribute to the development of ethical conflict. All focus groups and interviews were tape-recorded, transcribed into written text, and then imported into Atlas.ti data management software for coding and sorting.

Five structural categories of data emerged: general and specific descriptions of ethical situations, nurses' challenges and actions, early interventions that work, consequences of ethical conflicts, and healthcare system factors that influence ethical conflicts. During second-level coding within each category, the researchers used constant comparison in sentence-by-sentence coding. Those detail codes subsequently were sorted into similar, higher-level patterns that finally were conceptualized into themes (Saldaña, 2009). Attempting to be as descriptive as possible, the researchers often used participants' words as detail codes. To enhance trustworthiness, researchers coded data separately and met regularly to discuss detail codes. An audit trail was created for recording analytic decisions. Together, the researchers created a code list that was conceptualized into broader themes. Each theme was supported by multiple participants' quotes across focus groups. Themes found in ethical challenges, nurse actions, and consequences are reported in this article.

TABLE 1. Sample Characteristics

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Findings

Nurse participants in focus groups represented five professional positions (19 staff nurses, 4 clinical educators, 3 nurse practitioners, 3 nurse administrators, and 1 clinical nurse specialist) in community and academic hospital and clinic settings. Mean years in nursing and oncology nursing were 16.1 and 12.7, respectively (see Table 1). During focus group discussions, nurses detailed 51 ethically difficult situations and indicated three primary moral obligations: preventing pain, suffering, and injury; informing and being honest with patients and families about medical conditions; and contributing meaningfully to patient-stated goals and improved condition. End-of-life situations accounted for 32 cases and often were described as being difficult because of intrapersonal and interpersonal conflicts.

Challenges of Working in Ethically Difficult Situations

Nurses provided fascinating narratives that reflected six distinguishable yet related challenges (see Figure 2). First, nurses described the pain and guilt of witnessing and sometimes contributing to patient suffering without having a voice in the treatment plan. Bringing prescribed treatments with strong side effects to patients who already were suffering seemed to violate the moral tenet, “Do no harm.” In a sense, nurses saw themselves as part of the problem when causing patient suffering. That difficulty was compounded when working with physician teams who dismissed nurses' concerns or were unaware of the difficulties nurses experienced when delivering potentially harmful treatments.

Participants described the challenge of working within situations of competing obligations without always having enough power to determine priorities. Nurses identified moral obligations to patients, families, the healthcare team, organization, profession and, occasionally, themselves. Their primary obligation was to patients, yet nurses appeared acutely aware of competing obligations. For example, nurses frequently felt constrained by physicians from discussing end-of-life options with patients. An oncology nurse manager suggested that when nurses discuss options, some physicians become angry. She stated, “I think it makes nurses feel like they're only task masters, and not really useful in the patient's true plan of care.”

Nurses identified the delicate intricacies of balancing hope with honesty when working with seriously ill patients. People's unique responses to diseases and treatments and nurses' recollections of “miraculous recoveries” contributed to prognostic uncertainty and delicate balancing. One participant commented, “I worry about killing someone's hope because you're a nurse and you're supposed to be symbols of hope and getting people through things. I worry about the risk of not being that symbol anymore.” In addition, that delicate balancing often is complicated when working in different cultural contexts and across languages. Nurses described situations when family members prevented nurses from discussing a cancer diagnosis for fear of destroying the patient’s hope for recovery. Nurses emphasized the importance of balancing hope with reality so patients and families develop more realistic expectations.

The urgency of making instant decisions when end-of-life conversations have been avoided also was challenging. Several nurses recounted situations in which their patients deteriorated
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Managing the Urgency Caused by Waiting

▶ A nurse described accompanying a six-year-old, terminally ill, post-transplantation patient being quickly transferred to intensive care. The internist turned to the mother and said, “There’s a 3% chance that we’re going to be able to keep her alive. You want us to intubate?” The mother then turned to the nurse and asked, “What am I supposed to say, she’s my child.” The nurse described postintubation conflicts between nurses and physicians and lamented delayed conversations about choices toward the end of life.

Straining to Find Time

▶ “Doctors come in and say, ‘Do this,’ and they think in the next half hour all that is going to get done and you think in the next 12 hours I’m going to try to get that done.”
▶ “I felt I spent the whole day in that room and then at the same time I had three patients who needed me and instead I paid attention to that [ethics situation]. One of my other patients complained of not getting his meds on time.”

Weighing Risks of Speaking Up in Hierarchal Structures

▶ “I am afraid if I talked to a patient [about end-of-life choices] and influenced him and then he dropped my name in front of a doctor, there would be repercussions.”
▶ “You don’t want to create conflict between you and the physician. You don’t want to alter the relationships that you have with the people that you work with every day. For me, I just don’t want to step on anyone’s toes. I’m not trying to be disrespectful, but at the same time you want to intervene because this is not right, something has to be done. It’s just the fear that I am going to offend someone.”
▶ “There’s also the concern about stepping outside your scope of practice . . . and it isn’t for us to approach ethical situations.”
▶ “The [doctors] do not want nurses to suggest or bring up hospice [with patients] when we could definitely see [the need] but we do not bring it up, we do not discuss it.”
▶ “Coming from a teaching hospital, I think we are really encouraged to be the patient advocate, but sometimes that line is blurred . . . I can’t really kick up too much dirt because I will anger physicians.”

FIGURE 2. Primary Challenges for Nurses Working in Ethically Difficult Situations

quickly. However, because code status (orders for resuscitation) or end-of-life conversations had not yet occurred, nurses were faced with difficult and stressful decisions about treatment. Some nurses even discussed “slow codes” when very debilitated or dying patients were still full code, and they believed resuscitation would not be in a patient’s best interest or sought by patients themselves.

Nurses described the sadness of working in “circumstances when there is always more that could be done” to help patients cope with life-threatening conditions and associated treatments. Working within ethically difficult situations requires time and space; however, nurses often expressed frustration with a healthcare system that often operates like a “car wash” or “cattle maze” and sacrifices comprehensive care for efficiency. The experiences of constantly needing to prioritize moral obligations to multiple patients and often sacrificing other tasks to address ethical conflicts were consistently apparent in nurses’ narratives.

Finally, some nurses expressed fear of speaking up when their own professional or personal perspectives differed from prevailing voices. Some nurses recounted being reprimanded by nurse managers. Other nurses described the rippling impact of witnessing colleagues who were penalized for speaking up. One nurse asked, “Isn’t my life easier if I don’t have to [work on ethical issues]? If I just go give meds, isn’t my life easier?”

Being the Eyes and Arms of Patient Suffering

▶ A nurse described administering chemotherapy to a patient who was “almost in a vegetative state on a vent. You ask yourself, ‘What good are you doing this patient?’ Because you know you weren’t doing him any good, and yet, we were required to do it. It was horrendous.”
▶ A patient said he was ready to die and wanted to stop being on a research study but was afraid of the physician. The nurse said, “Here we were giving him blood products, [chemotherapy], and knowing his heart wasn’t in it. We felt we were torturing this poor man.”
▶ Nurses see themselves as part of the problem. “The distress was particularly high when we realized that every time we did something, she would bleed or something else would pop up.”

Experiencing the Precariousness of Competing Obligations

▶ “Being the nurse, you feel in the middle because . . . you don’t want to go above the doctor, you don’t want to step on family members’ toes, but you still want the best for the patient . . . without disrespecting any of the other people who are involved.”
▶ “What do we do when doctors will not address [end of life]? The family knows what’s going on, the patient knows what’s going on, but [doctors are] not addressing it.”
▶ “I find it hard . . . being the patient’s advocate and yet running the risk that I am going to cause issues and concerns with my colleagues. . . . I also get concerned about, am I tooting my ethical beliefs and not the patient’s? Am I going to cause more stress for the patient [when speaking up]?”

Navigating the Intricacies of Hope and Honesty

▶ “When physicians talk about research, patients and families don’t hear ‘research,’ they hear ‘hope.’”
▶ “I think we do a great job of giving [patients] hope when we develop a plan for them, but then suddenly it doesn’t go well and then you are left with all these decisions. . . . We don’t talk enough about what if treatment doesn’t work.”
▶ “We’ve had situations here where you really think that they’re not going to make it, they’ve had every bad side effect possible, but then they come back and they look fantastic and they’re living their lives productively and happily, so if we took that hope away, we would not have seen the recovery process.”

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Nurse Actions and Their Mediators

Participants eloquently described a spectrum of action responses when discussing ethically difficult situations (see Figure 3). Ranging from speaking up to turning away, those actions seemed dependent on an implicit appraisal of risk. Factors that determined whether nurses chose to speak or remain silent pertained to trust in working relationships, time for intervention, opportunity for communication, and self-confidence. For example, nurses clearly identified physician colleagues who could be trusted when approached with ethics-related questions.

About physicians and nurses, it doesn’t matter what dynamic we have, I think patients are the common interest because we’re there to take care of patients, to get patients better. To me, as long as you speak very frankly with them openly about the patient, about your concern, the physician respects that. As long as you don’t get emotional, just be matter of fact and tell them what you think. If you can’t get it through their head, you go through your chain of command. You go to your supervisor. . . . You want them to listen to you because ultimately if you don’t do that step, who’s going to be suffering? The patients.

Conversely, nurses felt unsafe raising ethical concerns with physicians who had responded negatively, and nurses often imbued the verbalized response with physicality (“jumped down my throat” or “dragged her into the hallway”). Trust in management support during ethically difficult situations and strength of the nurse-patient relationship also mediated actions. Nurses tended to take greater risks for patients with whom they had a strong bond.

When I get someone that I might be seeing for years in a metastatic setting, I will address best-case scenario and worst-case scenario and say, “You know, I always tell people when they have this, it’s a really good idea to have your affairs in order,” and also saying that “I have gotten mine in order and I’m perfectly healthy, so that if anything happens I’ve told my husband and my sister this is where the things are so I don’t have to put that burden on my family. So, especially if you have an illness, if you’ve had a heart attack, if you have cancer, it’s really a good idea to designate this person can speak on my behalf. There’s also a California living will. Do this before it’s at a place where things aren’t going so well and [discussion about death] becomes uncomfortable and they’re more hesitant to discuss it.”

![FIGURE 3. Nurses’ Action Responses to Challenges in Ethically Difficult Situations](image-url)
One nurse described advocating for a patient she had cared for prior to his transfer to the intensive care unit and passionately declared, “One part of me said I was putting my license on the line, but the other part said I cannot walk away from him.”

Many nurses commented that ethics-specific education and experiences influenced self-confidence in raising ethics-related concerns. Some nurses described ethics rounds, which provided valuable opportunities to communicate with others about ethical concerns. However, even in ethics rounds, nurses’ voices were not consistently acknowledged. One participant said, “I’ve tried to talk to physicians like, ‘What’s the plan for this patient? What are we trying to do?’ And they’ll just dismiss me. Some of them don’t even respond.” Finally, time was a crucial factor in two ways. First, many nurses noted that concerns build over time and that several episodes of ethical concerns, particularly regarding nonbeneficial treatment at end of life, multiplied the impact. Second, working within ethically difficult situations requires time. Describing current acuity measures that neglect accounting for complex ethics work, one nurse commented, “Suddenly there are 10 family members to deal with and 5 are at the bedside and 5 others are from 5 different states or there are 10 doctors on the case and you’re thinking, ‘Take a number.’”

Interestingly, to determine the relative risk of speaking up, nurses seemed to analyze mediating factors in the context of each specific ethical issue. For example, nurses described speaking confidently to physicians about ethical-legal matters such as ensuring informed consent or following specific policy on required documentation forms for procedures including transfusions—regardless of the perceived risk of speaking up. However, nurses seemed less vocal in conditions of uncertainty. For example, when considering appropriateness of care at end of life, many nurses remained silent regardless of the opportunity to raise their concerns. Some nurses wondered, “Is it my job [to raise this concern]?” or “Will I make things worse for the patient?” and finally, “What are my values and do they really matter?” Nurses’ vacillating internal struggle often left them silent. One nurse said, “Sometimes I sit in rounds and I get really frustrated and feel ‘guilty’ or ‘distressed’ when considering appropriateness of care at end of life, multiplied the impact. Second, working within ethically difficult situations requires time. Describing current acuity measures that neglect accounting for complex ethics work, one nurse commented, “Suddenly there are 10 family members to deal with and 5 are at the bedside and 5 others are from 5 different states or there are 10 doctors on the case and you’re thinking, ‘Take a number.’”

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Nurses also distanced themselves from ethical questions.

“I don’t understand why the physicians . . . their model of practice is . . . not care but cure, so I understand that to a certain degree. But I can’t understand their subjective blind-
challenging. Caring for patients whose families or physician teams avoided end-of-life conversations or withheld prognostic information to preserve hope also was challenging (Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Pergert & Lützén, 2012). Practicing in environments that failed to respect nurses’ ethical perspectives resulted in feelings of powerlessness and failure (Elpern et al., 2005). Nurses may suffer “damaged identities,” experience moral ambiguity, and disengage (Peter & Liaschenko, 2004, p. 220). Similar to the current results, conflicting goals, fear of physician backlash, and hierarchic power structures have been found to constrain critical care nurses’ behavior (Gutierrez, 2005). Interestingly, some nurses used their relationships to establish “authentic dialogue” with patients (Pergert & Lützén, 2012, p. 25), which was similar to the current finding of nurses “speaking around” constraints to discuss end-of-life options with patients.

Overall, the current study’s participants indicated that, in addition to their own moral perspectives, environmental factors mediated behavior. Other researchers have found practice environments strongly influenced nurses’ actions (Attree, 2007; Corley, Minick, Elswick, & Jacobs, 2005; Penticuff & Walden, 2000). Many nurses pondered ethically relevant questions but remained silent or were not heard (Hamric & Blackhall, 2007). Those lost opportunities significantly hinder true collaboration and, therefore, quality of care.

Limitations

Study limitations included the small sample size and context-specific rather than generalizable results. Future studies should emphasize larger samples and additional geographic settings and investigate the strength of relationships depicted in the model.

Conclusions and Implications for Nursing

Providing opportunities for setting-specific and cross-disciplinary ethics education and collaboration is needed, and more specific descriptions for nurses’ roles in ethically difficult situations are required. Many organizations such as the American Nurses Association (2010) and Oncology Nursing Society (2010a, 2010b) have developed position statements regarding ethical practices at the end of life. From those important statements, specific standards that clearly establish nurses’ roles in ethically charged situations need to evolve. For example, during the focus group conversations, several nurses wondered how to initiate an ethics consultation or did not believe they could call an ethics consultant. Standardizing and mainstreaming ethical consultation processes could address system and interpersonal risks that participants identified in the current study. Ethics-specific standards also could lead to specific competencies for

![FIGURE 4. Contextual and Dynamic Model of Nurses’ Moral Action in Ethically Difficult Patient Situations](Note. Copyright 2012 by Carol Pavlish, Katherine Brown-Saltzman, and Patricia Jakel. Used with permission.)
moral self-awareness, ethical deliberation, and conflict mediation that prepare nurses to enter ethics-based conversations more proficiently with patients and colleagues. However, simply developing nurses’ skill set is not enough. Accumulating evidence about healthcare environments’ role in mediating nurses’ moral action requires specific intervention models that create ethics-enriched practice settings where all voices matter and are heard. Early, interdisciplinary, and team-based ethics dialogue and collaboration should form the core of those models. In addition, practice settings should embrace innovative processes (e.g., regularly scheduled ethics rounds, interdisciplinary ethics education) and programs (e.g., life-choices communication initiatives, team-based conflict transformation) that mainstream early and frequent ethics-based dialogue in daily practice. Ethically difficult clinical situations will continue to arise in complex healthcare systems. Mitigating the distress that often results requires developing nurses’ competencies in addressing frequently encountered ethical challenges and designing ethics friendly environments where moral responsibilities are discussed and respected openly and ethics conversations become routine rather than unusual. High-quality care can emerge only from healthcare organizations that are equally committed to delivering science and ethics-based health care for patients and providing team-based, ethically responsive work environments for healthcare professionals.

References


