

ETHICAL DECISION-MAKING -
THE EXPERIENCE OF NURSES
IN SELECTED
CLINICAL SETTINGS

GLORIA GAOGAKWE SEHUME

Submitted in fulfillment for the degree of
Magister Curationis
NURSING EDUCATION
in the
Faculty of Health Sciences
at the
University of Pretoria

Supervisor: Doctor S J C van der Walt

March 2008

DECLARATION

I, **GLORIA GAOGAKWE SEHUME**, declare that "Ethical decision-making - The experience of nurses in selected clinical settings" is my own work, and that all sources used or cited have been indicated, and acknowledged by means of complete references, and that this work has not been submitted before, for any other degree at any institution.

.....
SIGNATURE

.....
DATE

ACKNOWLEDGEMENTS

Let me praise God who gave me endurance and hope, the author and guide of my life. The dark moments came and went, and I remained afloat.

I wish to thank my Mom, my children, Thabo, Lovey, and Mongo, for the constant support, believing in me and their love, which, I held firmly to. My gratitude goes to my supervisor Dr S J C Van der Walt, who kept my hopes alive, the registered nurses in the two hospitals, who willingly came on board, as well as Denosa and the Department of Health of Gauteng Province, for financial support.

ABSTRACT

The qualitative study was designed to study how ethical decision-making realises in difficult care situation in nursing.

A hermeneutic phenomenological approach was used. Data collection was done through writing of critical incidents by registered nurses and midwives in two hospitals in Gauteng Province. The critical incident technique was developed by Flanagan (1954:327). Narratives/stories were analysed by: naive reading, structural analysis and comprehensive understanding (Sorlie 2000:52).

The study population was 30 registered nurses and midwives, who held in-charge positions, and have dealt with ethical problems themselves. The methodology was about understanding and interpreting lived experiences in clinical practice about ethically difficult care situations in nursing.

Guba's model was used for truth value, which was obtained through human experience as was lived and perceived by narrators, who then described/narrated their stories, this was true of critical incidents.

The credibility of the findings depends on accurate documentation of the experience as was narrated, so that the participants would recognise their stories. The participants could not validate the findings due to sensitivity of the critical incidents.

Applicability was not relevant, as it was description of a particular experience that could not be generalised.

Because of the contextual nature of the study, I could not guarantee consistency, as interpretation is based on shared values, norms and beliefs in a particular profession, and is recognised by readers sharing the same values.

Anonymity and confidentiality was maintained to protect the narrators, due to the sensitive nature of the study.

Ethical principles and respect for human dignity was adhered to. Permission was granted by the hospital authorities as well as Research Ethics Committee at the University of Pretoria.

Limitations of the study have been noted. Interpretation of the findings of realisation of ethical decision-making in difficult care situations as well as guidelines for teaching ethics to nursing learners has been done

Findings of the study indicate that the context and impact of realisation of ethical decision-making in difficult care situations was different to different narrators and completely dependent on the ethical problem that had to be dealt with and be realised or failed to be achieved.

ABSTRAK

Die kwalitatiewe studie is ontwerp om, hoe etiese besluitneming in moeilike versorgingsituasies plaasvind, te bestudeer.

'n Hermeneutiese, fenomenologiese benadering is gebruik. Data is ingevorder deur die opskryf van kritiese insidente, deur geregistreerde verpleegkundiges en vroedvroue, in twee hospitale in die Gauteng Provinsie. Die kritiese insident tegniek is deur Flanagan (1954:327) ontwikkel. Narratiewe/stories word geanaliseer deur: naïwe lees, strukturele analise en omvattende begrip (Sorlie 2000:52).

Die studie populasie het bestaan uit 30 geregistreerde verpleegkundiges en vroedvroue wat in beheer posisies was en voorheen etiese probleme self hanteer het. Die metodologie was aangaande die verstaan en interpretasie van beleefte ondervindinge in die kliniese praktyk, oor eties moeilike versorgingsituasies in verpleging.

Guba se model is gebruik vir waarheid waarde, wat deur menslike ondervinding, soos dit deur die vertellers gesien en beleef is, en so deur hulle beskry/vertel is in hulle stories, soos waar vir kritiese insidente.

Die geloofbaarheid van die bevindinge hang af van akkurate dokumentasie van die ondervinding soos dit oortel is, sodat deelnemers hulle storie sou herken. Die deelnemers kon nie die bevindinge geldig verklaar nie as gevolg van die sensitiwiteit van die kritiese insidente.

Toepaslikheid was nie relevant nie omdat dit die beskrywing van 'n bepaalde ondervinding was, wat nie veralgemeen kan word nie.

As gevolg van die kontekstuele aard van die studie, kon ek nie die konsekwentheid daarvan waarborg nie, want interpretasie word gebaseer op gedeelde waardes, norme en geloof in 'n bepaalde profesie en word herken deur lesers wat dieselfde waardes handhaaf.

Anonimiteit en konfidensialiteit is behou om die vertellers te beskerm, as gevolg van die sensitiewe aard van die studie.

Etiese beginsels en respek vir menswaardigheid is gehandhaaf. Toestemming is verkry van die hospitaal outoriteite sowel as van die Navorsingsetiekkomitee van die Universiteit van Pretoria.

Daar is kennis geneem van beperkinge van die studie. Interpretasie van die bevindinge, die besef van etiese besluitneming in moeilike situasies, sowel as riglyne oor hoe om etiek aan verpleegkunde studente te leer, is gedoen.

Bevindinge van die studie dui aan dat die konteks en impak van die besef van etiese besluitneming in moeilike versorgingsituasies verskil het van verteller tot verteller en afhanklik was van die etiese probleem wat hanteer moes word en wat bereik is of nie gerealiseer kon word nie.

TABLE OF CONTENTS

	Page
CHAPTER 1:	
ORIENTATION TO THE STUDY	
1.1 INTRODUCTION	1
1.2 BACKGROUND AND RATIONALE FOR THE STUDY	1
1.3 RESEARCH PROBLEM	4
1.4 RESEARCH QUESTION	5
1.5 AIM OF THE STUDY	5
1.6 METHODS AND PROCEDURES	5
1.6.1 Study design	5
1.6.2 Study population and sample	6
1.7 PROCEDURE FOR DATA COLLECTION	6
1.8 DATA ANALYSIS	7
1.9 STRATEGIES TO ENSURE TRUSTWORTHINESS	7
1.9.1 Truth value	8
1.9.2 Applicability	8
1.9.3 Consistency	8
1.9.4 Neutrality	9
1.10 ETHICAL CONSIDERATIONS AND STATEMENT	9
1.11 OUTLINE OF THE DISSERTATION	10

CHAPTER 2: RESEARCH DESIGN AND METHODS

2.1	INTRODUCTION	11
2.2	AIM OF THE STUDY	11
2.3	RESEARCH APPROACH	12
2.4	STUDY POPULATION AND SAMPLE	13
2.4.1	The setting	13
2.4.2	Population and sample	13
2.5	DATA COLLECTION	14
2.6	PROCEDURE FOR OBTAINING CRITICAL INCIDENTS	16
2.6.1	Guide for writing about a critical incident concerning ethical decision-making in a difficult care situation	17
2.7	ETHICAL CONSIDERATIONS	18
2.8	DATA ANALYSIS	18
2.8.1	The hermeneutic circle	19
2.9	STRATEGIES TO ENSURE TRUSTWORTHINESS	20
2.9.1	Truth value	20
2.9.2	Applicability	21
2.9.3	Consistency	21
2.9.4	Neutrality	21
2.10	CONCLUSION	21

**CHAPTER 3:
LITERATURE REVIEW**

3.1	INTRODUCTION	22
3.2	ETHICS IN NURSING	22
3.3	PROBLEMS IN ETHICAL DECISION-MAKING	25
3.4	MODEL FOR ETHICAL DECISION-MAKING	29
3.5	PREREQUISITE FOR ETHICAL DECISION-MAKING	31
3.6	CONSEQUENCES OF ETHICAL DECISION-MAKING	35
3.7	METHODOLOGICAL ISSUES	37
3.8	CONCLUSION	38

CHAPTER 4: FINDINGS AND DISCUSSION

4.1	INTRODUCTION	39
4.2	HERMENEUTIC PHENOMENOLOGICAL INTERPRETATION	39
4.3	RESEARCHER'S PERSPECTIVE (PRE-UNDERSTANDING)	41
4.4	UNDERSTANDING FROM THE NAIVE READING	42
4.4.1	Narratives about wrong decisions taken by narrators and/or other staff members	43
4.4.2	Narratives about conflict between the narrator's own values and those of others	44
4.4.3	Narratives about personal and professional values conflict	46
4.4.3	Narratives about conflict between the narrators and other staff members and management	48
4.4.5	Summary of the naive reading	52
4.5	FINDINGS FROM THE NAIVE READING	53
4.5.1	Narratives about wrong decisions taken by narrators and other staff members	53
4.5.2	Narratives about value conflicts between the care giver and the patient and/or his family	54
4.5.3	Narratives about value conflicts between the narrator and colleagues and management	55
4.5.4	Narratives about conflict of interest between the rights of patients and the rights of the family	55
4.6	UNDERSTANDING FROM STRUCTURAL ANALYSIS	56
4.6.1	Conflicting values	56
4.6.1.1	<i>Professional values</i>	56
4.6.1.2	<i>Personal values</i>	57
4.6.1.3	<i>Cultural values</i>	58
4.6.1.4	<i>Organizational values</i>	59
4.6.2	Impact of the incidents on narrators	60
4.6.3	Summary of structural analysis	64

4.7	ETHICAL REASONING USED BY THE RESPONDENTS	64
4.7.1	Effects on the conscience of the narrator	64
4.7.2	Taking the blame	64
4.7.3	Silencing the conscience	65
4.7.4	Feeling of guilt	65
4.7.5	Authority, power, powerlessness and rules	65
4.7.6	Feelings of anger, fear, compassion and relief	65
4.7.7	Taking responsibility of the situation	65
4.8	THEMES	68
4.8.1	Relational ethics	68
4.8.2	Action ethics	69
4.9	COMPREHENSIVE UNDERSTANDING	71
4.10	CONCLUSION	75

CHAPTER 5:
FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1	INTRODUCTION	77
5.2	SUMMARY OF FINDINGS	78
5.2.1	Implications of findings	78
5.2.1.1	<i>Practice</i>	78
5.2.1.2	<i>Management</i>	80
5.2.1.3	<i>Education</i>	80
5.2.1.4	<i>Further Research</i>	81
5.3	RECOMMENDATIONS	81
5.4	LIMITATIONS OF THE STUDY	83
5.5	CONCLUSION	84
	LIST OF SOURCES	85

ANNEXURES

ANNEXURE A	
PARTICIPANT INFORMATION LEAFLET	94
ANNEXURE B	
WRITING A CRITICAL INCIDENT	95
ANNEXURE C	
INFORMED CONSENT	97

ARTICLE

NAME : G.G SEHUME
POSITION : NURSE EDUCATOR
QUALIFICATION : RN, RM, RPN, RNA, RCN, N.ed. Hons.N.ed.
PLACE OF WORK : ANN LATSKY NURSING COLLEGE
ADDRESS : P. O. BOX 13797
VORNA VALLEY
MIDRAND, 1686

Ethical decision-making in difficult care situations in nursing

1.1 INTRODUCTION AND RATIONALE

Teaching ethics in nursing to learners is to enable them to make sound and effective ethical decisions in clinical practice. This is a task of a nurse lecturer, incorporating clear knowledge and skill to deal with ethical issues, and codes of conduct (SANC, 1992:2). "Ethics" in nursing refers to the practical study of the norms and values, which guide the judgement of what is right or wrong.

Ethics is the philosophy of nursing behaviour (Searle & Pera, 1998:40). The concept ethics, merges well with the nursing profession's fourfold philosophy, which is: promotion of health, prevention of illness, restoration of health and alleviation of suffering. The above are ethical according to the nursing profession practice, and the reverse is unethical. A professional nurse/midwife has to know and uphold the ethical principles and caring values, inherent in the profession.

Ethical principles, such as beneficence, veracity, justice and fidelity, as well as caring values such as: commitment, conscience, confidentiality, compassion and competence, help to guide the nurse in ethical decision-making. Doing good and not harming the patients, keeping promises and confidences is morally correct. These are practical issues that a professional nurse/midwives are obliged to live up to (Searle & Pera, 1998:32).

Ethical decision-making in difficult care situations in nursing is therefore, the purposeful mental and spiritual judgement of the nurse/midwife in order to perform a moral act, and to justify or account for such an act according to moral values, responsibility and obligations in that particular situation (Muller, 1998:92).

Nursing ethics is applied ethics, and in the nursing field, ethics reflect different approaches to decision-making, offering the nurse practitioners guidance in taking decisions. Unfortunately ethical decision-making in difficult care situations is more complex than this. Experience has shown that nurses feel uncertain and experiences great difficulty in clinical practice when having to deal with ethical problems. It is clear that in many situations there is no simple answer (Muller, 1998:95).

Yung (1997:28) contends that, experience of repeated frustrations, related to the time to make ethical decisions resulted in decentralisation to aspects of the dilemma. It is clear that, there is a need for an interactive process-orientated approach to ethical issues and a rational activity, which uses sound moral structures as a means rather than an end.

When choosing among alternatives, values hold the key position. Values determine the choice of action in the decision-making process. Such values is said, include professional, societal and cultural values per se; and provide a perspective to analyse the situation, but there are no objective means to determine which set of values are paramount. Therefore, to find the "best fit" solution in the light of the needs of the patient, nurses, other health care providers and the institution, are needed to resolve the dilemma. This makes ethical decision-making an exceedingly complex undertaking (Bandman & Bandman, 1978:18).

According to Selman (1996:45), health professionals are criticized for making decisions without involving the patient and families, or without making explicit, the range of options available from which the patient can choose. This approach he sees as paternalistic and can be seen to predominate in the history of health care, the above sets light why the South African Nursing Council calls in so many nurses for professional conduct hearings.

Ethics in relation to the health care field is the principle of proper professional conduct, as it concerns the codes of conduct of health care providers. Rakish (1999:7), states that, such is traditionally taken for granted with the immense ethical problems dominating the health scene. This code of conduct, he says, should be seen as very important in health care and in the education of upcoming nurse professionals. According to him such ethical foundation will encourage strong "ethical decision-making ability". Reflection on alternatives also provides opportunity for the professional to communicate and conceptualise.

Ethics in nursing attempts to find good reasons for holding certain values or adopting certain principles or duties as a guide to decision-making. Ethical codes can be instrumental in arbitrating disputes, balancing conflicting ethical principles, values and obligations, so as to

establish priorities in action taking. Health care faces ethical dilemmas daily, these are situations where “there are two allegiances” and one set of duties cannot be met without dereliction of the other” (Rackich, 1999:7).

In all aspects of care, it is important for health professionals, to be aware of the fact that ethics, especially ethics in nursing is humanistic, personal and dependent on ones conscience. Nursing education need to establish reliance on ethical framework that one establishes for self. Such framework will have a profound effect on overall organizational effectiveness. With the complexities of different situations and differing value systems as well as necessity of to-days thinking contextually, rather than dualistically, it is no wonder that ethical decision-making can be an overwhelming prospect.

Lewis (1990:11) indicates that virtually, all the evil of this world is the responsibility of the people who are absolutely certain that they know what they are doing. But the capacity for ethical behaviour is solely dependent on the capacity for self-questioning. The ability to differentiate what is right from what is wrong, and these are challenges we face, as the health care system becomes more technologically advanced. As such, ethical decision-making will continue to be at the core of health care.

It is evidently clear that if during preparation of learners in the profession, learners are socialised to become unthinkingly obedient to clinical goals and needs of their seniors, rather than the needs of the patients, the same learners when confronted with ethical issues, they may find themselves handicapped in making ethical decisions, which often present a certain degree of risk and uncertainty.

Yung (1997:30), advises that, the socialisation of learners during education and training, should be such as to considerably impact on their ability to make sound ethical decisions, because nurses are being held responsible for their choices of action.

Mattison (2000:201), reiterates that, ethical decision-making in day-to-day care does not give time to decide what to do. In health care, some aspects of care require thinking beyond scientific proficiency, and there is no way of deferring action to a later time, which needs to be dealt with immediately. But the process of systematic analysis of the dilemma by the individual decision maker still remains. In the education of health care professionals, attempts should be made to shift moral decisions from personal and subjective decisions, and treat ethically difficult care situations with intellectual rig.

It is important to build intellectual moral resources, by ensuring that moral judgements are tied to reason and are supported by an intellectual base. As well as documenting procedures, which were involved in realising ethical decision-making, to justify a person's action if the health professional ends up at professional hearings. In ethical decision-making, the nurse's stance is commonly sensitized by his/her cultural background, beliefs and values, which cast judgement on the rightness or wrongness of attitudes and behaviours.

Fry and Johnston (2002:5), states that whatever information one has, information alone however, cannot help the nurse to make sound ethical decisions, according to him, to decide what is ethically right thing to do, one must consider information about the patient within a framework or context of values. It is unfortunate that, individuals are often unaware of the values that motivate their choices of ethical decisions. As a result, understanding one's value system is the first step in learning "self awareness". Stereotypes and biases are not made explicit in ethical decision-making, but may undoubtedly influence professional conduct.

The nurse must therefore, be able to think critically and be willing to take "risks" in order to determine a morally best alternative in a complex ethical dilemma, maybe it is the "risk" that subject professionals to neglecting the issues that are ethical and end up in conflict with their registering body.

When an individual experiences conflict with values of another person or institution, a reasoned and logical approach, based on moral values and principles, that are separate from institutional norms and authority should be adopted in solving the conflict, but that can possibly lead to the individual compromising his or her professional values. Davis and Aroskar (1987:155), questions if the nurse who is in the employment of a bureaucratic system of a hospital, can be ethical? If they practice according to ethical principles, do they run the "risk" and if so, the risk of what? Also what can the nurse expect from the nursing profession in a way of being supported, if she/he takes an ethical stance that disrupts some aspects of the hospital norm? These questions may explain reasons why nurses encounter problems with ethical decision-making, which often lead them to be disciplined.

1.2. PROBLEM STATEMENT

Principles of ethical decision-making form part of all nursing science curricula in South Africa, in accordance with the regulation on approval of, and the minimum requirement for the education and training of a nurse (General, psychiatry, and community) leading to registration, Regulation 425 of February 1985 (SANC, 1985).

In spite of this prescription, nurses have problems in ethical decision-making in difficult care situations in nursing. My experience as a registered nurse and nurse educator, as well as evidence from the professional conduct hearings, dealt with by the registering body, (SANC, stats: 1998, 1999, 2000, 2001, 2002), indicates that there is a problem with ethical decision-making in difficult care situations in nursing, so as to develop strategies to ensure that our learners are better prepared for reality.

1.3 **RESEARCH QUESTION**

Against the above background, the following arose: "How ethical decision-making realises in difficult care situations in nursing".

1.4 **CENTRAL STATEMENT**

The central statement of this study is that, insight is needed on how to deal with ethical issues and realise ethical decision-making in nursing.

1.5 **OBJECTIVES**

- To explore and describe how ethical decision-making realises in difficult care situations in nursing.
- To formulate guidelines for teaching nursing ethics.

1.6 **METHODS AND PROCEDURES**

1.6.1 **Study design**

The study was planned with a primary aim and a secondary aim. During the primary stage, in addressing the first aim, a hermeneutic phenomenological approach was followed in order to explore the phenomenon of ethical decision-making in difficult care situations in nursing.

The critical incident technique, which is an in-depth exploration of specific incidents and behaviours related to the phenomenon under investigation, was used to collect the data. The incidents were self reports, as informants/narrators provided narratives, describing specific incidents of ethical decision-making in difficult care situations that could have been both positive or negative, but that they perceived as significant to the purpose, or had influenced their behaviour (Stromberg, 1999:334).

Second to the first aim, based on the findings of the first phase, as well as an extensive literature review, on ethical decision-making. I formulated educational guidelines for the teaching of ethics to nursing students.

1.6.2 Population and sample

Critical incidents were obtained from a group of volunteers who were purposefully selected at two hospitals in Gauteng Province, on the basis of their knowledge and experience with ethical decision-making in difficult care situations in nursing. These participants were senior and well experienced and had dealt with ethical dilemmas before. Sample size of a study of this nature depended on the aim of the study and the number of critical incidents, as well as the depth of information needed to answer the research question.

An in-depth sample was achieved after 30 critical incidents were analysed and additional critical incidents did not yield any new understanding of the phenomenon. The sample eventually consisted of 30 narratives of critical incidents provided by unit managers. I recruited the managers during staff meetings. The characteristics of the narrators who participated in my study were not presented to protect their identity.

1.7 DATA COLLECTION

The narrators were asked to write an incident about how they were involved in ethical decision-making in difficult care situations, after they consented. Flanagan (1954:329) was the first person, to describe the critical incident as a data collection strategy. The method is an excellent way to obtain first hand information from individuals, concerning their mistakes or successes. To be "critical", an incident must have occurred in a situation where the purpose or intent of the act seemed fairly clear to the purpose and where its consequences were sufficiently definite, to leave little doubt concerning its effects (Flanagan, 1954,329).

The volunteers were asked to write in their own private time, specific incidences where they were involved in ethical decision-making in difficult care situations. Participants were given two weeks to write from memory about what was important to them, related to their experiences. In remembering an incident, the narrators revived the important aspects of the incident that made an impact on them personally (Uden et al, 1995:245).

1.8 DATA ANALYSIS

After the narratives on ethical decision-making in difficult care situations were collected, the narratives were analysed. The analysis was based on Ricoeur's (1992:172) approach.

I used the descriptive and interpretive elements of hermeneutic phenomenological method to understand how ethical decision-making realises in difficult care situations. The hermeneutic phenomenological method was used, to uncover meaning of ethical decision-making in difficult care situation in nursing (Crotty, 1998:13).

The analysis was started by being based on my pre-understanding, of ethical decision-making in difficult care situations, known as professional pre-understanding. Hereafter, I started the formal analysis using hermeneutic circle: which is naive reading, structural analysis and finally using professional pre-understanding and relevant literature to come to comprehensive understanding of the realisation of ethical decision-making in difficult care situations in nursing (Ricoeur, 1976:92).

1.9 LITERATURE CONTROL

Literature control was done to verify the findings. In the literature it was found out that ethics, as the science of morality was central in ethical decision-making in difficult care situations. Ethical decision-making in difficult care situations was seen to be greatly influenced by availability or unavailability of recourses, beginning of life or end of life issues, palliative care as well as genetic advancement. The fact that such influences are escalating, the need for all type of knowing, has become of uppermost concern. A sound educational basis in ethics was seen as necessary in the literature. Ethical decision-making in difficult care situations was seen as a cognitive process, the knowledge of which was based on the knowledge of the decision maker in health care.

1.10. TRUSTWORTHINESS

1.10.1 *Truth-value* was obtained through discovery of human experience as was perceived and described by narrators.

1.10.2 *Applicability*: The strength of this study is that it was conducted in naturalistic settings, with little control over variables. Each situation was unique, and was not meant to be generalised.

1.10.3 *Consistency*: Measure to ensure that the findings would be similar, if they were replicated, with the same subject or in similar context. A description of methods of data collection, and analysis procedures and use of external coder was used so as to provide an audit trail to the reader.

1.10.4 *Neutrality*: The finding of this study was the function of solely participants and conditions of research and not other biases.

1.11 **ETHICAL CONSIDERATION**

The researcher made it a priority to ensure protection of the rights of participants in this study by ensuring that the Ethics Committee of the Faculty of Health Science, University of Pretoria approved the research proposal and information leaflet as well as informed consent.

1.12 **RESEARCH FINDINGS**

Ethical decision -making in difficult care situations, led to different feelings and in some cases difficulties in action taking due to the fact that there are no methodological guidelines. Narrators said nothing told them exactly what to do, in decisions of such a nature, as situation occurred. So, everyone had to find a solution, in spite of their uncertainty.

There was a complex interplay, between thought and action, as was evident in the narratives. The narrators indicated that it was no longer a question of making a decision, but rather a decision was forced upon them. Narrators indicated that they lost freedom of action, which became a personal responsibility.

1.13. **RECOMMENDATIONS**

It is recommended that in clinical practice, recognising values or questions of right or wrong, be taken as a basis in ethical decision-making in nursing. Nurses need to be able to integrate personal values and beliefs with knowledge of ethical concepts, approaches and standards of ethical behaviour. Such integration will become the framework for ethical decision-making.

1.14 **LIMITATIONS**

The study itself has its own limitations, a hermeneutic phenomenological study is a description of the current life world of a person, and will not reflect the continually changing social reality of the other persons. A text is always the result of an inter-subjective, contextual situation, and therefore the reality represented will always be a function of both the subject and the researcher, rather than a representation of the reality of one or the other.

1.15 CONCLUSION

The study concludes another interpretation, another way of understanding our life world. The constant challenge to all who do research, to realise the ongoing nature of what is to understand the world, and be inspired by the inherent potential in this humility, to be willing and open, to know or understand in other ways.

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The aim of this study is to explore the process of ethical decision-making and to describe how it is achieved in difficult care situations in nursing with the aid of a hermeneutic phenomenological approach. Registered nurses who volunteered to participate in the study described critical incidents of ethical decision-making in difficult care situations and thus provided an insider perspective on the phenomenon. The views of the participants on ethical decision-making are described from their perspective rather than being translated into scientific or theoretical language. The findings of the study are used to formulate guidelines for the teaching of ethics to nursing students.

In spite of all our efforts to educate nursing students in ethics, it remains a problematic issue for registered nurses and midwives in their everyday practice. This study could help us to understand the phenomenon of ethical decision-making in difficult care situations in nursing and how to improve the education of students in this regard. Educators involved in the teaching of nursing ethics are not ethicists, but use ethical principles to guide students in ethical decision-making in difficult care situations. This study was done in the context of nursing education and not ethics.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

Teaching nursing students to make sound and effective ethical decisions in practice is the task of all nursing educators, incorporating appropriate attitudes, knowledge and skills about ethics and ethical codes of conduct (SANC, 1992:2). "Ethics" in nursing refers to the practical study of the norms and values that guide the judgment of what is right and wrong. It is embedded in the philosophy of nursing (Searle & Pera, 1998:40). It is the responsibility of educational institutions to ensure that their students develop moral behaviour within the context of nursing and are educated on how to practically uphold the ethical principles and caring values in difficult care situations. More specifically, this refers to the generic ethical principles of respect for people, beneficence, non-maleficence, veracity, justice and fidelity.

It also refers to the caring values of commitment, conscientiousness, confidentiality, compassion and competence to guide the nurse in ethical decision-making (Searle & Pera, 1998:132).

Ethical decision-making forms part of every registered nurse and midwife's daily practice. Botes (2000:4) considers the registered nurse as a moral agent. Ethical decision-making requires a purposeful judgement by the nurse/midwife in order to perform a moral act and to justify or account for such an act according to her or his moral values, responsibilities and obligations in that particular situation (Muller, 1998:92). Botes (2000:15) suggests that in a situation where rules are not adequate to use as basis for the solution to an ethical problem, something else is needed. It is no longer the mere application of the rules that is important, but the interpretation of the situation, weighing alternatives of action, and the appropriateness of the resultant decision to the care situation. Nurses and midwives need to develop sensitivity to ethical issues in care situations in order to identify the issues and then principles that were taught should be used as guidelines for the interpretation of ethical questions.

Literature in the field of nursing ethics reflects different approaches to decision-making and offers the nursing practitioner guidance in the making of these decisions (Muller, 1998:93-95). Unfortunately, it is more complex than this. Experience has shown that registered nurses/midwives feel uncertain and experience difficulty in dealing with ethical matters in difficult care situations in clinical practice. We know that for many situations there is no simple answer. Nurses often have difficulty in identifying ethical dilemmas and choosing appropriate courses of action (Yung, 1997:28).

Patients are more concerned about their rights than ever before and want to be involved in decisions about their care and treatment, hence the need to empower them to be autonomous and to reduce their dependence on healthcare professionals. According to Mysack (1997:27), there is a need for an interactive process-oriented approach to ethical issues and rational actions that uses sound moral structures as a means rather than an end. There is a need for awareness and understanding that knowledge is limited, that beliefs change and those conclusions are temporary. All ethical decision-making needs consultation with all the structures available and it becomes a learning curve to everyone involved.

Bandman and Bandman (1978:18) state that when a choice is made between alternatives, values hold a key position – they determine the choice of action in the decision-making process. Such values include professional, societal and cultural values. They provide a perspective to analyse the situation, but there are no objective means of determining which set of values is paramount. Therefore, to find the “best fit” solution to resolve a dilemma in the light of the needs of the patient, the nurse, other healthcare providers and the institution make ethical decision-making an exceedingly complex issue.

Sellman (1996:45) is of the opinion that health professionals are often criticised for making decisions without involving the patients and the families, or without explaining the range of available options from which the patient can choose. He views this approach as paternalistic and one, which can be seen to predominate in the history of healthcare.

Botes (1994:66) describes the process of ethical decision-making as problem identification and the consideration of possible options that could promote success in ethical decision-making. This process takes place within the human rights arena within the legal, philosophical ethical framework of a registered nurse who functions as an independent practitioner. Each moral situation requires an independent moral judgement on the part of the moral agent. Therefore, the nurse must be able to think critically and be willing to take “risks” in order to determine a morally best alternative in a complex ethical dilemma. It is possible that this “risk factor” causes professionals to neglect the issues of ethical behaviour and then they end up in professional-conduct hearings held by the registering body.

Despite the already acquired skills of dealing with ethical matters, it is necessary to ensure that professional nurses are given some form of guidance and support by ethical committees in institutions in order to help them with the kind of ethical situations they are likely to encounter (Sellman, 1996:45).

When an individual's values are in conflict with the values of another person or institution, a reasoned and logical approach based on moral values and principles that are different from institutional norms and authority should be adopted in solving the conflict; but that could lead to the nurse/midwife compromising his/her profession values. Davis and Aroskar (1987:155) question if the nurse employed in the bureaucratic system of a hospital can be

ethical in situations such as these. If they practise according to these ethical principles, do they run the “risk” and if so, of what? Also, what can the nurse expect from the nursing profession in the way of support if she takes an ethical stance that disrupts some aspects of the hospital norm? These questions may explain why nurses encounter problems with ethical decision-making, which often lead them to be disciplined.

The professional nurse/midwife must also maintain a balance between obligations to the institution, the patient and colleagues. In addition to the already acquired skills of dealing with ethical matters, professional nurses must be given some form of moral guidance and support by ethical committees in institutions to help them with the kind of ethical situations they are likely to encounter (Sellman, 1996:45).

Botes (1994:66) contends that certain moral values, knowledge and experience are necessary for optimal ethical decision-making. Over and above knowledge of the ethics of nursing, it is essential for nurses to be familiar with the Bill of Rights as it appears in the South African Constitution (Act no 108 of 1996 as amended) as well as the scope of practice for nurses and midwives in order to practise in an ethical way.

Health services comprise a joint service, rendered by various members of the multidisciplinary health team. Each of the professional groups in the health team makes decisions about the health and wellbeing of the patient that fall within the scope of its responsibility and practice. Such decisions require cooperation, consultation and reference. Cooperation between nurse and physician in particular is paramount for high-quality ethical decision-making (Botes, 2000:14).

1.3 **RESEARCH PROBLEM**

Principles of ethical decision-making form part of all nursing science curricula in South Africa, in accordance to the Regulation on the approval of and the minimum requirements for the education and training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration, Regulation 425 of 22 February 1985 (SANC, 1985).

In spite of this prescription, nurses have problems with ethical decision-making in difficult care situations. The researcher's experience as a registered nurse and a nursing educator, as well as evidence from the large number of professional conduct cases handled annually by the South African Nursing Council (SANC Stats, 1998, 1999, 2000, 2001, 2002), indicates that there is a problem with ethical decision-making in difficult care situations, but the nature thereof is unknown and therefore it is difficult to prepare students appropriately for the future. It is therefore necessary to determine how ethical decision-making occurs in difficult care situations in nursing practice to better understand what is required of nurses and midwives in practice. This could help educators to develop strategies to ensure that students are better prepared for practice.

1.4 **RESEARCH QUESTION**

Against the above background, the following question arises: *How does ethical decision-making occur in difficult care situations in nursing?*

1.5 **AIM OF THE STUDY**

The aim of the study is to explore and describe how ethical decision-making is achieved in difficult care situations in nursing.

1.6 **METHODS AND PROCEDURES**

1.6.1 **Study Design**

A hermeneutic phenomenological approach was followed in order to explore and describe the phenomenon of ethical decision-making in difficult care situations in nursing practice. The critical incident technique, which is an in-depth exploration of specific incidents and behaviour related to the phenomenon under investigation, was used to collect the data. These incidents were self-reports, as informants provided narratives describing specific incidents of ethical decision-making in difficult care situations that could have been either positive or negative, but which they perceived as significant, or which had influenced their behaviour (Stromberg, 1999:334).

1.6.2 Study Population and Sample

The unit of analysis was a critical incident reflecting the participants' ethical decision-making in difficult care situations in nursing. Critical incidents were selected from those narrated by a group of volunteer unit nurse managers, who were purposively selected at two big city hospitals in Gauteng on the basis of their knowledge of and experience with ethical decision-making in difficult care situations in nursing. These participants were senior and experienced registered nurses and midwives who had dealt with ethical dilemmas before. The sample size in a study of this nature depends on the aim of the study. The number of the critical incidents therefore depended on the depth of information that was needed to answer the research question. An adequate sample size was achieved after 30 critical incidents had been analysed and additional critical incidents did not provide new understanding of the phenomenon (Polifroni & Welch, 1999:325; Burns & Grove, 2001:358).

1.7 PROCEDURE FOR DATA COLLECTION

Research participants were recruited from unit managers working at two big city hospitals in Gauteng. It was explained to them that their participation was voluntary and anonymous. After they had consented to take part in the study, each participant was asked to write about an incident in which they had been involved and that had involved ethical decision-making in a difficult care situation.

Flanagan (1954:327) was the first person to describe critical incidents as a data-collection strategy. He described the method as an excellent way to obtain first-hand information from individuals concerning their own mistakes or successes. To be *critical*, an incident must have occurred in a situation where the purpose or intent of the act seemed fairly clear to the person and where its consequences were sufficiently definite to leave little doubt concerning its effects (Flanagan, 1954:329).

To provide direction to the participants for writing about the critical incident, a guideline was developed with the aid of Johns's Model for Critical Reflection (Johns, 1994:71). This guide is explained in more detail in the Chapter 2.

1.8 DATA ANALYSIS

Analysis of the narratives was based on Ricoeur's philosophy that claims that there is always a dialogue between an event (the critical incident) and the meaning of the discourse. Ricoeur wanted to bridge the gap between phenomenological and hermeneutical approaches. In phenomenology an experience is described as purely as possible without interpretation, whereas in hermeneutics the event is interpreted to find the meaning behind it. In this study it was also necessary to establish how the participants defined ethical decision-making.

Before the narratives were analysed, a pre-understanding of ethical decision-making in difficult care situations in nursing was laid out. This is known as professional pre-understanding (see Chapter 2). This was an important phase in the preparation for the understanding of the analysis of the narratives (Von Post, 1999:983).

The formal analysis procedure using the hermeneutic cycle was then applied. Firstly, the critical incidents were read to obtain a global understanding. This is known in hermeneutics as naive reading and is similar to Tesch's first step of data analysis (De Vos, 1998:343-344). A structural analysis was then done to elucidate parts of the narratives to see how they related to one another. The coding focused on the content of the incident and also reflected on the actions and feelings involved. The researcher then used her professional pre-understanding and relevant literature to come to a point of comprehensive understanding of the realisation of ethical decision-making in difficult care situations in nursing (Ricoeur, 1976:92).

This may seem like a linear process, but it involved a thorough analysis to try and understand what the narrators had experienced and to gain a better understanding of how ethical decision-making realises in difficult care situations in nursing practice. It was actually very time-consuming because of the relative inexperience of the researcher, but in the end an understanding of what the participants experienced was reached.

1.9 STRATEGIES TO ENSURE TRUSTWORTHINESS

Guba's model was used to enhance the planning and conduct of rigorous research (De Vos, 1998:348-351). The following strategies were used:

1.9.1 Truth value

The truth value was obtained through the discovery of first-hand narratives on how ethical decision-making realises in difficult care situations in nursing practice and is perceived by the participants. Although the incidents occurred in the past and it is possible that narrators could have forgotten part of what really took place, the content will be accepted at face value

The credibility of the findings depended on the accurate description or interpretation of the incident, in such a way that the participants would immediately recognise their experience. It was not possible to go back to the participants to validate the findings because of the sensitive nature of the critical incidents provided. It was therefore necessary to rely on two experienced researchers to co-analyse the narratives (see Chapter 4). This researcher has 34 years of practical experience and 24 years of teaching nursing ethics. It was therefore possible to understand the narratives quite well.

1.9.2 Applicability

The strength of this study lies in the fact that a naturalistic setting was used. Each situation was unique and was not meant to be generalised. Applicability therefore was not relevant in this study because it described a particular phenomenon or experiences that cannot be generalised. What was important, though, was that sufficient data had to be provided to allow comparison.

1.9.3 Consistency

Because of the contextual nature of the study consistency is not claimed. The assumption is that interpretation is based on shared cultural meanings and is therefore recognisable to other readers who share the same culture. A thorough description and a clear audit trail of the data collection and data analysis procedures are provided and an external coder was used during phase 1.

1.9.4 Neutrality

Neutrality refers to the degree to which the findings of a study were a function solely of the informants and conditions of research, and not of other biases. The researcher has a thorough professional pre-understanding of the phenomenon concerned. The input of an external coder during analysis was an important measure to reduce bias. The expert panel ensured that the guidelines were clear, neutral and not biased.

1.10 ETHICAL CONSIDERATIONS AND STATEMENT

All research should be ethical; therefore the principles of respect for people, beneficence, non-maleficence and justice were upheld during the planning and conduct of the study. There were no known risks involved in taking part in the study. It was of particular importance, though, that participation was voluntary and that participants stayed anonymous because of the sensitive nature of the narratives.

Before the data was collected, information leaflets and informed consent forms were handed out to the volunteers. The aim of the study, what was expected of the participants, and their rights – in particular their right to participate anonymously and voluntarily and to withdraw at any stage – were explained in the information leaflet. They were requested not to use their names or that of any person or institution in the narrative in order to maintain anonymity. The researcher's contact information was provided. Opportunity for asking questions was given and answers were provided. Confidentiality was promised and written informed consent was obtained from all the participants.

After informed consent had been obtained and the forms were signed, the signed consent forms were put in an envelope and kept in a safe place. This was necessary because of the sensitive nature of the critical incidents. Only the researcher had access to these documents. After analysis of the data the consent forms and description of the critical incidents will be kept for two years and then destroyed.

The Ethics Committee of the University of Pretoria approved the study proposal, the information leaflet and the informed consent form.

1.11 OUTLINE OF THE DISSERTATION

The dissertation is organised as follows: Chapter 1 provides an overview of the research process, and the methodology followed is presented in Chapter 2. Chapter 3 is a discussion of the researcher's professional pre-understanding, and a review of the literature on ethical decision-making is presented. In Chapter 4 the findings of the study are presented and the use of the hermeneutic phenomenological method is demonstrated to uncover how ethical decision-making realises in difficult care situations. Chapter 5 presents the conclusion and recommendations.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

This chapter deals with the research approach and design, as well as the methods as it progressed. The primary aim of the study was to describe how ethical decision-making in difficult care situations realises in nursing practice. This study aims to help educators of nursing staff to prepare students to make difficult decisions in care situations. Nurses and midwives are involved in caring, and caring provides stories. "We understand ourselves by interpreting the stories we live to tell" (Sorlie, 2001:52). In order to gain insight into how professional nurses and midwives make ethical decisions in practice, critical incidents were used to provide such scenarios.

2.2 AIM OF THE STUDY

To answer the research question "How does ethical decision-making realise in difficult care situations in nursing?", the primary aim of the study was to explore and describe how ethical decisions are made in difficult nursing care situations in two city hospitals, and secondly to formulate guidelines for the teaching of ethics in nursing.

A hermeneutic phenomenological approach was used to explore and describe the phenomenon of ethical decision-making in difficult nursing care situations. To obtain 'stories' the critical incident technique was used, which is an in-depth exploration of specific incidents and behaviour related to the phenomenon under investigation. The incidents were self-reports, as participants provided narratives describing specific incidents of ethical decision-making in nursing care situations that could have been either positive or negative. The participants had to perceive the situations or incidents as significant to the purpose, or these situations had to have influenced their behaviour later in life (Stromberg, 1999:334).

2.3 RESEARCH APPROACH

This study was inspired by Ricoeur's (1976:93) work, which was unique in the sense that he views stories as providing identity and awareness that we are part of a greater continuity. Stories change practices in everyday life and open up understanding in a different way than the use of numbers, statistics and concepts. It is important to listen to narratives in order to understand the meaning of acting ethically in difficult care situations. We all have actions, thoughts, wishes and even fantasies that can be revealed in stories.

The choice of research design was further influenced by the researcher's belief that reality can be interpreted in various ways and that understanding of reality is dependent on the subjective interpretation of that reality (Granecheim & Lindman, 2003:106). The hermeneutic phenomenological approach was therefore used in this study. Hermeneutic phenomenology strives to understand the meaning of a person's experience, which holds a particular appeal for the discipline of nursing and especially for this study (Cohen, Kahn & Steeves, 2000:4; Robertson-Malt, 1999:292). More specifically the researcher sought to gain an understanding of the meaning of experience as it is understood by those dealing with it – in this case professional nurses and midwives in clinical practice, who had to make ethical decisions in difficult care situations. The focus was on how professional nurses and midwives 'interpret' and attribute meaning to ethical decision-making in difficult nursing care situations. The researcher attempted to understand their experiences as they had been understood by the participants (Gadamar, 1975:448). The hermeneutic phenomenological approach made it easier to make these experiences and their meaning visible to those who had not shared the experiences (difficult care situations).

Life experiences such as ethical decision-making in difficult care situations are revealed in the situations themselves – they cannot be experienced at a distance. They have to take place to be experienced, to manifest themselves, as existence is its own disclosure (Annels, 1996:705). According to hermeneutic phenomenology, experiences have to be understood within the whole, which gives them meaning (Gadamar, 1975:45).

MacIntyre (1985:203) contends that experience means comprehending within the framework of a story, which is not so much a told story but a lived story. A basic premise of the hermeneutic phenomenological approach is a driving force of human consciousness (being) that makes sense of the experience. In general, people try to reach an understanding by interpreting their experiences as they occur. In other words, the understanding people have of their practical experience and the meaning they allocate to that experience is usually contained in the stories they tell (Robertson-Malt, 1999:300). Therefore, by analysing the stories about ethical decision-making in difficult care situations, the researcher will demonstrate the understanding of the narrators, their experience and the perception they have of that experience.

Understanding the context in which the incidents took place was very important in order to understand the phenomenon (Gadamar, 1975:45). As the researcher has a background and experience in nursing and midwifery, and is also a lecturer in nursing ethics, it helped her to understand the language that the participants used and therefore to understand the realisations of ethical decision-making in difficult care situations as they became evident through the narratives.

2.4 STUDY POPULATION AND SAMPLE

2.4.1 The setting

The study was conducted with the help of volunteer professional nurses and midwives at two hospitals in Gauteng Province, South Africa. The hospitals are situated in an urban area and both are referral hospitals to community clinics and nearby healthcare centres. These hospitals serve diverse ethnic groups with different cultures. Because of the sensitive nature of the stories told in the critical incidents, the hospitals are not identified in this report.

2.4.2 Population and sample

The unit of analysis was critical incidents, reflecting the narrators' stories about incidents of ethical decision-making in difficult care situations in which they had been involved. The term 'narrators' instead of 'informants' was chosen because of the methodological nature of the study and to avoid the negative connotation attached to the term 'informant'.

The target population from which potential participants were recruited consisted of registered nurses and midwives who were unit managers at two big city hospitals in Gauteng. Cohen, *et al* (2000:78) recommend that in studies such as this one should utilise narratives generated by individuals rather than a collective narrative generated by a group. Individual registered nurses and midwives from the study sites were therefore recruited.

A purposive sample was used to obtain the critical incidents in the form of rich narratives from nurses and midwives who could provide descriptions of ethical decision-making in difficult care situations. The potential participants had to be senior and experienced registered nurses and midwives who had dealt with many ethical dilemmas before. The area of practice or speciality was not limited; so the participants were from across the study site. Gender differences were not taken into account or types of reasoning demonstrated, because the aim of the study was to establish how ethical decision-making realises in difficult care situations in general.

The aim of this study was not to find narratives that could be used to give a generalised description of the realisation of ethical decision-making in difficult care situations in South Africa. To obtain an in-depth understanding of this phenomenon, all the aspects of ethical decision-making in this context were studied. Therefore the sample size in this study depended on data saturation (Polifroni & Welch, 1999:325). In hermeneutic phenomenology a sample size is typically small, as the representativeness of the sample is replaced by what the recurring themes and patterns identify.

The aim was to use at least ten critical incidents. The sample eventually consisted of 30 narratives of critical incidents provided by 30 unit managers. These unit managers were recruited during staff meetings. The characteristics of the narrators who participated are not discussed in order to protect their identity.

2.5 DATA COLLECTION

The critical incident technique was used to collect narratives from volunteers after the project had been introduced to them. The critical incident technique is an effective method of enabling critical reflection (Von Post, 1999:983). Von Post (1999:983) also states that reading the text and having a dialogue about the nurses' reality gives a voice and language to knowledge. It is true that a reaction to reflection in difficult or traumatic experiences is

part of nursing practice. This technique could provide rich stories about how ethical decision-making realises in difficult care situations in nursing and midwifery.

A critical incident is defined as any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the "act". To be critical, an incident must occur in a situation in which the purpose or intent of the act seems fairly clear to the observer and in which its consequences are sufficiently definite to leave little doubt concerning its effects (Flanagan, 1954:328).

The use of critical incidents in research is based on the work of Flanagan, first published in 1954. Flanagan made use of the critical incident technique in the study of the Aviation Psychology Programme in the United States of America Army during World War II. This procedure was effective in obtaining information from individuals concerning their own errors, from subordinates concerning the errors of their superiors, from supervisors with respect to their subordinates, and also from informants with respect to co-informants. However, it was only in 1947 that the critical incident technique was more formally developed and given its present name (Flanagan, 1954:329). From Flanagan's perspective, this method of data collection was intended to provide the basis for the development of selection tests, proficiency measures and procedures for evaluating both job performance and research report. Flanagan (1954:335) warned against the uncritical use of the critical incident technique as a single rigid set of principles, however. It had to be modified and adapted to meet the needs of a specific situation.

The critical incidents thus provided a narrative truth, emphasising lifelike intelligible stories. Stories are regarded as something valuable when one wants to bring nurses' knowledge to life (Sorlie, 2001:52). Van Manen (1997:345) reiterates that a story/text/narrative is always the result of an inter-subjective contextual situation. Narrating an experience means giving meaning to the experience. The narrators reflected on their experience as they wrote down critical incidents (Uden, Norberg, Lindseth & Marhoug, 1992:245). According to Tappan (1990:239), when a story is narrated, as was done with critical incidents, there is interplay between the cognitive, emotional and conative elements, thereby providing a more comprehensive view of ethical decision-making. Therefore, the reality presented is the function of both the informant/narrator and the researcher, rather than that of one person only (Van Manen, 1997:345).

As far back as 1980, Clamp (1980:1755) stated that the critical incident provides a “snapshot” view of the everyday reality of the nurse in clinical practice, and since then it has been used in a number of studies. More recent studies in nursing were those of Cox, Bergen and Norman (1993:408), Cheek, O’Brian, Ballintyne and Pincomb (1997:66), and Kemppainen (2000:264).

Cox, *et al* (1993:408) used the critical incident technique to explore consumer views of care provided by Macmillan nurses. Cheek, *et al* (1997:66) used the technique to explore nursing contributions with regard to the aged and extended care, and Kemppainen (2000:264) studied the nursing care quality. More specifically, Meurier (2000:42) used the critical incident technique to collect narratives that described the circumstances surrounding a specific event of ethical decision-making in difficult care situations in nursing practice. These narratives provided descriptions of the interaction that occurred between, in this case, the patient, family and the professional nurse or midwife, as well as the outcomes of the care-giving event

Ethical decision-making in difficult care situations is the ability to distinguish the ethical dimension of a situation from other situation that often overlap (such as legal, medical and resources), and the ability to identify a range of morally acceptable options and their consequences.

2.6 PROCEDURE FOR OBTAINING CRITICAL INCIDENTS

Volunteers from the target population were informed about the study in detail at a meeting of unit managers of the two hospitals. They were given the opportunity to ask questions. Because of the sensitive nature of the incidents, the volunteers who stayed behind after the meeting were informed of their rights, especially with regard to anonymity and confidentiality. All the potential participants were provided with information leaflets and informed consent letters, which they had, time to read again before they decided to sign informed consent forms. These written informed consent forms were collected from the participants together with the description of the critical incident. However, the signed forms were placed in a different envelope and sealed in their presence. This was done to demonstrate how high the regard for the ethical promise of anonymity was and the participants were assured that these signed forms would be kept in a safe place for at least two years after the completion of the study.

The volunteers were asked, in their own private time, to write down specific incidences in which they had been involved in ethical decision-making in difficult care situations. Participants were given two weeks to write from memory about what was important to them in relation to their experiences. In remembering an incident, the narrators revived the important aspects of the incident that had made an impact on them personally (Uden & Norberg, 1995:245).

The participants were also provided with a guideline on writing about the critical incidents, as they had to reflect on the incident. (See Appendix A). Johns's model (Johns, 1994:71) was used to guide the participants in writing their stories (see table 2.1).

2.6.1 Guide for writing about a critical incident concerning ethical decision-making in a difficult care situation

- Description of the incident
- Reflection of what happened
- Influencing factors
- Could I have dealt with the situation differently?
- What did I learn from the situation?

The use of this technique was to facilitate reflection in line with hermeneutic phenomenology. The researcher needed to encourage the narrators to move past the superficial explanation of an experience that the narrative offered at first. The language used to recollect experiences becomes the very material that the method works upon during analysis (Robertson-Malt, 1999:292).

The written texts and the informed consents were collected personally by the researcher after two weeks. Only the researcher and the supervisor had access to the documents. After analysis of the data, the documents (critical incidents and informed consents) would be kept for two years and then destroyed.

2.7 ETHICAL CONSIDERATIONS

The Ethics Committee of the Faculty of Health Sciences, University of Pretoria, approved the research proposal and the information leaflet and informed consent form. (See Appendix)

For the first part of the study, the nature and purpose of the study were explained to the volunteers. They were supplied with a written information leaflet concerning the study and their rights as participants. In the first phase of the study, the participants were given two weeks to write the story and to re-think their consent. They were also informed of their right to withdraw from the study, although this could not happen after they had handed in the stories, as it would have been impossible to track their particular stories. Written informed consent from all the participants was obtained. The written consent forms were sealed and kept in a safe place so as not to be linked with critical incidents. The critical incidents were very sensitive. The risk of violating the rights of the participants was prevented by protecting their identity and keeping the accounts of the critical incidents in a safe place. Anonymity and confidentiality were important issues and the participants were reminded in the information leaflet not to identify themselves, or to mention any person or institution in their stories. The written texts were typed by a person who understood the importance of the confidentiality of the texts, and this prevented the researcher from recognising the participants from their handwriting and the stories. It could have been important to return to the narrators to validate or to increase the credibility of the interpretation of their stories (Reissman, 1993:15; Sandelowski, 1993:27). This was not possible or advisable because of the sensitivity and anonymity of the data.

2.8 DATA ANALYSIS

After the narratives on ethical decision-making in difficult care situations had been collected, the narratives were analysed. The analysis was based on Ricoeur's (1992:172) approach. According to this approach, there is always a dialogue between events (critical incidents) and meaning in a discourse.

The descriptive and interpretative elements of a hermeneutic phenomenological method were used to understand how ethical decision-making is achieved in difficult care situations. The hermeneutic phenomenological method was used to uncover meaning, and it also provided a hermeneutical interpretation of the meaning of ethical decision-making in difficult care situations in clinical practice (Crotty, 1998:13). In phenomenology the central question concerns the meaning of a phenomenon, while in hermeneutics the focus is on the interpretation of what the text is saying (its meaning or sense) and what it talks about (Ricoeur, 1988:110).

The interpretation is therefore performed in what is called a hermeneutic spiral/circle as guesses and validation, and is related to the text in a manner as subjective and objective approaches (Sorlie, 2001:20).

2.8.1 The hermeneutic circle

The analysis was a critical, in-depth interpretation of the critical incidents against the background of the researcher's pre-understanding of ethical decision-making in difficult care situations, the phases of naive reading and structural analysis, and finally, with the aid of the literature, to come to a point of comprehensive understanding of the realisation of ethical decision-making in difficult care situations (Ricoeur, 1976:92).

The analysis using the hermeneutic circle began as parts of the text are understood in relation to the whole and vice versa. The individual text (critical incidents) is understood in relation to the whole text (the other critical incidents) and vice versa. The researcher started with a vague and tentative notion of the meaning of the whole, of the data (after reading all the critical incidents) and reflexive awareness, that this notion was anticipation of meaning. This awareness contributed to a dialectical examination of the parts of the data to understand the whole better. With better understanding of the whole, the examination of the data or the same parts of the data at a deeper level drives the analysis ahead (Cohen, *et al*, 2000:72).

The critical incidents were read and re-read. Reading and re-reading confirmed the hermeneutic circle as a description of a circular relationship between explanation and understanding, which involves seeing something familiar in a new light (Polifroni & Welch, 1999:235).

The first phase of an analysis is known as naïve reading and represents the first superficial interpretation of the stories as a whole within the context. This phase provided direction to the next phase, namely structural analysis. The aim of the structural analysis was to find meaningful ways to explain what the text said. It included a thorough examination of the parts of the text. Ricoeur (1988:6) regards structural analysis as a necessary stage between naïve reading and a critical interpretation, between superficial and deep interpretation. The third phase, the critical interpretation, led to a comprehensive understanding of what the re-contextualised text as a whole indicated or pointed to with reference to the research question “How ethical decision-making is realised in difficult care situations in nursing?”

2.9 STRATEGIES TO ENSURE TRUSTWORTHINESS

Guba’s model was utilised to ensure rigor in this study (De Vos, 1998:348). The strategies below were implemented.

2.9.1 Truth value

Truth value was obtained through the discovery of human experience as it was perceived and described by the narrators. This was true of the critical incident reports, as the registered nurse/midwife had perceived and experienced the incidents herself. The credibility of the findings depended on the accurate description or interpretation of the incident in such a way that the participants would immediately recognise their own experience. In this study it was not wise to go back to the participants to validate the findings, because of the sensitive nature of the critical incidents provided. Two experienced researchers were relied on to co-analyse the narratives, although this method presented problems of its own.

2.9.2 Applicability

The strength of this study lies in the fact that it was conducted in naturalistic settings with little control over variables. Each situation was unique and was not meant to be generalised. Applicability therefore was of no relevance in this study, because it described a particular phenomenon or experience that cannot be generalised. Each incident was unique and therefore less open to generalisation (Poggenpoel, 1998:334).

2.9.3 Consistency

A thick description of the methods of data collection and data analysis, procedures and the use of an external coder during phase 1 is included. The aim is therefore to provide an audit trail to the reader.

2.9.4 Neutrality

Neutrality refers to the degree to which the findings of a study are a function solely of the participants and conditions of research, and not of other biases. The help of other researchers with the analysis was important to prevent bias. The expert panel also ensured that the guidelines were neutral.

2.10 CONCLUSION

In this chapter the approach to the study, the study design, and the methods and procedures of data collection and data analysis were presented. It also showed how the study was planned and conducted in a scientifically rigorous and ethical way. The value of a hermeneutic phenomenological methodology is its ability to encourage the researcher to move past the superficial explanation or description of an experience that the story offers at first. The language used to write the experiences became the very material that the method worked on during analysis.

The hermeneutic phenomenological methodology enabled the researcher to bring to light and gain depth and scope in the understanding of the human experience and in realising ethical decision-making in difficult care situations (Vitz, 1990:757).

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

The aim of the study is to explore the process of ethical decision-making in difficult care situations in clinical practice, using a phenomenological approach. Clinical scenarios (as described by volunteers) will be described using the critical incident technique. Findings will be described from the participants' narratives, rather than being translated into scientific or theoretical language. The researcher identified themes found in the data and from these themes a structural explanation of the findings was developed (Burns & Grové, 2001: 604).

The study might help in understanding the process of ethical decision-making used in nursing and healthcare in general, as well as in these clinical scenarios, with the aim of seeking some way of avoiding conflict. This chapter aims to give a detailed review of what is known about ethical decision-making in difficult care situations in clinical practice.

3.2 ETHICS IN NURSING

Teaching nursing students to make sound and effective ethical decisions is the lecturer's task. Lecturers should include knowledge and skills about ethical codes of conduct in students' learning programmes, since the student will later have to work with and manage patients' rights like:

- The right to care facilities
- The right to medicines
- The right to respect
- The right to consent.

A profession develops a code of ethics to which members have to subscribe. This is not only a unifying mechanism, but also brings people from diverse cultures, religions, beliefs and practices into a common system of behaviour. This system provides the profession with a set of norms and values within a given context. The health profession has to recognise that human life is very fragile. Those entrusted with the responsibility of tending to this life

need a guideline for action. These guidelines have to be valuable to the recipient of care by the healthcare professional and society as a whole (SANC, 1992: 2).

Ethical codes in the profession set the parameters of the professional's responsibility towards the client – in this case the nurse's responsibility towards her/his patient. Professional preparation needs to emphasise the fact that ethics are moral dimensions of attitude and behaviour based on values, judgement, responsibility and accountability. The practitioner takes these ethics into account when weighing up the consequences of his/her professional actions.

Ethical codes of conduct are adopted and promulgated as a means of establishing standards of behaviour to protect the recipient of healthcare and the reputation and credibility of the profession. Nurses pledge to provide a service to humanity, where the total health of their patients is the first consideration. The professional nurse/midwife professes to maintain the utmost respect for human life as expected in all decision-making.

The concept "ethics" in nursing refers to the practical study of the norms and values, guiding the judgement of what is right and what is wrong. Ethics is the philosophy of nursing behaviour. The concept of ethics merges well with the nursing profession's fourfold philosophy, namely promotion of health, prevention of illness, restoration of health and alleviation of suffering. The above are ethical according to the nursing profession practice, and the reverse is unethical. A professional nurse/midwife has to know and uphold the ethical principles and caring values inherent to the nursing profession.

A sound educational basis in ethics is necessary, because nursing ethics is concerned with the code of conduct for safe nursing practice. Ethical problems arise when, in the course of practice, the nurse's conduct is in conflict with the following:

- Preservation of human life
- Regard for the human as a total being
- Recognition of a human's uniqueness and his personal values
- Beliefs and traditions
- Preservation of human dignity
- Freedom of choice of a person who is competent to make an independent decision
- Preservation and enhancement of the health of the individual and the community

The SANC calls for professional conduct hearings after inappropriate ethical decision-making (SANC, 1998:2). Ethical principles such as beneficence, veracity, justice and fidelity, as well as caring values such as commitment, confidentiality, compassion and competence, help to guide the nurse in ethical decision-making. Doing good, not harming the patient, and keeping promises and confidences are morally correct. They are practical issues that professional nurses must live up to (Searle & Pera, 1998:12).

Ethics as the science of morality is central to the decision-making process. Ethics in relation to the healthcare fields is “the principles of proper professional conduct” concerning the rights and duties of the healthcare professional, his/her patient and his/her colleagues. Ethics deals with understanding approaches to morality. It is the disciplined study of the nature of justification of moral principles, decisions and problems. Ethics also provides guidance to human behaviour at both personal and professional level (Peer & Rakich, 1999:7).

Ulrich (2001:2) contends that students in nursing are limited in ethics education to confronting complex societal issues and a theoretical basis from which to derive ethical questions. He suggests that nurses must recognise that types of knowledge beyond empirical knowing are necessary for building the science, since the profession is currently faced with daunting ethical questions such as allocation of scarce resources, beginning and end-of-life decisions, palliative care issues and genetic advancement.

These concerns will escalate, requiring us to take advantage of all types of knowing. Other important issues are preparation and skills development in discerning ethical outcomes. “Will” is the key issue in building the future knowledge base of ethical decision-making. According to Yung (1997:128), nurses are constantly confronted in day-to-day nursing practice with decision-making that is moral in nature. The indication is that nurses are becoming increasingly aware of their ethical responsibility in providing care, though experience has shown that nurses have difficulty in identifying an ethical dilemma and choosing an appropriate course of action.

Ethical decisions will never disappear. With all the advances in technology, professionals to an increasing extent do not have the luxury of ignoring them or thinking others will solve them. Consumer awareness, patient-rights advocates and ethical issues are more prevalent than ever before. Ethical dilemmas may be painful to confront, but nurses need to realise the ethical nature of their work and also acknowledge their authority to make ethical decisions. Continuous education with the view of adherence to proper ethical decision-making is imperative (Davis & Aroskar, 1987:60).

Ethical decision-making is a rational and analytical process in which a morally best course of action in a situation involving conflicting alternatives is determined (Gaul, 1987:114). As ethical decision-making is a process of deciding what should be done, it allows individuals to assess the advantage and disadvantage of different courses of action, which ultimately results in the selection of one of them. Reflection on alternatives provides the opportunity for communication and conceptualisation (Peer & Rakich, 1999:7).

According to Lauri, Salanter, Chalmers, Ekman, Kim, Kappeli and MacLeod (2001:83), decisions are outcomes of cognitive processes. Their contents are based on the knowledge of the decision-maker. That is why it is necessary to teach and follow up ethical decision-making in clinical practice. The professional is a moral agent, continuously involved in moral situations. This must be seen not as a mere application of rules, but as the interpretation thereof, with appropriate results of ethical decision-making.

Botes (2000:1080) states that rules and principles taught should only be used as guidelines to interpret ethical questions. Where rules are not adequate to determine solutions to a thorny problem, more than just rules and principles are naturally required.

3.3 PROBLEMS IN ETHICAL DECISION-MAKING

Gaul (1987:113) regards ethical decision-making as being complicated by issues of bureaucracy, autonomy, status and power. Although decision-making implies that one has to choose without undue coercion, the nurse, being an employee who is accountable to various health authorities, is often not in a position of being a free agent. The clinical area is seen as an unpredictable situation in which the professional nurse/midwife has to have the ability to interpret cues, weigh the evidence and respond appropriately and expeditiously to the changing situation.

Making decisions requires at least some conscious deliberation on what to do and how to do it. Such critical and conscious deliberation is the aim of the profession, in order to realise ethical decision-making and avoid inappropriate, erroneous decisions, which can lead to a patient losing his/her life (Greenwood, 2000:1106).

Yung (1997:128) states that the experience of repeated frustrations related to lack of time to make ethical decisions results in decentralisation of aspects of the dilemma. As the experienced professional nurse/midwife experiences uncertainty and difficulty in dealing with ethical matters in clinical practice, for many situations there is no simple way of thinking. That is why unethical acts occur more often in the clinical setting. The professional nurse or midwife needs to be aware of the fact that patients today tend to be more concerned and want to be involved in decisions about their care and treatment. That is why it is necessary to enable patients to develop their own autonomy and reduce their dependency on health professionals. The study of ethical decision-making in healthcare has to be centred on resolving ethical dilemmas, due to morally confusing situations occurring in the healthcare setting and leading to mistakes by the professional nurse/midwife who fails to realise ethical decision-making and ends up at professional conduct hearings.

The realisation of ethical decision-making is problematic. There are different perspectives the professional could use to avoid conflict and promote mutual understanding about such decisions in healthcare. The health team needs to examine the ethics of care and the ethics of justice in ethical decision-making. Certain ethical dilemmas would almost surely remain unresolved, considering that the fair and equitable way of dealing with people from the ethics of justice point of departure and the holistic, contextual and need-centred nature of such treatment from the ethics of care approach has to be focused on in realising ethical decision-making (Botes, 2000:1076).

Nurses have to work within the "ethics of care" if they want to avoid being disciplined for failure to realise ethical decision-making. Ethics of care is concerned with:

- The relationship between people
- The nurse's character
- The nurse's attitude towards others

Caring knowledge is gained through personal and emotional involvement with others, through joining in their struggles. Professional nurses/midwives must have experience in order to apply such knowledge in their work. For them to be able to make ethical decisions, they must move from the “self-centred” to the “other-centred” approach. They must be able to take action on behalf of others. The health professional has to function sensitively in unequal relationships that could lead to the abuse of power over others.

Potter and Perry (1997:320) are of the opinion that a lack of sensitivity leads to the neglect of a patient or harming of the patient. In the healthcare setting, patients/clients and families are often on an unequal footing with professionals. This is due to:

- Illness of the patient
- Lack of information
- Regression due to pain and suffering
- Unfamiliar circumstances

This is why the advocacy role is critical in helping people to deal with health problems. The nurse has to be sensitive to each situation and respond with technical and moral knowledge, compassion and competence as well as personal integrity.

Ethical decision-making has become important for nurses due to technological advances and questions about the beginning and end of life. The most pressing questions of our era are being asked in healthcare; it is there that people come face to face with real-life choices about health, caring, life and death. Complex issues of abortion, suicide and the allocation of resources are debated in the media, and nurses find themselves on the “front line” of those same questions because they are in the “front line” of caring. Due to economic issues and treatment approvals, healthcare providers’ independence to make decisions has been limited, resulting in the dissatisfaction and discouragement of the provider and the patient. Because of this, the resolution of ethical dilemmas necessitates close examination of the impact on healthcare.

Economic issues created a dichotomy for many healthcare organisations that were originally dedicated to providing some level of uncompensated care, but that have been taken over by profit entities. According to Peer and Rakich (1999:67), healthcare providers

find that decision-making, ethical or otherwise, is increasingly linked to legal versus medical care implications.

What may be legal may not be ethical. The law is standardised, bureaucratic and impersonal. Ethics, on the other hand, is humanistic, personal and dependent on one's conscience. The law and a strong ethical foundation should complement each other in the operation of the organisation. In some cases, the administrative rewards for unethical decision-making and behaviour outweigh the punishment for the act. This further perpetuates the problem of ethical decision-making (Peer & Rakich, 1999:4).

Grunwald and Becker (2000:58) reiterate that in some cases the nurse finds him-/herself in conflict with the physician as he/she advocates for the patient. This damages the personal sense of moral integrity. The conflict may be even more acute due to family-centeredness as a hallmark of good nursing care. Due to cost invasiveness and the many intervention morbidities, harm may be caused to the patient. According to Howarth (2001:36), the patient may be subjected to unnecessary risk due to the withholding of care in order to achieve economic efficiency, which may still lead to more spending if the situation becomes a lawsuit.

Howarth (2001:37) goes on to say that persons should be respected as self-determining agents, and should be free to decide between different courses of action on the basis of the information given, as the freedom of the individual is a requirement for any ethical framework in modern society. In other cases, the nurse has to make such a decision for the patient.

Problems in ethical decision-making are endless. Coverston and Rogers (2000:4) state that making ethical decisions often feels like a journey down a winding road, where there is always a bend preventing one from seeing what lies ahead. Signposts are often faded, twisted in the wrong direction, lying on the ground or even hidden by vegetation. Facing the unknown can be exhausting to the professional nurse/midwife. Coverston and Rogers (2000:4) hold the opinion that ethical dilemmas are never far removed from the nurse's practice. Ethical decisions are based on values, and there is no concurrence in values or agreement as to which value takes precedence over the other. As a result, the decision becomes difficult to make.

Mattison (2000:3) mentions that the code of ethics offers a set of rules, principles and standards to guide the decision-making conduct when ethical issues arise. However, it does not provide set rules that prescribe how the professional should act in all situations.

3.4 MODEL FOR ETHICAL DECISION-MAKING

Most models are based on ethical principles or steps such as gathering information and the identification of ethical issues. Others are based on the issue at stake, like best interest or reflective practice.

Botes' (1994) model for ethical decision-making is used in this study as a point of departure. It involves steps for ethical decision-making and the parameters within which ethical decisions need to be made. Botes looks at ethical decision-making as a process of planning, problem identification and consideration of possible options that can promote success in ethical decision-making. The process takes place within the human rights arena and within the legal, philosophical and ethical framework of the registered nurse practising independently. Knowledge and experience also play a role. Accuracy and correctness are necessary to follow the scientific approach in making ethical decisions.

According to Botes (1994), the model incorporates the practice of the registered nurse according to the Nursing Act (50 of 1978 as amended), acting as an independent practitioner or as a member of the health team within the philosophical, legal and ethical framework of nursing practitioners. This is the framework that guides and determines ethical decision-making.

The professional nurse/midwife as an independent practitioner chooses to accept prescription from another registered professional. All the professionals are guided by rules and regulations (SANC, 2598/387), which require the knowledge of correctness and acceptability of the said prescription according to the philosophical and legal framework of nursing. The professional nurse/midwife's acceptance of a prescription means he/she is responsible for the scientific method of implementation.

Even if the ethical prescription is decided upon by the ethical committee, the professional nurse/midwife still remains responsible to address it and will take responsibility for any omission in addressing the prescription or problem. Within the health team the professional nurse/midwife is still responsible for cooperation, coordination, consultation and direction, as well as advocating for his/her patient.

According to Botes (1994), ethical decision-making needs to follow a scientific method of nursing, because a scientific method for decision-making is systematic, orderly, logical and can be answered. This model suggests the planning, problem identification and weighing of possible options within the following spheres: human rights, legal framework, philosophical framework and ethical framework. According to Botes (1994), the weighing of alternative action is the most problematic.

After deciding on the best suitable action, implementation can be done and the action evaluated to see if it was effective. The professional nurse/midwife must take into consideration that ethical decision-making has to take into account:

- Respect for humanity
- The right to life
- The right to physical and psychological health
- Political rights
- The right to confidentiality

The health team must not be paternalistic, as all patients are autonomous and responsible for their own decisions. The patient must be well informed about his health and treatment. The professional has to weigh the alternatives within the human rights arena, the legal framework of the nurse practitioner according to the Nursing Act (Act 50 of 1978 as amended), and the relevant rules and regulations, because that is the basis for ethical decision-making.

The legal framework according to Botes (1994) is a major determinant in ethical decision-making, which is why any unethical act by the professional triggers the registering body to investigate and deal with the issue on behalf of the public. The professional nurse/midwife must also keep other laws, such as the Human Tissue Act (Act 65 of 1983), in mind.

Botes (1994) incorporates the utilitarian philosophical framework in his model, according to which proper care caring (the most useful in practice) is essential in ethical decision-making. Other philosophical frameworks include:

- Deontology, in which thinking is grounded in the belief that actions in or of themselves can be determined to be right or wrong or good or bad, regardless of the consequences they produce. From this philosophical perspective, adherence to rules is central. Once formulated, ethical rules should be upheld under all circumstances. Rules remain in place across all situations, and circumstantial factors do not serve to justify disregard for rules.
- Christian approach: This may not be applicable to all, but it is what the nursing profession is based on, i.e. "love made visible" (Searle, 1968:3). It is the unconditional acceptance of others.
- Teleological, i.e. the professional nurse's preparation. Attention is directed to understanding the multiple influences. It calls for the consideration of the possible consequences of proposed action as being central.

There is a need to weigh potential consequences of actions decided on in ethical decision-making (Mattison, 2000:201). Botes (1994) concludes that the model she formulated should make ethical decision-making easy as long as it is within the human rights and philosophical and legal frameworks of nursing.

3.5 PREREQUISITE FOR ETHICAL DECISION-MAKING

The prerequisite for ethical decision-making lies with the purposeful use of mental and spiritual judgement so as to perform a moral act. Realising ethical decision-making, justification and accountability for a moral act rests with moral values as well as responsibility and obligation, according to the way in which the situation presents itself (Muller, 1998:92).

Ethical decision-making requires critical thinking by the professional nurse/midwife to be able to make sound decisions about the situation at stake. Critical thinking demands cognitive ability to process information in order to make proper decisions, in this case ethical decision-making (Ulrich, 2001:2). According to Mysack (1997:27), there is a need for an interactive approach and rational activity, which uses structure as a means rather than as an end. There is a need for an awareness and understanding that knowledge is limited, beliefs change and conclusions are temporary. All ethical decision-making needs consultation with all structures available and it becomes a learning curve to all involved.

It is necessary for ethical decision-making to incorporate or be based within the framework of the national health policy mission statement. The statement looks at the process of consultation, transparency, democracy and inclusivity in a sound professional and administrative manner. It does so to ensure that the highest quality of ethically based nursing care is rendered to all people in South Africa. It involves, to name but a few:

- Quality nursing care based on values clarification
- Adequate knowledge, which is ethically based and comprehensive
- Skills competence
- Holistic patient care (SANC policy statement, 1998:2).

Bandman and Bandman (1978:18) contend that when choosing between alternatives, values hold the key position. They determine the choice of action in the decision-making process. Such values are said to include professional, societal and cultural values per se and provide a perspective to analyse the situation. However, there are no objective means of determining which set of values is paramount. Therefore, to find the "best fit" solution in the light of the patient, nurses, other healthcare providers and institutions are needed to resolve the dilemma. This makes ethical decision-making an exceedingly complex issue.

The practice of the professional nurse/midwife has to be legal and be what he/she believes in within the ethical legal framework as a member of the health team. Sellman (1996:45) argues that health professionals are often criticised for making the range of options from which the patient can choose explicitly. He regards this approach as paternalistic and predominating in the history of healthcare. The above sheds light on why nurses need to be disciplined.

Wurzbach (1999:3) reiterates the fact that ethical decision-making has to be supported by a “willingness to take risks” of greatest possible penalty, which possibly is the deterrent in realising ethical decision-making. Husted and Husted (1998:45) consider the process of realising ethical decision-making as having contextual certainty, which goes hand in hand with the extent to which one has relevant facts and relevant knowledge to realise ethical decision-making. It is believed that professionals have to use practical knowledge accrued over time in practice, which is not always the case. It is said that ethical decision-making has the practical and subject component, which cannot be shared with others and cannot even be generalised.

According to Potter and Perry (1997:320), the process of realising ethical decision-making has to consider the following:

- Goodwill
- Identification of all persons
- Gathering relevant information
- Identification of important ethical principles
- Proposing alternative courses of action
- Action taking, as no two ethical problems are the same

Using a systematic model for ethical decision-making and communicating with or sharing with all healthcare members concerned increase the probability of success in realising ethical decision-making.

Ethics reflect personal values, principles and standards that govern professional behaviour. Potter and Perry (1997:322) consider values and ethics as related. Values are building blocks for personal and professional morality, influencing one’s ethical decision-making. It is also important to know that valuing something does not necessarily make it right or good. Ethical decision-making needs investigation beyond values and norms, so as to maintain the integrity of the profession.

Nurses need the necessary skill and insight to realise ethical decisions and make effective contributions to ethically sensitive situations. Clients look to professional nurses/midwives to help them with their concerns. Nurses need to realise very seriously their accountability and responsibility for autonomous ethical practice and yield their responsibility for a full scope of practice.

According to Raffin (1991:2), the first step in optimising ethical decision-making in practice is to become proficient in the basic principles of ethics. However, in the analysis the best interest of the patient is the most important consideration. The prerequisite that Raffin (1991:2) sees is that nurses/midwives must become conversant with ethical principles and discuss them openly with colleagues, patients and the public. He feels that seminars, major doctors' rounds, ethics committees and community education should be encouraged. He suggests communication as the key to thoughtful decision-making, followed by veracity, i.e. faithfulness, saying that nothing is more powerful or simpler than honesty.

Knowledge that guides ethical decision-making, theoretical and practical, is formalised as general, abstract rules and principles. Lauri, et al (2001:84) states that practical knowledge is derived from experience. Howarth (2001:36) suggests that professionals need to balance advantages and disadvantages, and be cognisant of the fact that no principle is absolute or dominant. All principles must be respected and adhered to. Ulrich (2001:2) suggests that taking advantage of all types of knowing, thereby advancing theoretical knowledge as well as preparation and skill in discerning ethical outcomes, will be a key to building the future knowledge. Brinchman (1999:37) also mentions that decisions are made on the basis of expert judgement and experience, though experience does not seem to make these difficult decisions easier.

Currently, there are concerns about the morality of the professional. These concerns focus on issues like what is to be considered the correct or "ethical" position to promote or action to take in a professional capacity. Moral responsibility as the obligation for professionals to "act correctly" in situations is being scrutinised carefully. Mattison (2000:2) holds the opinion that individual practitioners are being held responsible for their choices of actions, as was mentioned earlier.

Mattison (2000:4) suggests that pragmatic approaches to ethical decision-making must be better linked to daily practice, and that decision-makers themselves should be developing insight into how they typically respond to value conflicts. It is important for professionals to scrutinise their value decisions and realise if they tend to follow rules or policies or maybe over-exercise their discretionary judgement. He advises that professionals should develop a greater awareness of the self throughout the ethical reasoning process. It is necessary to be aware of and sensitive to the ways in which their value preferences continuously influence and pervade the process.

According to Mattison (2000:4), professionals who have to make ethical decisions do not have an ethical code that specifies which values or principles to consider as primary in the case of competing interests. Thus, professionals must have a framework or strategy to guide them in determining which principles, values or obligations to honour foremost when ethical obligations are in conflict. It could still be argued to be impossible, since ethical dilemmas are unpredictable and completely different, like the winding road described by Coverston and Rogers (2000:4), where you never know what is around the bend. Thus, according to Coverston and Rogers, it is better to use discretionary judgement supported by experience.

Mattison (2000:201) goes on to indicate that professionals do not make ethical decisions in an arbitrary manner. They are grounded in the conditions and factors related to the decision-maker, the situational circumstances, and the process itself. Ethical decision-making not only involves distinguishing right from wrong, but also addressing the more troubling good/good or bad/bad variety of deliberations. Commonly, the more troubling ethical decisions involve choosing from among possible choices of action, each of which offers potential benefits (good/good) or those in which each of the options at hand appears unattractive or undesirable (bad/bad). In either case, no option ever entirely satisfies. Attention should be given to weighing the potential consequences of the proposed action (Mattison 2000:5).

Peer and Rakich (1999:3) suggest that ethical decision-making needs to provide a strategy for fostering professional responsibility by focusing on:

- The stimulation of moral imagination
- The recognition of ethical issues
- Development of analytical skills
- Promoting a sense of moral responsibility
- Tolerance
- Resolution of disagreement

3.6 CONSEQUENCES OF ETHICAL DECISION-MAKING

Ethical issues are often hard to settle; therefore the participation of nurses in this dimension of practice can lead to frustration. Nonetheless, nurses need to realise ethical decision-making, because they have a primary commitment to patients/clients. They are also accountable to families, peers, institutions and society, yet they often say that ethical issues

leave them “feeling trapped” or “in the middle”. Thus, the need to get out of the middle means occupying a position of “powerlessness”. However, a position of power can be accomplished by expanding one’s knowledge base in ethical decision-making, seeking professional support and developing a strong positive sense of the nurse’s moral position. Being in “the middle” can also be taken as “a privileged position” of advantage, pointing to the nurse as a “client advocate”, who is sensitive to differing points of interests (Murphy, 1979:19).

Many times, nurses realise that it is not clear what the right action should be. Wurzbach (1999:287) states that in such instances, a person experiences moral uncertainty or distress or a person may describe the situation as a moral dilemma. In other situations, a person is certain. In such a position of moral certainty, a person feels empowered and has a strong belief in the rightness of the solution to the problem.

Oberle and Hughes (2001:707) regard ethical problems as a source of tension for health professionals, leading to misunderstanding or conflict from differing perceptions of ethical problems. They are of the opinion that uncertainty about the best course of action for the patient and family is a source of moral distress. It leads to inability to realise ethical decision-making, with competing values, hierarchical processes and scarce resources compounding the problem. Opportunities for discourse need to be created to help professionals reduce moral distress and generate creative strategies for dealing with dilemmas.

If professionals view moral issues differently, there may be potential for conflict, but decisions still have to be made. Oberle and Hughes (2001:707) state that for collaboration to be achieved, it is important to understand the perspective of others, as that will help realise ethical decision-making. It is acceptable to view ethical problems differently and apply different reasoning in ethical decision-making. It should not be merely rejected.

The need for enhanced awareness in realising ethical decisions and increased understanding are important factors in improving collaborative practice. From an earlier discussion it is evident that failure to realise ethical decision-making is probably due to taking “risks” because of bureaucratic situations in practice relating to “administrative” and “economic” implications, i.e. the anxiety of working in hopeless situations of life and death.

Stress of nurses/midwives can be ascribed to various factors: having to decide on appropriate action; repeated frustrations related to the time available to make ethical decisions; the lack of support since decisions are from the “bottom up”; the practice situation that puts the nurse in “the middle”, making them “feel trapped”; situations where there is no “clear right or wrong” or has a “more right” possible cause of action; the decision to have power, while the client is powerless; nurses being in the “self-centred” rather than “other-centred” position; if emotions play an important role in the sense of caring or not caring; legal considerations leading to fear to get involved; or the professional culture of “everybody does it”. Concerning the last factor, it has come to light that professionals with knowledge of legal obligations wilfully violate this obligation so as to serve a perceived “greater good”.

3.7 METHODOLOGICAL ISSUES

This study follows a hermeneutic phenomenological approach, which in practical terms means studying how people interpret and understand what they experience. In other words, the study uses the critical incident technique. Action based on common meaning between nurses and patients provides a most effective base for a helpful nurse-patient relationship (Cohen, et al, 2000:4). The realisation of ethical decision-making seeks to understand the situation at hand, creating meaning of the experience and then making an ethical decision.

Flanagan (1954:327) describes the critical incident technique as outlining procedures for collected, observed incidents. What the nurse experiences has special significance and meets certain criteria. Therefore, Flanagan contends that to be critical, an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects.

The method is essentially to obtain a firsthand report of what was experienced and interpreted; in this case to be able to realise an ethically sound decision. Hermeneutic phenomenology takes us on a journey, leading us to a place we neither control nor predict (Cohen, et al, 2000:3). This is also clearly illustrated in critical incidents, where a registered nurse cannot control or predict that a woman will come for termination of pregnancy for the third time, but still she must understand and give meaning to such behaviour and end up realising an ethical decision.

The researcher has to share the intersubjective experience of such an existence or situation. Hermeneutic phenomenology describes the experience of the registered nurse, where consciousness exists. The realisation of ethical decision-making occurs consciously according to day-to-day experiences at the time, and such experiences have to be interpreted, described and interpreted in the study. The registered nurses are informants, as they inform the researcher about their experience in incident reports and, in this case, have to realise ethical decisions.

3.8 CONCLUSION

Ethics as the science of morality was found to be central to ethical decision-making in difficult care situations. Ethical decision-making in difficult care situations was seen to be greatly influenced by availability or unavailability of resources, beginning or ending of life decisions, palliative care as well as genetic advancement. As such influences are escalating, the need for all types of knowing has become of uppermost concern. A sound educational basis in ethics was seen as necessary in the literature. Ethical decision-making in difficult care situations was seen as a cognitive process, the knowledge of which was based on the knowledge of the decision-maker, especially in healthcare.

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 INTRODUCTION

After the critical incidents on ethical decision-making in difficult care situations had been collected, the narratives were analysed. The analysis was based on Ricoeur's (1992:172) philosophy, which states that there is always a dialogue between events (critical incidents) and meaning in a discourse. In the previous chapter the approach to the study, the study design, and the methods and procedures of data collection and data analysis were presented. The researcher showed how the study was planned and conducted in a scientific rigorous and ethical way. In this chapter the findings of the data analysis of the first phase of the study are provided, namely showing how ethical decision-making realised in difficult care situations in given context.

4.2 HERMENEUTIC PHENOMENOLOGICAL INTERPRETATION

The narratives (critical incidents) were interpreted using the hermeneutic phenomenological method. In phenomenology the central question concerns the description of a phenomenon, while in hermeneutics the aim is also the interpretation of its meaning (Ricoeur, 1988:110).

There is always an ongoing dialectic movement between the parts and the whole of the text, between de-contextualisation and re-contextualisation, between understanding and explanation, dissociation and appropriation, and between what the text is saying semantically and what it is saying hermeneutically, pointing to the referential function of the text (Ricoeur, 1976:91).

In this study the interpretation of the critical incidents meant seeing something new in what was given as stories or narratives on ethical decision-making in difficult care situations (Sorlie, 2001:20). Ricoeur (1988:177) as well as Hettema (1996:38) views this process of interpretation as moving from pre-figuration (lived experience) to con-figuration (text); to re-figuration of the world as the stories open up in the text. The interpretation is therefore performed in what is called a hermeneutic circle as guesses and validation, and is related in a manner as subjective and objective approaches to the text (Sorlie, 2001:20).

The hermeneutic circle was applied by performing a critical in-depth analysis and interpretation of the critical incidents describing ethical decision-making in difficult care situations, against the background of a pre-understanding. This was followed by working through the phases of naive reading and structural analysis, and finally using published literature to come to a point of comprehensive understanding of the realisation of ethical decision-making in difficult care situations (Ricoeur, 1976:92).

Analysis using the hermeneutic circle began as parts of the text were understood in relation to the whole and vice versa. The individual text (critical incidents) is understood in relation to all the text (the other critical incidents) and vice versa. It was started with a vague and tentative notion of the meaning of the whole of the data (after all the critical incidents had been read) and with a reflexive awareness, that this notion is an anticipation of meaning. This awareness contributed to a dialectical examination of parts of the data to understand the whole better and with better understanding of the whole, the examination of the different parts of the data at a deeper level drove the analysis ahead (Cohen, Kahn & Steeves, 2000:72).

The critical incidents were read and re-read. Reading and re-reading confirmed the hermeneutic circle as a description of a circular relationship between explanation and understanding, which involves seeing something familiar in a new light (Polifroni & Welch, 1999:235).

This first phase of the analysis is known as naive reading and represents the first superficial interpretation of the stories as a whole in their context. This phase provided direction to the next phase namely structural analysis. The aim of structural analysis was to find meaningful ways to explain what the text says. It included thorough examination of the parts of the text. Ricoeur (1988:6) regards structural analysis as a necessary stage between naive reading and a critical interpretation, between superficial and deep interpretation. The third phase then, critical interpretation, led to a comprehensive understanding of what the re-contextualised text as a whole indicated or pointed to, with reference to the research question "How does ethical decision-making realise in difficult care situations?"

4.3 RESEARCHER'S PERSPECTIVE (PRE-UNDERSTANDING)

The researcher's understanding of ethical decision-making is based on professional pre-understanding and a dialogue with the text. Describing internalised professional knowledge and skill applied in practice is a form of professional judgement.

According to Gadamar (1975:446), all people have a pre-understanding of something in life. However, professional pre-understanding should not be regarded as existential pre-understanding, but rather as a pre-understanding arising from the profession one studies.

Professional pre-understanding is made up of the knowledge, skill, duty and commitment that a person achieves through being part of that profession (Von Post, 1999:984).

Professional pre-understanding is based on the scientific perspective, knowledge, experiences, duty and commitment as nurse educators and nurse researchers. It is also due to the encounter with ethical dilemmas related to healthcare situations. Nursing is viewed as a discipline of knowledge and as professional care, the goal of which is to promote the process of being and becoming through caring (Robertson-Malt, 1999:299).

Professional pre-understanding prepares the researcher to receive the text and to interpret it. The text becomes part of the researcher as the researcher enters into it. The story becomes comprehensible.

The story is comprehensible to a person who is not affected by it. Understanding presupposes that one is able to enter into the reality of the story (Von Post, 1999:983).

When a story about a critical incident occurring in a person's time and environment is read, the author and the reader move within the same world of ideas, having approximately the same questions and answers to existence. A text/story as narrated from the professional pre-understanding talks to the reader. It expresses a message from "you to me".

In critical incidents, the text speaks from its horizon of meanings, prejudices and questions. Gadamar (1975:447) objects to reading as a mere manifestation of a personal life. Professional pre-understanding makes the nurse's knowledge understandable, communicable and articulate.

According to Gadamar (1975), dialogue within a text/story as narrated brings back to memory experiences of the past. The reality of the story becomes the same as that of the reader. But since the reader cannot free the self from the situation, it does not mean that the author/narrator has moved. It rather means that the reader within the pre-understanding has broadened his/her mind. The story as narrated in the critical incident has meaning only when related to the professional pre-understanding of the reader. The field of the story and that of the reader are brought together into a relationship with each other through a hermeneutic phenomenological relation. The reader grasps the problems or joys of the narrator, and the story is brought to life by being placed within a horizon of pre-understanding. Our pre-understanding makes us aware of the fact that the stories in critical incidents reveal knowledge about what professional nurses/midwives goes through in an attempt to deal with ethical dilemmas (Von Post, 1999:983).

Botes (2000:4) postulates that with pre-understanding in ethical decision-making, there is a need to balance, since there is no hierarchy of ethical principles. No ethical principle dominates the other.

This researcher has taught ethics and professional practice to nursing students, guiding them in preparation for clinical practice and indicating to them that ethical dilemmas are part of the deal in clinical practice. Experience has shown that regardless of information given, the South African Nursing Council is still inundated annually by professional-conduct hearings due to unethical acts by practising nurses.

4.4 UNDERSTANDING FROM THE NAIVE READING

During the first phase of analysis, namely naive reading, all the narratives were read with an open mind, with the intention of understanding what the narratives were all about. During this phase the research question was kept at the back of the researcher's mind.

The first impression was that the participants intended to do no harm, regardless of how difficult the situation was. The participants took the responsibility to resolve the ethically difficult care situations, considered various options and were influenced by values and norms, as well as cultural issues.

In most of the cases the participants were either happy that they had succeeded, or expressed sadness that they could not resolve the dilemma.

The urgency of most of the described situations required immediate action. This urgency influenced the decision-making by participants, being unable to consult, which increased the complexity of the situation.

It became clear that not only did a critical incident occur within a specific context and have an effect on the narrator, but also that the narrator used various reasoning mechanisms.

The question was “what are the stories all about?”. The narratives were read over and over, and it was possible to categorise the narratives into groups. The cases are now presented according to this first level of understanding. The texts presented are given verbatim.

4.4.1 **Narratives about wrong decisions taken by narrators and/or other staff members**

In the following cases the narrators reflected on difficult care situations where resolving the situation meant making wrong decisions or having to resolve situations where others made bad decisions.

Case 15 “During hand over of report, it was reported that a registered nurse was sick in the paediatric unit. She was pregnant and apparently miscarrying. I told her to go to casualty for consultation, while I was organising a replacement. On my return, I was told that she has left. I got worried, anxious and confused. It was late at night. The fact that she was bleeding got me panicking, asking, what if she bleeds to death. I questioned my empathy. I unethically involved the police, all was explained to the police woman, I was wrong, but it was the only way”.

Case 23 “The patient was involved in a car accident, the nurse undressed him in preparation for operation, and the patient had R100 on him which the nurse took. The following day the nurse was day off as the patient asked for his money. He was under the impression that the nurse kept the money for him, as he saw her taking the money. When the nurse came back to work and was asked, she denied, but the patient explained what he saw. The nurse was told to replace the money. I felt ashamed for lack of trustworthiness, was disappointed. I reassured the patient, told him that it was an isolated occurrence and not common”.

Case 26 "The patient came from casualty, was admitted with confusion, restlessness, and was given Etomine 40mg injection, which was to be repeated if patient became uncontrollable, with symptoms as above. The registered nurse on duty did not assess the blood pressure before administering the drug, when the patient presented with the symptoms. She was newly qualified, but not an excuse for lack of knowledge. The patient never woke up again after the injection, I felt guilty, inefficient, felt I did not teach her, angry with her. The reason for death was poisoning. The doctor said the nurses are taught pharmacology and should know".

Case 27 "I was taking rounds with a final year student and a houseman, when we got to a patient; he was not on his bed. The patient was lying under the bed, semi-conscious. Looking in his file, I realized that the doctor had prescribed Tegretol and Epanutin to be given simultaneously. I was disappointed, in disbelief, as well as angry, that the prescription was wrong, but the nurses never draw the doctor's attention, and actually gave the drug. I told the doctor that the two drugs have the same effect, so cannot be given together. The doctor apologized and changed the prescription; he expressed appreciation for the correction"

4.4.2 Narratives about conflict between the narrator's own values and those of others

A number of incidents demonstrated conflict between the narrator's own beliefs and those of others.

Case 2 "The family members came to fetch the unconscious patient as she was to present at the funeral of a family member. The patient was on intravenous infusion, had indwelling catheter and nasogastric tube. They insisted on taking her with them, all convincing did not help, the family said they had the right. I eventually had to release the patient, the drip was removed and nasal feeding tube, I felt guilty and incompetent, as well as out of control, giving the patient to incompetent hands. The family members were told to bring her back after the funeral or if they experience any problems".

Case 3 "The following day the patient was wheeled to theatre for sterilization without the husband's knowledge, whilst in theatre he came to visit his wife and was told that she had gone for operation. He demanded to know the reason, as his wife had delivered normally and was not sick. An argument ensued, I was called to intervene, as I was briefed about his attitude, of not wanting the wife to sterilize, I took it upon myself to protect the woman, as well as the midwife, who the woman had confided in. I told him that his wife was bleeding, and the doctor was going to remove retained products that caused the bleed. The patient came back and was fine. It was pleasing that the woman managed to exercise her right, though secretly, and the nurse was helpful".

Case 1 "The baby had diarrhoea and vomiting, was brought to hospital by its mom and got admitted. The father of the baby came and was very angry, he took the drip off, and was shouting, he took the baby home. I was shattered, he would not listen to me, I knew him, I was helpless, and told myself that I am a failure, as I failed to convince him. I was in charge of the unit, I felt alone, I had a dilemma, and I decided to tell my father, for the sake of the baby. My father confronted him and he listened to him, he brought the baby back to hospital but he was worse, my father told him he was going to report him to the police, if the baby died. He said he believed in prophecy, and it would heal the baby, he was not prepared to listen to a young woman, I was happy that the baby was now in safe hands".

Case 14 "The baby was 8 months old, she was 33yrs, very educated. Her baby was HIV +, when asked about her status, she refused to divulge it, she looked hopeless, in disbelief, shameful, angry, and in denial, she could not imagine the uncertainties of the diagnosis, she was counselled, but vowed never to tell her family. She was crying uncontrollably, but told to share the burden with the family, so as to get support, which was crucial at the time. I felt incompetent when the client cried, it was like the whole counselling was a disaster".

Case 16 "A woman miscarried, the husband wanted to see the stillborn, which was only 24 weeks. The baby was sent for incineration after the mother saw it and signed, not knowing that the husband will want to see it. He was told that it has been sent away to be burned as it was very small. He was very angry. The superintendent had to inform, they were of the same culture, he was able to talk him down. I was puzzled, failed to understand, but I knew he was right, if that was he wanted to do. He wanted to bury the baby, irrespective of how small it was. I got relieved when he relented though it was a policy".

Case 5 "A Zimbabwean father came to visit his child in the morning at 07.00. I explained to him that it was not visiting time, but he ignored me. The following day I confronted him, he told me that he loves his baby. He started being rude, saying in Zim they visit any time, I called the security to take him out as we still busy with the morning routine. I felt insulted, and especially that he does not belong to this country".

4.4.3 Narratives about personal and professional values conflict

Further cases illustrated conflict within the narrators themselves, between their personal and professional values and beliefs.

Case 13 "A patient had a car accident, he was conscious but very confused, and he was also very pale as he had bled a lot. The doctor had ordered three units of blood for transfusion, and he was going for operation. He was with his parents who said, no blood must be given to him even after a lot of explaining was done they insisted. The parents gave consent for operation. The doctor said he was going on with the operation to save the patient` life, while the parents could not be convinced otherwise. Their believe interfered with treatment, but they were happy when he came back from theater, and looked much better. The blood was transfused without their knowledge. I was unsure of what to say, guilty that I was not truthful, but relieved that the patient was fine".

Case 20 "I was in charge of paediatric ward. There was a baby who was very sick, had pyrexia of unknown origin and investigations were on, the baby had just been admitted. The mother of the baby was phoned from work and came to hospital to see her baby, it was not long that it was given antipyretics, and was sleeping but actually dead. When the mother came the nurse checked the baby before allowing the mother in, only to find that the child was dead .I was called to the seen as the one to break the news, it was a predicament, the doctor was called, she was screaming, collapsed, she had to be taken to casualty for resuscitation. Relatives were called to take her home. It was a difficult situation, I felt guilty, that the child died without being observed, it was desperate situation, I needed to act, casualty helped to calm her down".

Case 6 "A patient was in hospital with pyrexia, while doctor was still establishing the cause of the pyrexia, the mother came and said she is taking her home, she was told the investigation were on to diagnose the cause of the high fever. The mother said she could see her daughter was going to die, and want her to die in her hands, she insisted that she has the right to take her where she thinks she will be helped. The patient was confused, hallucinating, running away. The mother signed refusal of hospital treatment and took her home. I felt very bad that the patient was not able to make that decision herself; maybe she would have done it differently.

Case 22 "She was 20 weeks pregnant, which was a contradiction for TOP, according to the Act, She was from Natal – at the time such facilities were still scarce, but before she came to our clinic she had consulted general practitioners, who referred her from place to place, while the pregnancy was growing. The reason for TOP were authentic, though not reason enough that could outweigh the possible complications. She was slighted by the boyfriend, fees for school paid by the granny, sonar revealed 20 weeks. She was counselled, signed consent, it was a risk I was prepared to take. I was angry with her, felt pity for her, angry with the doctors who send her around, I was uncomfortable with my "actions", torn in between helping her, and breaking the law. My profession was on the line, I prayed that there be no complications, fortunately all went well".

Case 25 "I was taking rounds with the senior doctor in a gynae ward as the previous day was intake day, some patients were for operation. When we got to this lady who was 40yrs old the doctors said she should sign consent, she had a growth in the uterus, which she thought was going to be removed, on explanation as the doctor wanted to clarify, the doctor spoke about removing the uterus, the patient was shocked as that was not what she came in for, as she wanted to have a baby since she had never had one. This was explained to the doctor who was very sorry, and knew that the patient can still conceive. I explained to the patient that the doctor was given wrong information about her. I was very touched, disappointed, felt how patients rights were violated, that indicated how poorly nurses and doctors communicate, and patients made to give uninformed consent".

Case 11 "A teenager aged 17yrs came for termination of pregnancy for the third time, She was previously given advice on family planning, as well as complications of repeated TOP, I was not going to terminate her pregnancy for the third time, I referred to other clinics as she was abusing the service. The Act on TOP say a woman can be treated as often as she wishes, the ethical principle, on reproductive health indicates that the individual should be free to act as she chooses, as long as her behaviour does not interfere with the rights of others, I felt after my efforts, the client should not be coming for TOP for the 3rd time".

Case 29 "The mother of twin babies, knew that she was HIV positive, but apparently the husband did not know, the other twin got very ill, the doctor suggested that the baby be tested for HIV, but she refused altogether, even if it was indicated that it will save the baby's life by giving the correct treatment. The father of the baby questioned why the baby was so sick, and what the doctor was saying about it all, the wife said nothing should be said to the husband about HIV, I realised that she had something to hide, and if I insist I will be revealing something, it was difficult since I wanted to save the baby, who was the vulnerable in this case, but the mother was also vulnerable as she said I am going to disrupt her marriage, I had to maintain trust, but also to advocate for the baby, I decided the woman has a choice as well, and responsibility towards her baby and husband, I was lost, in a difficult situation, left with no direction, my advocacy role was now what do I do?.

4.4.4 Narratives about conflict between the narrators and other staff members and management

Some of the narratives indicated conflict between the narrators and other staff members.

Case 4 "My cousin was admitted in a medical ward where I worked, he gave history of vomiting and lack of appetite for two weeks, he was dehydrated, weak and disorientated. The doctor said he had TB and RVD. The doctor did a test without consent from the patient. The patient was not aware, and said people will think he has HIV since he had lost weight. According to patients rights he had a right to refuse treatment, be informed, and give consent to treatment. I was forced to advocate, since he had children, and a wife who should know. I confronted the doctor to inform him, looking at the infectious nature of the disease to his wife, I told the doctor to counsel him and inform him of his status, which he did".

Case 8 "In terms of TOP though my ethical obligation, I find it difficult to participate. This emanate from my religious upbringing, that terminating life is wrong. I feel I have a responsibility to conserve life and promote health. I am quite aware of the fact that, legally in our country's constitution and bill of rights, it is a choice. In this case I felt that I would be disregarding the rights of the patient and the unborn baby, A 15yrs old came for TOP, I was in the middle, conflict with my personal belief, and the system. After deep reflection, I referred the client to a colleague, basing my refusal on the Act as there is provision for not wanting to take part in the procedure. I reassured the client, that she will be helped. One of my conscience was relieved, but the other was haunted by guilt for not helping the client".

Case 9 "In the staff establishment there is nurse who is absent on every weekend, manager says the case is being attended. Allocating her to the unit is a problem as she is absent e very pay day, and days after, she is aware of her weakness as she brings sick notes to cover up, and goes to different doctors all the time. She has been warned several times, with no improvement, she is a danger to patients, and self. Other staff members do not want to work with her, unfortunately she cannot be just be dismissed, especially if she produces a sick note for absenteeism. This is not fair to other staff members, and is also an ethical risk, when she is on duty you are always on edge, anxious, and worried about patient safety".

Case 10 "A patient was admitted with antepartum haemorrhage, Ringers lactate and Haemacel was infused immediately, Doctor was called, he said the patient be prepared for operation, I felt that the blood pressure needed to be raised as it was very low, I tried to sensitise the doctor but he insisted that he was going to operate The patient was send to theater as he instructed, with a low blood pressure, and died on the table. I feel I should have kept the patient and gave boluses of ringers lactate and haemacel before calling the doctor, as the blood pressure would rise. I feel very bad, a life was lost, I did not do much, I have failed the patient and myself".

Case 12 "As I was doing routine checks in the wards, I picked up that a patient had no consent for operation, so, he could not be given premeditation, the most concerning part was that he was also confused, nothing was done to obtain the consent correctly, the person in charge of the unit used the patient's thumb print for a signature, when I corrected the error, she said I am interfering, I felt bad, the patient was denied the right, but I was

alone in questioning this, my knowledge failed me, the patient was operated without his consent”.

Case 17 “A patient died after disconnecting the intercostals drainage bottle, he used the bottle to pass urine, as he was pressed. There were no nurses insight to ask for help, this means the patient was not educated about the drainage system, the patient next to him called the nurse when the patient collapsed on the floor, such bottles were used as urinals in the hospital, due to shortage of urinals. I rushed to the scene, but it was late, the patient was dead. The matter was never pursued, as the family did not know what happened, I feel guilty, to blame for his death, also haunted by the incident.

Case 18 “I was a student midwife, a woman had delivered an Encephalic baby, the doctor in charge said the baby must not be fed, the parents of the baby had hope of the baby surviving, he insisted that the doctors do something to help save the baby, I was on night duty and would find the baby really neglected, he would cry with a hoarse voice, that touched my heart, without informing other staff members I would clean his mouth and feed him because I felt he was not going to die in my hands. I decided not to be party to such decisions, I kept on feeding him, and the doctor was surprised that he was actually gaining weight, my conscience was in turmoil starving the baby weighed heavily on my soul, on the last night before going off I decided to tell the truth, I was reprimanded, but relieved that I cleared my conscience I went off and said they can continue with doctors decision in my absence”.

Case 19 “I was a night supervisor, during report it was indicated that, there was a problem in theater. It was about the anaesthetist on call who was drunk, before we could start with the night rounds the in charge in theater called to say she cannot go on working as long as this anaesthetist was working, in theater we found the operation in progress, with him leaving the patient and going out to the toilet, could not even balance as he was standing, but managed to reverse the patient successfully, the next patient was due and he was preparing to induce her to sleep, but he was staggering smelling liquor and holding on to machines. The senior was called and he came immediately, he saw how he was and took over from him, it was reported to management, and was changed to polyclinic. This was difficult to understand, it was also confusing, I was disappointed, but could do nothing as the case was with management”.

Case 7 "My cousin's daughter was involved in a car accident with the boyfriend who was not seriously injured like her, he was only bruised while she ended up unconscious due to brain swelling, the doctor responsible decided not to prescribe anything, only to be observed, after three days she was still same, very restless, with my pharmacology knowledge I felt the doctor should have prescribed Decadron. On the fourth day I decided to act , I gave the patient Decadron 8mg twice daily, as I felt desperate, I did not inform anybody, I knew I was not killing her, but I was torn in between, as what I was doing was unethical and illegal, I took a colleague into confidence, after 12hrs the patient improved, I had given 4 doses, I was worried my colleague will talk, but she did not, the medicine was not recorded, the patient got well and discharged, I had helped, my conscience was clear but I was wrong.

Case 21 "I was working in a very busy surgical ward, most of the time alone as a registered nurse, as we were only two, on this day there were lots surgical cases for operation and I had to give pre-medication, with auxiliary nurses to counter check me. I was called for a problem in theater, as the emergency went straight to theater, at the time I was checking a drug, so I quickly placed it in my pocket, and rushed to theater, when I got back I removed the gown as I was about to go off, I had completely forgotten about the drug, the gown went to the laundry where they found the drug and headed to the matron, I was in big trouble, it was thought I abuse drugs, after all the investigation it could not be proven, but I was blamed for being negligent, I did not feel guilty, as I thought it is normal to forget, I blamed my mistake on staff shortage, I felt unfairly blamed, as I was busy and alone".

Case 24 "The two students sat at the desk, it was visiting time, the enrolled nurse, rang the bell for visitors to leave, apparently the student said she is making noise, the enrolled nurse produced a knife, threatening to stab the nurse, which she refused to admit, saying she does carry a knife, but for self protection as she travels far and sometimes late after 7pm. The student had already called her parents about the incident, they arrived and said they were going to the press about such a threat, I was caught in between, that reporting the matter will mean dismissal, that I might be stabbed, if I report to management, I got both to write statements, got the enrolled nurse to apologise, to the student parents, as they were going to report, but the apology was accepted. The case still haunts me. I worry about it even after it is over"

Case 28 "There was a shortage of staff in the operating room, I was only 4 months in the profession, I was allocated to theater due to staff shortage, orientation was only one week, so I was for small operations, this particular day I had to scrub for a hysterectomy, and was on duty with a nursing auxiliary, who had to be the floor nurse, and co-count with me, the patient was bleeding profusely and it abdominal closure, the swab got left behind, I had also lost the swab count, as I got panicky, the patient came back after a week, with a sinus. The x-ray revealed a swab inside the abdomen, the matter was reported to the nursing council, the doctor said he depended on me for swab counting, all responsibility was left on me ,newly qualified, was found guilty, the profession intimidated me, I had failed myself, fortunately I was only cautioned, that gave me a relieve".

Case 30 "A woman was admitted diagnosed as pelvic inflammatory disease, but the signs and symptoms were, not of that which was indicated, I decided to do a pregnancy test, which was positive, it was an ectopic pregnancy, which the doctor had missed, doctor was notified, he came to re-affirm my diagnosis, his test was also positive for pregnancy, he immediately booked the patient for operation to do salpinjectomy. The doctor was grateful that I saved a life, when he had made a wrong diagnosis, proper assessment is necessary, and working hand in hand as a team".

4.4.5 Summary of the naive reading

At the end of the naive reading a conclusion was made about the critical incidents:

- Narratives about wrong decisions taken by participants and other staff members
- Narratives about value conflicts between care givers and patients and/or their families, or between the narrators and colleagues or management
- Narratives about conflict of interest in the rights of patients and the rights of the family

4.5 FINDINGS FROM THE NAIVE READING

4.5.1 Narratives about wrong decisions taken by narrators and other staff members

CASE NUMBER	DESCRIPTIVE NAME OF INCIDENT
Case 7	Difficulty in dealing with a situation where a patient needed medication which was not prescribed.
Case 15	Difficulty in dealing with conflict with self for involving outsiders, due to fear of safety of a colleague
Case 20	Difficulty in informing a mother that her baby died in a situation of poor patient assessment and observation.
Case 23	Difficulty in convincing a patient to believe in the truthfulness of nurses after his money was taken by a nurse.
Case 25	Difficulty in dealing with a situation where conflicting information was given to the patient about her operation.
Case 26	Difficulty in managing a situation where a subordinate gave the wrong medication.
Case 27	Difficulty in managing a situation where a patient was overdosed due to wrong prescription.
Case 30	Dealing with wrong diagnosis made by a physician.

4.5.2 Narratives about value conflicts between the care giver and the patient and/or his family

CASE NUMBER	DESCRIPTIVE NAME OF INCIDENT
Case 2	Difficulty in managing conflict of interest in the case where a patient needed treatment and the need of the family to take the dying patient home.
Case 3	Difficulty in managing conflict of interest between the patient's right to control her fertility and the perceived need of her husband to be involved in the decision.
Case 5	Difficulty in managing conflict of interest of a father's right to visit his sick child and the nurse's perceived duty to maintain order in the unit.
Case 6	Difficulty in dealing with the rights of a patient to treatment and the need of the mother of the patient to remove the patient from hospital for alternative treatment that she believed would be better.
Case 8	Difficulty with a conflict of interest between a nurse's values and beliefs about TOP and the patient's health needs and the law.
Case 11	Difficulty in managing the conflict of interest of a patient's right to the termination of pregnancy and the nurse's values and beliefs about the use of a healthcare facility.
Case 13	Difficulty in dealing with parents who denied a blood transfusion for their unconscious son.
Case 16	Difficulty in managing a situation where the father wanted to see his 24-week stillborn baby, who had already been incinerated while he had not been involved in the decision about disposal of the baby.
Case 22	Difficulty in decision-making about helping a woman who desperately needed the termination of a pregnancy that the narrator legally could not perform.

4.5.3 Narratives about value conflicts between the narrator and colleagues and management

CASE NUMBER	DESCRIPTIVE NAME OF INCIDENT
Case 9	Inability to deal with a drunken nurse due to sick certificates issued by her doctor.
Case 10	Difficulty in managing conflict of opinion about correct treatment.
Case 12	Difficulty in managing conflict between opinions of staff about the capacity of patient to give consent.
Case 17	Dealing with the death of a patient who died because of a lack of equipment.
Case 18	Difficulty in dealing with own perceived value of a patient's right to treatment and a decision for passive euthanasia.
Case 19	Difficulty in managing a situation of Management's way of dealing with a drunken anaesthetist.
Case 21	Having to deal with managing pressure of work and handling habit-forming medicines wrongly.
Case 24	Dealing with a conflict of interest between the narrator and other staff's right to safety, and the decision to report an incident that could lead to dismissal of that staff member.

4.5.4 Narratives about conflict of interest between the rights of patients and the rights of the family

CASE NUMBER	DESCRIPTIVE NAME OF INCIDENT
Case 1	Difficulty in managing conflict of interest between the mother's right to non-disclosure of her HIV status and the right of her baby to treatment.
Case 4	Difficulty in managing conflict of interest of a patient's right to informed consent for HIV testing and confidentiality, and the right of the family to be informed of his health status.
Case 14	Difficulty in convincing the father of a baby of the child's right to treatment and his right to take the baby for alternative treatment.
Case 29	Difficulty in dealing with the right to confidentiality about HIV status of a woman and the baby's right to treatment as well as the husband's right to be informed about his child's health.

4.6 UNDERSTANDING FROM STRUCTURAL ANALYSIS

A further reading of each incident, line by line, allowed three themes to emerge from the data, namely the presence of conflicting values, the impact that the making of these decisions had on the narrators, and the nature of ethical reasoning in solving the problem. During this phase of analysis, a deeper understanding of the meaning of ethical decision-making in difficult care situations as described by the narrators was sought. The narratives were read again in order to understand the context in which the incident had taken place and that had given meaning to the experience. As the researcher is part of the same background from which the narrators came, it helped her to gain an understanding of what happened as the themes emerged.

4.6.1 Conflicting values

The one thing that stood out was that the narrators strove to adhere to different norms and values, often against the odds of their own personal values. Dealing with conflicting values becomes part of ethical decision-making in difficult care situations.

4.6.1.1 Professional values

Nurses believe that their role is to care for and protect the patient at all times, as well as advocate for them, but it seemed not to have been possible in these cases. One narrator resolved the issue by seeking non-professional help. This was a case of a father who had taken the baby out of hospital. The narrator called in the help of her father to convince the father of the baby to bring the baby back (case 1). The narrator shared confidential information with an outsider because she believed that this could save the baby's life, although it was against her professional norms.

"I decided to tell my father, for the sake of the baby. My father confronted him and he listened to him. He brought the baby back to hospital but he was worse. My father told him that he was going to report him to the police, if the baby died. He said he believed in prophecy, and it would heal the baby, he was not prepared to listen to a young woman, I was happy that the baby was now in safe hands" (Case 1).

In further analysis of the incidents, it was apparent how one of the narrators experienced conflict although she had taken the right action. The narrator in this case, because of her personal belief system, could not help a young girl to terminate her pregnancy and rather referred the girl to a colleague to get appropriate care (case 8).

“15yrs old came for termination of pregnancy, I was in the middle of conflict with my personal belief and the system. After deep reflection, I referred the client to a colleague” (case 8).

The next narrator told a story about administering medication that had not been prescribed and was therefore not within her scope of practice.

“Felt the doctor should have prescribed Decadron. I gave the patient decadron 8mg twice daily, as I felt desperate, I did not inform anybody. I knew I was not killing her, but I was torn in between, as what I was doing was unethical and illegal” (case 7).

4.6.1.2 Personal values

The narrators wanted to protect their patients by all means, even if it meant behaving wrongfully, in this case lying.

In this case the narrator so desperately wanted to protect her patient, that she was willing to tell a lie.

“The following day the patient was wheeled to theatre for sterilization without the husband’s knowledge, he came to visit his wife, and was told that she had gone for operation. An argument ensued, I was called to intervene, as I was briefed about his attitude of not wanting her to sterilize, I took it upon myself to protect the woman, I told him that his wife was bleeding, and doctor was going to remove retained products that caused the bleed” (case 3).

In the next case the narrator did not know what to do, because the woman did not want her baby to be tested for HIV as she feared her husband might think she herself was HIV positive, and that might threaten their relationship. The narrator expressed confusion because she wanted to help, and at the same time protect the woman's vulnerability and the baby's health. This might have been a case of conflict of interest: on the one hand the mother's right to confidentiality and on the other the baby's right to be tested and treated if HIV positive.

"The other twin got very ill, the doctor suggested that the baby be tested for HIV, but the mother of the baby refused altogether. She said nothing should be said to the husband about HIV. It was difficult since I wanted to save the baby, who was vulnerable, but the mother was also vulnerable, she said I am going to disrupt her marriage. I was lost, in a difficult situation, left with no direction, (case 29).

In the next case the narrator did what was professionally correct, namely to refer the patient for appropriate care in spite of contradicting personal values.

"A teenager aged 17yrs came for termination of pregnancy for the third time. I was not going to terminate her pregnancy again, I referred her to other clinics as she was abusing the service (case 11).

4.6.1.3 *Cultural values*

In case 16 the cultural values of the family were in conflict with the hospital policy, resulting in a difficult care situation.

The father of a stillborn baby wanted the baby to be buried, but it had already been incinerated according to hospital policy.

"The baby was send for incineration after the mother saw it, not knowing that the husband will want it. He was very angry. I was puzzled, failed to understand, but I knew that he was right if that was what he wanted. He wanted to bury the baby irrespective of how small it was" (case 16).

In this case the family demanded to take an unconscious patient home, in order to be present at the funeral of a family member. They insisted on taking her home with them.

“All my arguments did not help as, the family said they had the right. I eventually had to release the patient” (case 2).

4.6.1.4 Organizational values

It was either that the narrators had to “act” or not. The participants reported that they had been held back by rules and had failed to “act” as they wished. They knew the rules, but in some instances they broke the rules deliberately for the sake of their patients.

In case 19 the registered nurse did not know what to do, as a doctor was involved. She had to call upon a senior physician to resolve the issue and to take over the patient.

“He was staggering, smelling liquor, and holding on to machines, this was difficult to understand, it was confusing, I was disappointed, but could do nothing” (case 19).

In the next case a heavy case load ended in a difficult care situation.

“I had completely forgotten about the drug, I was in big trouble, I blamed my mistake on staff shortage, I felt unfairly blamed, as I was busy and alone on duty” (case 21).

A poor referral system could have caused a desperate patient in case 22 to end up seeking termination of a pregnancy at a time that midwives are legally not allowed to perform the procedure and caused the narrator to be in a very difficult care situation.

“It was a risk I was prepared to take, I was angry with her, felt pity for her, angry with the doctors who send her around, my profession was on the line, I prayed that there be no complications”(case 22).

In one of the cases it was clear that the narrator’s decision was guided by her perceived organizational values, namely those of order in the unit and not having visitors outside visiting hours.

“A Zimbabwean father came to visit his child in the morning at 07.00. I explained that it was not visiting time, the following day I confronted him, he started being rude, saying in Zim they visit any time, I called the security to take him out as we were still busy with the morning routine. I felt insulted, and especially that he does not belong to this country (case 5).

It is clear from the above cases that the narrators often took the responsibility to resolve the difficult care situation in spite of contradicting values, whether professional, personal, cultural or organizational.

4.6.2 Impact of the incidents on narrators

The nurse as a holistic person is affected by the decision she makes in a difficult care situation. This was evident in various ways, such as the pain of their conscience, taking the blame, feelings of guilt, etc. The following conclusions from the stories may be interpreted as having had an effect on the narrators’ conscience:

FEELINGS	EXAMPLE
Loneliness	“I felt lonely, had a dilemma, I decided to tell my father, for the sake of the baby” (case 1)
Disappointment	“I was very touched, disappointed, felt how patients right were violated, that indicated how poorly nurses and doctors communicate” (case 25).

<p>Relief of conscience</p>	<ul style="list-style-type: none"> • “I reassured the patient that she will be helped, one of my conscience was relieved, but the other was haunted by guilt for not helping the client” (case 4) • “I achieved to assist the patient to have control of her body, and empower her right as a woman” (case 3). • “I Felt insulted and suddenly he does not belong to this country” (case 5) • One side of my conscience was relieved, but the other side was haunted, as I did not help to take part in the procedure” (case8). • “I was not going to terminate her pregnancy for the third time, she was abusing the service, though the act says a woman can be treated as often as she wishes” (case 11). • “He was with his parents, who said no blood must be given to him, even after a lot of explaining was done, they insisted. Their belief interfered with treatment, but they were happy when he came back from theatre, and looked much better, the blood was transfused without their knowledge. I was unsure of what to say, guilty that I was not truthful” (case 13).
-----------------------------	--



Taking the blame

- “I felt incompetent, when the client cried, it was like the whole counselling was a disaster” (case 14)
- “I felt ashamed, for lack of trustworthiness, was disappointed, I reassured him that it was an isolated occurrence” (case 23).
- “The nurse on duty did not assess the blood pressure before administering the drug, she was new, not an excuse for lack of knowledge, the patient never woke up again after the injection, I felt guilty, inefficient, felt that I did not teach her, angry with her” (case 26).
- “I felt guilty and incompetent, as well as out of control, giving the patient to incompetent hands. The family members were told to bring her back after the funeral or if they experience problems” (case 2).
- “I rushed to the scene, but it was late, the patient was dead. The matter was never pursued, as the family did not know what had happened, I felt guilty, to blame for his death, also haunted by the incident” (case 17).
- She was pregnant and apparently miscarrying, I was organizing a replacement, I was told she had left, I got worried, anxious, and confused, it was late at night, I questioned my empathy” (case 15).
- “It was not long that the baby was given antipyretic, the nurse checked the baby before allowing the mother in, only to find

the child was dead, it was a predicament, a difficult situation, I felt guilty that the child died without being observed" (case 20).

<p>Feelings of anger, fear, and frustration were evident in a number of cases.</p>	<p>“Allocating her to the unit is danger to patients, this is not fair to other staff members, and is also an ethical risk, when she is duty, you are always on edge, anxious and worried” (case 9).</p>
<p>The narratives showed instances of frustration, not being allowed to participate in resolutions or ever knowing if the problem was ultimately resolved.</p>	<p>“The patient was lying under the bed, semiconscious. The doctor had prescribed Tegretol and Epanutin to be given simultaneously. I was disappointed, in disbelieve, as well as angry, that the prescription was wrong, but the nurses never draw the doctor’s attention and actually gave the drug” (case 27).</p>
<p>The narratives displayed feelings that could indicate that the narrators at times felt overwhelmed by the uncertainty of what the consequences of the actions would have been. Furthermore, ethically difficult care situations often need to be urgently attended to. The narratives indicated that, in some cases, the narrators strove to protect themselves, whereas at the same time they had to protect the patient, the institution, as well as the image of the profession.</p>	<p>“The doctor spoke about removing the uterus; the patient was shocked as that was not what she came for. I explained to the patient that the doctor was given wrong information about her, I was touched, disappointed, felt how poorly nurses and doctors communicate, and patients made to give uninformed consent” (case25).</p>
<p>Pain of conscience was displayed as the narrators expressed sadness about what happened in the narratives.</p>	<p>The reasons for termination of pregnancy were authentic; though not reason enough, as to outweigh the possibility of complications. Sonar revealed 20 weeks. It was a risk I was prepared to take, I was angry with her, felt pity for her, angry with doctors who send her around, I was uncomfortable with my “actions”, torn in between helping her, and breaking the</p>

<i>law" (case 22).</i>

4.6.3 Summary of structural analysis

"How does ethical decision-making realise in difficult care situations"?

From reading the narratives three main themes became apparent:

The context in which the decisions were made.

The impact the decision had on the respondents e.g. the effects on the conscience of the narrators

4.7 ETHICAL REASONING USED BY THE RESPONDENTS

The context was that the respondents adhered to the morals and values of the profession, their belief system and cultural issues that were according to patient and nurses values. Patients' rights, ethical principles and caring values were incorporated. The impact on respondents varied. Sub-themes emerged, such as silencing the conscience, taking the blame, feeling guilty, having to deal with authority, adhering to rules, feeling angry, being fearful or compassionate, sometimes experiencing relief and using ethical reasoning. The respondents had to reflect on how to meet challenges and obligations inherent in the relations they entered into, and then act.

The respondents were faced with choices of actions.

4.7.1 Effects on the conscience of the narrator

Case 1	I felt alone
Case 4	One part of my conscience was relieved
Case 25	I was touched, disappointed

4.7.2 Taking the blame

Case 14	I felt incompetent when the client cried
Case 23	I felt ashamed of the lack of trustworthiness
Case 26	I felt that I did not teach her correctly

4.7.3 Silencing the conscience

Case 5	I felt insulted and because he does not belong to this country
Case 3	I achieved to assist the patient to take control of her body
Case 11	I was not going to terminate her pregnancy for the third time

4.7.4 Feeling of guilt

Case 2	I felt guilty, incompetent, as well as out of control
Case 17	I felt guilty, to blame for his death, also haunted by the incident
Case 15	I got worried, anxious and confused. I questioned my empathy

4.7.5 Authority, power, powerlessness and rules

Case 19	He was staggering, smelling liquor, I was disappointed but could not do anything
Case 13	I felt unfairly blamed, I was busy and alone on duty
Case 20	My profession was on the line and I prayed that there be no complications

4.7.6 Feelings of anger, fear, compassion and relief

Case 9	When she is on duty you are always on edge, anxious and worried
Case 13	Their belief interfered with treatment, the blood was transfused without their knowledge
Case 22	It was a predicament, a difficult situation, the child died without being observed.

4.7.7 Taking responsibility of the situation

Case 10	I Felt the blood pressure needed to be raised as it was very low, the patient was sent to theatre as he insisted, and the patient on the table
Case 12	The most disturbing was that he was also confused, nothing was done to obtain the consent correctly
Case 27	The doctor had prescribed Tegretol and Epanutin to be given simultaneously, I was disappointed

Case 30	I decided to do pregnancy test which was positive, it was an ectopic pregnancy, which the doctor missed, I saved a life
---------	---

4.7.8 Taking responsibility of the situation decision-making as actional and relational

<ul style="list-style-type: none"> ○ Naive reading ○ What were the stories al about ○ Wrong decisions taken by narrators and other staff members ○ Conflict between the narrators; own values and those of others ○ Personal and professional value conflict ○ Conflict between narrators, staff and management 	<div style="text-align: center; border: 1px solid black; padding: 10px; margin-bottom: 10px;"> <p>ETHICAL DECISION- MAKING IN DIFFICULT CARE SITUATIONS</p> </div> <div style="border: 1px solid black; padding: 10px;"> <div style="text-align: center; background-color: #cccccc; padding: 5px; border: 1px solid black; margin-bottom: 5px;"> <p>RELATIONAL</p> </div> <ul style="list-style-type: none"> ○ Structural analysis ○ Context ○ Personal values ○ Professional values ○ Cultural values ○ Organizational ○ Impact <ul style="list-style-type: none"> a. Feelings b. Taking the blame c. Pain of conscience </div>
<p>ACTION</p>	

The ethical decision is a function of a specific situation that required action and relationship in situations. This is in line with the concept of action ethics and relational ethics described by Sorlie (2000:16), that in ethical decision-making there is no way that we are free from

making a decision, of what to do, “act”. The nurse cannot detach the self from the patient as his/her existence depends on the relationship he/she has with others.

In caring nurses are confronted with the demand to maintain a relationship, as they make a decision to “act”. Sometimes they cannot avoid damaging the relationship, though sometimes a decision is forced upon them. The relationship must always be maintained. It is ethical to be open and honest, and that builds the relationship in caring situations (Sorlie, 2001:54).

The study showed that on the basis of the narratives, the way ethical decision-making realised in clinical practice focused primarily on ethical reasoning, and the impact that it had on the narrators’ conscience.

Narrators used both action ethics and relational ethics in ethically difficult care situations in the way they narrated, according to their reasoning.

Since the given narratives could be interpreted and understood in different ways, the interpretation in the comprehensive understanding can best produce recognition, or a deeper and different understanding of realisation of ethical decision-making in clinical practice (Sorlie, 2001:54).

It was clear from the narratives that the participants were in a situation of responsibility in ethically difficult care situations. The narrators were constantly faced with having to make choices of action and in most cases they were not sure what to do.

Botes (2000:1072) indicates that to address the complex ethical issues characterising the healthcare environment, the various members of the health team must learn to work together, with the nurse striving for ethics of care and justice. The narrators believed in some cases that their ethical responsibility ended when they had reported their concerns to higher authority, or confronted the actions or suggestions. They sometimes believed that the incidents had not been resolved to their satisfaction (Schroeter, 1999:293).

There is a dialogue at the heart of nursing that brings care givers into the uncertain world of caring. However, according to Searle and Pera (1998:178), the scope of the practice of nursing leaves the door open for an ongoing developmental situation that does not restrict,

but expands the manner in which the nurse adapts to new methods to keep pace with advances in respect of patient care.

It can be understood that the narrators had to choose between courses of “action” of nearly equal ethical and moral merit. This was very frustrating, as absolute certainty was not available because others may differ in their resolution of some issues, but that is a fact of life! Ethical decision-making requires the application of a number of principles, a deontological perspective, consequential casuistry, beneficence, autonomy and justice.

The participants realised that to do good, they had to have a reliable understanding of what was best in the moment of choice, which Botes calls a contextual nature of ethical dilemmas where ethical decisions should be made, and which is based on reasoning, facilitated by virtues.

Participants’ valuing of patients’ individual self, and knowing when to take over part of the responsibility for care, was shown to be a complex matter, according to the narratives, as there is no vantage point, no privileged position from which to collect the answers (Scott, 1995:290).

4.8 THEMES

The analysis offers an understanding of two themes that emerged from the hermeneutic phenomenological process. These themes also relate to the ontology of being human, as described by Taylor (1992:1042). The two themes are illustrative of all categories. No rules exist for deciding which form the presentation of findings should take. The hermeneutic phenomenological method is so closely tied up with the idea of narratives, the analysis of narrative narratives, however, is different from the narratives itself. The findings should be presented in a way that makes them maximally understandable (Cohen, *et al*, 2000:96).

4.8.1 Relational ethics

“Relational ethics” refers to the physical and emotional presence of the nurse, physician, patient and family. In particular it involves a special connectedness between

patient/nurse/family, who wishes to keep the “relation” with the concern for the wellbeing of the patient.

Armgaard (1993:54) states that interdependence and subjectivity are characteristics of our situation in life. As individuals we are responsible for the life which we hold in our hands to protect and develop. The professional nurse/midwife mostly narrates from a relational ethics perspective about what was missing in his/her relations with patients, family and colleagues (Logstrup, 1983:119).

The lack of dialogue between colleagues was narrated as one of the problems in the team. When we speak, we do not consider that it is to be open and honest. In clinical practice, the patient who is sick speaks to us. When we respond to the demand, we must look back from our relations to reply to the message of this impression. The demand lies in the expression, not in the need or condition, or something that becomes object of knowledge (Logstrup, 1993:97).

Botes (2000:1078) confirms the “relation” and says that healthcare constitutes a “team” effort at a joint “action” in rendering a service. The issue is health ethics, not any particular discipline. Humankind values life, as well as meaning, as an objective in its own right, for the very reason that it is each human being’s constant endeavour to establish and maintain harmonious “relations” with others (Botes, 2000:212).

It has been clearly shown in the narratives that aesthetically, phenomenological knowledge, as understanding, is intricately connected with the creative, expressive and perspective facets of a person, and the manner in which the person creates, discovers and perceives meaning in the “actions” and worlds of a shared “relation” with others (Van der Zalm & Bergum, 2000:212).

4.8.2 Action ethics

According to “action” ethics it is clear that the professional nurse/midwife has to decide and “act” in spite of uncertainty. The emotional closeness of the respondents to their patients was clear from the narratives. They “acted” according to the patients’ wishes and were their

advocates. They wanted to see their “activities” as part of a satisfactory whole (Uden, Norberg, Lindseth & Marhoug, 1992:1028).

The narrators displayed a wish to do good. “Action” ethics asks the basic question of “what should be done” and the nurse has to make a decision to “act” and “act” appropriately, as well as give reasons for this “action” taken.

Action as displayed in the narratives was deontological and teleological, i.e. duty and goal orientated. Action is based on meaning, common meaning between, nurse and patient, which provides the most effective base for a helpful nurse/patient relationship (Cohen, *et al*, 2000:4; Sorlie, 2001:48).

Bergum (1994:71) goes on to say that discovering the good is found in the relationship. Of course, there are underlying principles, such as truth telling, or respect for the rights of people, in deciding which action to take in ethically difficult care situations. Yet the appropriate acting in a moral sense is relational. It is based on sensitivity to timing, listening and attending to the parameters of the situation.

Ethical knowledge is “action” knowledge, and is discovered in the relationship between nurse/patient/family and staff. Bergum (1994:74) substantiates this statement that the two themes, “relation and action”, are intertwined: one cannot exist without the other.

The knowledge needed to answer the question of “what is the right thing to do” cannot be acquired only by understanding the different philosophical positions or different principles, but is discovered in understanding the persons, both self and others. Ethical knowledge of “what to do” cannot be known ahead of time (Van der Zalm & Bergum, 2000:214).

The strength of ethical decision-making is found in the ethical knowledge question of “are you sure” of “what action” to take? As such, it differs from the prescriptive or descriptive theory. What is the right “action” to take in a particular situation is not found in certainty of theory, principles or rules, but is found in listening by the nurse, and attention to the needs of the situation, for both nurse and patient.

The attitude of the question, “are you sure” is not one of confusion, but of attentiveness to what is needed for ethical “action”, to what should be done in a particular situation. This was displayed in the narratives. Knowledge for ethical action is founded in the relationship, and has to do with mutual respect, engagement, mutual thinking, embodiment, uncertainty, vulnerability and freedom. It is appropriate to think of ethical “action” as a responsibility rather than an obligation (Van der Zalm & Bergum, 2000:215).

Hermeneutic phenomenological knowledge as understanding is intricately connected with the creative, expressive and perspective facets of a person, the manner in which the person creates, discovers and perceives meaning in the “actions” and words of a shared “relation”. Nurses cannot respond to the needs of patients without “action”. Responsibility is responsiveness (Caper, 1992:71).

The narratives displayed relevant knowledge in “action” in a hermeneutic phenomenological sense. Understanding enlightens practice. Nurses have to understand their everyday situations with patients and communicate such understanding as they build relations and act (Caper, 1992:78).

4.9 COMPREHENSIVE UNDERSTANDING

To get a deeper level of understanding in order to explain how ethical decision-making realises in difficult care situations, the whole process of analysis was reflected on critically. In this study, comprehensive understanding forms the concluding leg of the hermeneutic circle, where the narrator’s pre-understanding, the naive reading and structural analysis, had to be compared to previous work in this field. A dialogue with the stories as narrated brought back to memory experiences from the researcher’s past. In the same way the reality of the narratives may become part of the memories of the reader.

My comprehensive understanding became necessary at this level of analysis in order to clarify and get a better understanding of how ethical decision-making realises in difficult care situations.

It is understandable that ethical decision-making does not arise or take place in a vacuum. Mattison (2000:201) states that ethical decision-making in difficult care situations is grounded in the condition and factors related to the decision-maker's situation and circumstances.

According to Sorlie (2001:12), ethical decision-making in difficult care situations arises from within the context of a particular relationship - the relationship that is closely bound, for example that of a parent/child or citizenship in a society. The relationship is the source from which the respective duties of the parties have to flow. It follows that the ethical responsibility of the narrators derived from this particular nature of nursing. The narrators strove for a therapeutic relationship that is based on respect and trust.

The nurse enhances the relationship in order to deal with the situation the patient presents in order to realise ethical decision-making in difficult care situations.

According to Botes (2000:1072), ethical problems may arise due to lack of justice and care, so in complex ethical issues that characterise the healthcare environment, the health team must strive for care and justice in ethical decision-making in difficult care situations so as to deliver appropriate care. Against the above background, ethical decision-making in difficult care situations realises through healthcare and justice, which is an active process.

From the narratives it was clear that the justice perspective as reiterated by Botes (2000:1072) was based on ensuring fair and equal treatment of their patients. The care perspective was to meet the needs of their patients harmoniously and to ensure ethical decisions in difficult care situations.

Fry and Johnston (2002:44) support Botes's caring perspective that caring is a moral foundation for nursing, as it enhances human dignity. According to the narratives, the narrators strove to maintain and enhance that dignity in their caring, however, such an objective is hampered by a lack of administrative support and nursing's authoritative designs of patient care systems, as was indicated in the narratives.

To gain a better understanding, it became necessary to fuse horizons of pre-understanding, naive reading and structural analysis. In doing that, the horizons of the interpreter and the interpreted were fused, and a new understanding developed. The new horizon develops through pre-understanding, co-constitution, confrontation of other levels of analysis and interpretation. Then such understanding deepens the horizon to facilitate insight into the experience of ethical decision-making in difficult care situations.

The understanding gave further insight into what healthcare practitioners are faced with in practice, giving insight into thoughts and values of the narrators in healthcare (Milligan, 2001:7).

Pre-understanding of ethical decision-making in difficult care situations led to a dialogue with the text. All people have a pre-understanding of something in life. However, professional pre-understanding in this study is pre-understanding arising from the profession one practises. Professional pre-understanding prepares the reader for receiving the narratives and interpreting them. The narratives became comprehensible as they became part of the researcher. The authors and the researcher moved into the same world of ideas.

A dialogue with text as narrated brought back to memory experiences of the past. The reality of the narratives became the same as that of the reader. The researcher did not move, but rather the reader within her pre-understanding broadened her mind, the reader grasped the problems and joys of the narrators in their realisation of ethical decision-making in difficult care situations, and the narratives were brought to life by being placed within a horizon of pre-understanding.

The next level of naive reading took the analysis further. The narratives were read and re-read open-mindedly over and over again in order to establish what the stories were all about:

- Narratives about wrong decisions made by informants and other staff members
- Narratives about value conflicts between care givers, patient, family, between narrators' colleagues and/or management

- Narratives about conflict of interest in the patients' rights and those of their families

The naive reading helped to get a sense of the whole, which also made pre-understanding more visible.

After the naive reading, a validation was necessary, which comprised the explanation of the text by means of structural analysis. In this case the parts and the whole were explained. A deep interpretation and understanding was confronted. A structural analysis yielded values, norms and beliefs which were:

- Professional values
- Personal values
- Cultural values
- Organisational values

The impact of ethical decision-making on the narrators in difficult care situations was evident. In this study it was evident that the various forms were:

- Pain of conscience
- Taking the blame
- Feelings of guilt
- Anger
- Fear
- Frustration

This impact is also mentioned by Peer and Rakich (1999:7), who indicate that ethical decision-making in difficult care situations can be very overwhelming, due to constraints that dominate the healthcare arena, and thus complicate the decision-making process.

The narrators' ethical reasoning within the context in which it was made defied the belief that Utilitarianism and Deontology as theories of moral reasoning are rivals. The narrators had the common aim of pursuing activities that could relieve patients' pain as well as of avoiding their own pain of conscience and maximising painlessness. Deontologically the narrators felt it to be their duty to act, regardless of the consequences. They had a duty to care and wanted to fulfil that duty. The above information is in conflict with what Jones

(1994:23) said about the rivalry of the two theories. Understandably the narrators reasoned within the context of their responsibility for the lives for which they were responsible so as to protect and develop. In that context, it was a practical necessity to realise ethical decision-making (Sorlie, 2001:16).

The researcher comprehensibly understood that time was also of importance in ethical decision-making in difficult care situations. This was different from what Van der Wal (2002:14) states, saying that the problem must be identified clearly in order to identify the decision more accurately, as this needed enough time to accomplish. The narratives indicated that in practice actions have to be very swift. That is, they had to think on their feet.

Yung (1997:128) is also of the opinion that in ethical decision-making in difficult care situations, nurses experience frustrations relating to the time required to make a decision. That resulted in decentralisation of the most pressing aspects of the dilemma.

People approach ethical decision-making in difficult care situations differently. The pre-understanding is that in the relationship of care between the nurse, organisation and patient/family, all bring in their own values and norms, which sometimes conflict with one another. Van der Wal (2002:15) reiterates this by saying that it is essential to understand the moral position of all the people involved, as it helps to clarify issues and can assist in the identification of alternatives as well as prediction of consequences. The caregiver must deliberate on what the individual affected believes in and what the moral conflicts may be.

4.10 CONCLUSION

This study reached a deeper level of understanding using a hermeneutic phenomenological approach to analyse how ethical decision-making realises in difficult care situations. Ethics as the science of morality was found to be central to decision-making in difficult care situations. Ethical decision-making was seen to be greatly influenced by resources available or unavailable, beginning and end-of-life decisions, palliative care as well as genetic advancement. Because such influences are escalating, the need for all types of knowing has become of the utmost concern. A sound educational basis in ethics was seen as necessary in the literature. Ethical decision-making in difficult care situations was seen

as a cognitive process, the knowledge of which was based on the knowledge of the decision-maker.

Ethical decision-making in difficult care situations led to different feelings and difficulties in action-taking, due to the fact that, there are no methodological guidelines. Narrators said nothing told them exactly what to do when making decisions of such a nature. So they all had to find a solution in spite of their uncertainty. There was a complex interplay between thoughts and actions, as was seen in the narratives. The narratives indicated situations in which they felt it was difficult to decide what the right thing was. Caring involves the impenetrable, mutual dependence on one another, nobody is anything by him/herself - it is action from the carer and the response from the cared in ethical decision-making in difficult care situations. The narrators indicated that it was no longer a question of whether to make a decision, but rather a decision that was forced upon the narrators. Narrators lost their freedom of action, which became a personal responsibility.

As a nurse researcher and nurse educator, it became necessary to share existence with the nurse in clinical practice. This can also be called "being" there along with them". The commonality of everyday existence allowed the researcher to experience the fears, risks, worries, frustrations and loneliness of dealing with ethically difficult care situations like those reflected in the narratives.

CHAPTER 5

FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The research problem was identified on the basis that, although principles of ethics form part of all nursing science curricula, experience and the large number of disciplinary cases handled every year by the South African Nursing Council (SANC stats, 1998, 1999, 2000, 2001, 2002), indicate that very often professional nurses/midwives experience difficulties in making ethical decisions in clinical practice. Rules/expectations devised by the registering body for nursing professionals are aimed at maintaining ethical standards and setting parameters for acceptable ethical practice.

The disciplinary hearings raised questions of why unethical acts by nurses continue, regardless of the fact that ethics and ethical codes of conduct, principles and caring values are taught to nursing students. The reasons for such occurrences could be that there is a gap in the knowledge of how ethical decision-making takes place in difficult care situations in clinical practice. There is a need for improved knowledge and understanding, which will emanate from studies such as "How ethical decision-making realises in difficult care situations".

The background of how the researcher got to understand what nurses go through in dealing with ethically difficult care situations is given in this study. It became clear that the educational goal of preparing nursing professionals should emphasise the ability to examine personal commitment and values in relation to the care of patients, engage in ethical reflection and develop the skill of moral reasoning and moral judgement.

It became clear that the need for an educational strategy that simultaneously develops problem solving and knowledge bases and skills is necessary.

5.2 SUMMARY OF FINDINGS

In this study the interpretation of the narratives meant seeing something in what was given as critical incidents, and which were the experiences of narrators in their tasks of care giving. This was a disclosure of aspects of decision-making in ethically difficult care situations in clinical practice.

The analysis focused on the meaning of being in ethically difficult care situations. Analysis began, as parts of the text were understood in relation to the whole and vice versa.

The researcher started the analysis process by reading and re-reading the narratives to obtain a tentative notion of the meaning of all the data with the reflexive awareness that this notion is an anticipation of meaning. This awareness helped the researcher to understand the whole better.

5.2.1 Implications of findings

5.2.1.1 Practice

The study showed that ethical decision-making in difficult care situations is a complex undertaking, as it has to be done in the “nick of time”, and often in very complex situations. Ethically difficult care situations needed urgent responses, as was indicated in the narratives.

The respondents considered possible options, took into account conflicting values, beliefs, norms of the client, family, institution and themselves. Options were considered even if there was conflict of interest, or the patient sounded unrealistic.

The ethically difficult care situations described differ entirely from those described by Fry and Johnstone (2002:29), namely that the majority of ethically difficult care situations faced by nurses are important but not necessarily complex, as they involve conflict of values in routine care only. Fry and Johnstone (2002:58) say that the complexity comes only when there are strong values, cultural, religious and moral beliefs.

It was realised in this study that the respondents took the blame as people who are at the helm of care. The difficult care situations left them “lonesome”. The emotional impact was huge when the respondents took the blame for what had happened.

There were clear indications of anger, fear, relief, even compassion, as well as frustration. Nursing rules, regulations and Acts were taken into account by respondents, but they ended up with conflict with self when taking into account ethics of justice and ethics of care, as reiterated by Botes (2000:1076).

The study indicated the respondents being blunt in order to bring issues into perspective, and minimal interpersonal skills were displayed in other cases. The situations were stressful for clinical practitioners.

The respondents took responsibility and accepted the consequences of their decisions. It came up that they were prepared to shoulder the burdens of their decision-making.

The respondents stood up for their choices of action, even when there had been uncertainty in their “actions” to resolve an ethical problem.

The respondents had to support clients’ preferences, and all they could do was to give alternatives as a basic contribution to the clients well being.

The narratives indicated that the respondents strove to understand attitudes, values and the beliefs of clients, as a lack thereof could produce a breakdown in activities of care as well as of trustworthiness.

The respondents had to have self-awareness, which instilled in them tolerance of differences in others as well as cultural sensitivity.

The narratives indicated that the respondents ended up resorting to “I did what I could”, which turned nurses into ethics technicians. Nurses ended up neglecting the fundamental commitment to forgo self-interest.

5.2.1.2 Management

The narratives indicated that honesty was compromised. The more complex the situation, the more lack of openness was displayed by management, to whom the ethically difficult care situation was reported.

Individuals were trying to protect their interpersonal association, because openness leads to interpersonal risks and exposure of self.

The findings indicated that the respondents got little if no support at all from management, which eventually would involve them in disciplinary hearings.

Management ignored time constraints and heavy workloads when a nurse was found to have failed in realising ethical decision-making.

It was clear that management dealt with some issues without involving the person who reported the unethical act, and narrators felt that the person was being protected from professional governing bodies by management.

5.2.1.3 Education

The study revealed that there is a need in nursing education to develop both problem solving and knowledge. An appeal to the “ethical rule book” could not provide answers in ethically difficult care situations.

When choices had to be made, knowledge of ethical codes could not provide answers about moral issues they were involved in. The knowledge could not even eliminate the necessity to make moral choices.

Knowledge of ethics and ethical codes of conduct could not make difficult care situations easier to deal with.

The narrators constantly indicated that their knowledge had failed them in other cases while they were in charge and yet they had to lead the group.

The respondents indicated that some practitioners lacked ethical sensitivity and actions had not been morally justifiable, and yet that is an acknowledged goal in nursing education.

It was clear that ethically difficult care situations were not discussed openly, as ethical committees were not viable in some areas of clinical practice.

Narrators indicated that their knowledge and clinical experience were not utilised in some situations, but they went on to make decisions to care for their patients.

Nurses indicated that they had felt powerless because, regardless of the fact that they knew what to do, the status quo of the bureaucratic policies were more important than patients' needs.

5.2.1.4 Further research

Further research studies are necessary to equip nursing lecturers to help learners to deal with ethical issues in order to improve patient care, despite the complexities of ethical problems in clinical practice.

5.3 RECOMMENDATIONS

It is recommended that in clinical practice the recognition of values or questions of right or wrong be taken as a basis in ethical care situations. In clinical practice, ethical decisions should be made by identification and effective response.

The nurses need to be able to integrate personal values and beliefs with their knowledge of ethical concepts, approaches and standards of ethical behaviour. Such integration will then become the framework for ethical decision-making.

It may not be enough to possess theoretical knowledge and practical skills, but perhaps the commitment to use them is the key. The recommendation is to appreciate the importance of moral issues and be committed to respond, even if such moral issues may be inconvenient or burdensome.

The recommendation is also that there is a need to discuss ethical issues rather than ignoring them or keeping them secret. If they are kept secret, the person involved is left with a bad conscience and feeling of guilt.

The following guidelines may help in teaching nursing students:

Nursing lecturers should teach students to critically assess ethical issues in clinical practice that pose difficulties for caring. Lack of resources was mentioned repeatedly in narratives, being material and human, as making practice and difficult care situations even more complicated (Chapter 4).

Lecturers should help learners to identify and diagnose moral problems as experienced in clinical practice. It is acceptable that learners have developed morally, but ethos and professional code of conduct in nursing cannot be left unattended.

Records of ethical problems encountered must be made available in strict confidence to help enlighten students about what can possibly happen in practice.

The conclusion of an ethically difficult care encounter must be revealed to the person involved so that it can be used as a teaching/learning opportunity. Narrators indicated that they never knew the conclusion after reporting to management, as managers dealt with some of the ethical issues without involving them.

Students should be informed that ethically difficult care situations can be very overwhelming, and that support structures must be utilised fully in clinical practice.

Students must have self-awareness training programmes to clarify values and accept the cultural diversity of the country.

Educators must use case studying in teaching ethics and use stories of ethically difficult care situations very early on in the students' entry to the profession. The students should be given problems of an ethical nature to solve as practice exposure.

The clinical practice area management should give learners the opportunity to take part in ethical committees so that they can get exposure before practising as professionals.

In clinical practice, learners should be given an opportunity to hold responsible positions with support by professional mentors so that they can identify and consult should they be confronted with ethically difficult care situations, and come up with a plan of action.

Students should use open debates as a learning strategy so that the individual student can examine his/her own moral commitment and clarify values in relation to patient care.

Educators should instil in students knowledge of the community, its culture, values, beliefs and norms as well as virtues, and a sense of deep moral and personal commitment to doing "what is right" at all times in clinical practice. Narrators indicated that they had been faced with situations in which they had to comply with the needs of families, even against their own or professional beliefs (Chapter 4).

5.4 LIMITATIONS OF THE STUDY

The study itself has its own limitations, as a hermeneutic phenomenological study is a description of the current life world of a person and will not reflect the continually changing social reality of other persons.

In this study, understanding and interpretation are bound together, and interpretation is always an evolving process. A definitive interpretation is therefore never possible. This means that the meaning documented in the text by the researcher is an interpretation and may be a distorted representation of the respondents' perception of reality, but the researcher worked closely with other researchers to analyse the narratives (Annels, 1996:705; Cushing, 1994:406).

Van Manen (1997b) on a contrary notion said that a text is always the result of an intersubjective, contextual situation, and therefore the reality represented will always be a function of both the subject and the researcher, rather than a representation of the reality of one or the other.

This study related to the interpretative understanding of the researcher. The researcher consulted with the supervisor and other researchers in the field of nursing in that respect. The limitations could also relate to the perceptive and descriptive ability of the respondents, as well as to the structure and tone of the narratives, and to the continuously changing social reality. As the experiences were perceived and described by the narrators in their own life world of ethically difficult care situations, the description may differ with the experience as perceived by others in their own life worlds.

5.5 CONCLUSION

The study concludes that there is another interpretation, another way of understanding our life world. The constant challenge to all who do research is to realise the ongoing nature of what it is to understand the world and be inspired by the inherent potential in this humility, to be willing and open, to know or understand in other ways.

As a nursing researcher and nursing educator it became necessary for the researcher to share existence with the nurses in clinical practice. This can also be referred to as “being there along with them”. The commonality of everyday existence allowed the researcher to experience the fears, risks, worries, frustrations and loneliness of dealing with ethically difficult care situations as was reflected in the narratives.

LIST OF SOURCES

ANNELS, M. 1996. Hermeneutic Phenomenology: philosophical perspective and current use in nursing research. *Journal of Advanced Nursing*, vol.23, no.4, p.705-713.

ARMGARD, L.O. 1993. *Authopology – Problems in K E Logstrup writings (Swe.)* 2nd ed. (original 1971). Mattizons forlag: Lund

ASTROM, G., FUKAR, C. & NORBERG, A. 1995. Nurses skills in managing ethically difficult care situations: Interpretation of narratives, vol.21, no.6, p.1073-1080.

BANDMAN, E.L. & BANDMAN, B. 1978. *Bioethics and Human rights*. Boston: Little Brown & Co.

BERGUM, V. 1994. Knowledge for ethical care. *Nursing Ethics*, p.17-79. Medlink.

BOTES, A. 1994. Model vir etiese besluiting in verpleegkunde. *Curationis*, vol.17, no.4, p.66-70.

BOTES, A. 2000. An integrated approach to ethical decision-making in the health team. *Journal of advanced nursing*, vol.32, no.5, p.1076-1082.

BRINCHMAN, B.S. 1999. Ethical decision about neonates in Norway, *Image: Journal of Nursing Scholarship*, Fall, vol.31, p.276.

BURNS, N. & GROVE, S.K. 2001. *The practice of nursing research: Conduct, Critique and Utilization*. Philadelphia: W.B. Saunders Company, 3rd ed.

CAPER, B.S. 1992. *Philosophical inquiry in nursing: An application in nursing* (Kikuchi, J.F. & Simmonds, H. Sage), Newbury Park, Carlifornia, p.71-80. (Context link)

CHEEK, J., O'BRAIN, B., BALLANTYNE, A. & PICOMB, J. 1997. Using critical incident technique to inform an extended care nursing. *Western Journal of Nursing*, vol.19, p.667-682.

CLAMP, C. 1980. Learning through incidents: *Nursing Times*, vol.76, no.40, p.1755-1758. (Medline Link) (Context Link).

COHEN, M., KAHN, D. & STEEVES, R. 2000. *Hermeneutic Phenomenological Research, a practical guide for Nurse Researchers*. Sage Publications, Inc. Thousand Oaks. London: New Delhi.

COVERSTON, C. & ROGER, S. 2000. Winding roads and faded signs. Ethical decision-making in a post modern world: *Journal of Peri-natal and neonatal nursing*, vol.14(i) 2, pL p.1-10.

COX, K., BERGEN, A. & NORMAN, I.J. 1993. Exploring consumer views of care provided by Macmillan nurses using the critical incident technique. *Journal of Advanced Nursing*, vol.18, p.408-415.

CROTTY, M. 1998. *The foundation of Social Science research*. St Leonards, New South Wales: Allen & Unwin.

CUSHING, A. 1994. Historical and epistemological perspective in research and nursing: *Journal of advanced nursing*, 20, p.406-411. (Medlink) (Cinahl Link) (Context Link).

DAVIS, A. & AROSKAR, J. 1987. *Ethical dilemmas and nurse practice*. 2nd ed. New York: CTT.

DE VOS, A.S. 1998. *Research at grassroots: A premier for the caring profession*: Pretoria: Van Schaik.

FLANAGAN, J.C. 1954. Critical incident techniques, *Psychological Bulletin*, vol.51, p.327-358.

FINNERTY, J., RINKERTON, J. & FERGUSON, J. 2000. Ethical theory and principle, do they have any relevance to problems arising in everyday practice, *Journal of Obstetrics and gynaecology*, vol.183, no.2, P.301-308.

FRY, S. & JOHNSTON, M. 2002. *Ethics in Nursing Practice, a guide to Ethical decision-making*. 2nd ed. Blackwell Science Ltd: USA.

GADAMAR, H.G. 1975. *Truth and Method*. London: Sheed & Ward

GAUL, A.L. 1987. The effects of a Course in nursing ethics on the relationship between ethical choice and ethical action in baccalaureate nursing students. *Journal of Nursing Education*, vol. 26, no.3, p.113-117.

GOVERSTON XX, & ROGERS, S. 2000. *Winding roads and faded signs. Ethical decision-making in a post modern World: Journal of Peri-natal and neonatal nursing*, vol.14 (1) 2: i

GRANECHEIM, U. & LINDMAN, B. 2003. Qualitative Content Analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness: *Nurse Education Today*, vol. 24, p.105-112.

GREENWOOD, J. 2000. Nursing scripts and organizational influences on critical thinking: *Journal of Advanced Nursing*, vol.31(5), p.1106-1114.

GRUNWALD. P. & BECKER, P. 2000. Contextual dynamics of ethical decision-making in The Neonatal Intensive Care Unit. *Journal of Peri-natal and Neonatal Nursing*, vol.14, no.2, p.58-59.

HETTEMA, T.L. 1996. Reading for good. Narrative theology and ethics in the Joseph story from the perspective of Ricoeur's hermeneutics. Kok Pharos: Kampen.

HOWARTH, G.R. 2001. Basic Bioethics, Medical Journal. Pretoria University.

HUMAN TISSUE ACT NO. 65 of 1983 as amended, Human tissue amendment Act No. 51 of 1989.

HUSSEY, T. 1996. Nursing ethics and Code of professional conduct, *Nursing ethics*, vol.3, no.3, p.251-257.

HUSTED, G.L. & HUSTED, J.H. 1998. Ethical decision-making and the role of the nurse in issues and trends in nursing. (Delougherty G.ed). Mosby, St Louis, p.216-242. (Context Link).

JOHNS, C. 1994. Nuances of reflection: *Journal of Clinical Nursing*, vol.3, p.71-75.

JONES, A.H. 1997. From principles to reflective practices or narrative ethics? In Carson, R.A. Burn, C.R. eds. *Philosophy of medicine and bioethics. A twenty year retrospective and critical appraisal*. Dordrecht: Kluwer Academic Publishers, p.195.

KEMPPAINEN, J. 2000. The critical incident technique and nursing care, quality research. *Journal of Advanced Nursing*, vol.32, no.5, p.1264-1271.

LAURI, S., SALANTERA, S., CHALMERS, K., EKMAN, S., KIM, H., KAPPELI, S. & MACLEOD, M. 2001. An Exploratory study of clinical decision-making in five countries. *Journal of Nursing Scholarship*, Spring, vol. 33, no.ii, p.83.

LOGSTRUP, K.E. 1983. *Systems and Symbols. Essays (Danish)*. Gyldendal: Copenhagen.

LOGSTRUP, K.E. 1993. *Norm and Spontaneity (Danish Original 1972)*. Gyldendalske Boghandel, Nordisk forlag As, Copenhagen.

LOGSTRUP, K.L. 1997. *The ethical demand. (Danish)* Gyldendal, Copenhagen.

MATTISON, M. 2000. Ethical decision-making: The person in process: National Association of social workers. vol.45(i), no.3, p.201.

MCINTYRE, A. 1985. *After virtue. A story in moral theory*, 2nd ed. Duckworth: London.

MEURIER, C.E. 2000. Understanding the nature of errors in nursing, a module for critical incidents: *Journal of Advanced Nursing*, vol.32, no.1, p.202-207.

MILLIGAN, I. 2001. The concept of care in male nurse work, an ontological hermeneutic study in acute hospitals. *Journal of Advanced Nursing*, vol. 35, no.1, p.6-7.

MULLER, M.E. 1998. *Nursing dynamics*, 2nd ed. Johannesburg: Heinemann.

MURPHY, C.P. 1979. Models of the nurse-patient relationship. Ethical problems in Nurse patient relationship (Murphy & Hunter eds) Allyn & Bacon, Boston, p.8-16 (Context link).

MYSACK, S. 1997. Strategies for promoting ethical decision-making. *Journal for perontological Nursing*, vol. 23, no.1, p. 25-31.

OBERLE, K. & HUGHES, D. 2001. Doctors and nurses perception of ethical problems in end of life decision (Philosophical and Ethical Issues). *Journal of Advanced Nursing*, vol. 33, no.6, p.707-715.

PEER, K. & RAKICH, S. 1999. Ethical decision-making in Health Care management. *Hospital topics*. V. 77i 4. 7. Heldref Publication.

POGGENPOEL, M. 1998. *Data analysis in qualitative research* 1st ed. Van Schaik Publishers: Pretoria

POLIFRONI, E. & WELCH, M. 1999. *Perspectives in Philosophy of science in nursing, a historical and Contemporary Anthology*. Lippincott: Philadelphia. New York. Baltimore.

POLIT, D. & HUNGLER, B. 1991. *Nursing research, principles and methods*, Boston College of 4th ed. J.B. Lippincott Company, Philadelphia: New York. Hagestown.

POTTER, P. & PERRY, A. 1997. *Fundamentals of Nursing. Concepts, process, and practice*. 4th ed. Mosby: St Louis Baltimore Boston.

RAFFIN, T.A. 1991. Biomedical ethics in the 1990's, *American College of chest Physicians*: July V. 100 N.L.4 (2).

Regulation 2598 30 November, 1984, as amended

R.1469 10 July, 1987

R.2676 16 November, 1990

R.260 15 February, 1991

Regulation relating to the Scope of practice of persons who are registered or enrolled under the Nursing Act, 1978.

Regulation 387, 18 February, 1985, as amended

R.866 24 April, 1987.

R.2490 26 October, 1990.

Regulation setting out the Acts or Omissions in respect of which the council may take disciplinary steps.

Regulation 425 22 February, as amended.

R.312 19 June, 1987.

R.2087 25 September, 1987.

R.753 22 April, 1988.

Regulation relating to the approval of and the minimum requirements for the education and training of a nurse (General, psychiatry and community) and Midwifery leading to registration.

REISSMANN, C.K. 1993. Narrative analysis. Qualitative research methods. Sage Publications: London.

RICOEUR, P. 1976. Interpretation Theory. Discourse and surplus of meaning. Christian University press: Fort Worth Texas.

RICOEUR, P. 1988. Hermeneutic's and Human Sciences Led. Translated by John, B. Thomson. Cambridge Press: New York.

RICOEUR, P. 1991. Narrative identity. In Wood D. Ed. Narrative and interpretation, p.188-199. New York: Routledge

ROBERTSON-MALT, S. 1999. Listening to them and reading me. A hermeneutic approach to understanding the experiences of illness. Journal of Advanced Nursing, vol.29, no.2, p.290-297.

SANDELOWSKI, M. 1993. Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, vol.16, no.2, p.1-8.

SCHROETER, K. 1999. Ethical perception and resulting Action in pre-operative nurses: AORN Journal, vol.69(i), no.5(1), p.991-993.

SCOTT, P.A. 1995. Role enactment and the health care practitioner. *Journal of Advanced Nursing*, vol.22, p.323-328. Ovid full text. Bibliography. Links (Context Link).

SEARLE, C. 1968. *A South Nursing African Credo*. South African Nursing Association, copy right reserved. Pretoria.

SEARLE, C. & PERA, S. 1998. *Professional practice: A South African Perspective: 3rd ed.* Butterworth: Durban.

SELLMAN, D. 1996. Why teach ethics to nurses. *Nurse Education Today*, vol.16, p.44-48.

SORLIE, V. 2001. *Being in ethically difficult care situations. Narrative interviews with registered nurses and physicians within internal medicine, oncology and paediatrics.* UMEA University Medical Dissertation, New Series no. 727-ISSN0346-6612.

SOUTH AFRICAN CONSTITUTION. 1996. *Constitution (108 of 1996)*. Pretoria: State Press.

SOUTH AFRICAN NURSING COUNCIL. 1992. *The philosophy and policy of SANC, with regard to professional education and training.* Pretoria: SANC.

SOUTH AFRICAN NURSING COUNCIL,

1998 *Statistics of professional conduct inquiries*, Pretoria.

1999 *Statistics of professional conduct inquiries*, Pretoria.

2000 *Statistics of professional conduct inquiries*, Pretoria.

2001 *Statistics of professional conduct inquiries*, Pretoria.

2002 *Statistics of professional conduct inquiries*, Pretoria.

STROMBERG, A. 1999. Factors influencing patient compliance: a critical incident. *Heart- lung. Journal of Acute and Critical Care*, vol. 28, no.5, p. 334-341.

TAPPAN, M.B. 1990. Hermeneutics and moral development: Interpreting narrative representation of moral experience. *Development Review*, vol.10, no.(3), p. 239-265.

TAYLOR, B. 1992. From helper to human, a reconceptualisation of the nurse as a person. *Journal of Advanced Nursing*, vol.17(a), p.1042-1049.

UDEN, G., NORBERG, A., LINDSETH, A. & MARHOUG, V. 1992. Ethical reasoning in nurses and physician's stories about care episodes. *Journal of Advanced Nursing*, vol.17, p.1028-1034.

UDEN, G. & NORBERG, A. 1995. The stories of physicians, registered nurses and enrolled nurses about ethically difficult care episodes in surgical care, Scandinavian. *Journal of caring Sciences*, vol.9, p.245-253.

ULRICH, C. 2001. Need for knowledge of ethics, *journal of nursing Scholarship*, vol.33, (i) no.4, p.306.

VAN DER WAL, D. 2002. *The caring ethic in Health Sciences Education*, Copyright, EBSCO Publishing.

VAN DER ZALM, J. & BERGUM, V. 2000. Hermeneutic Phenomenology, providing living knowledge for *Nursing Practice*, vol.31, no.(i), p.211-218.

VAN MANEN, M. 1997(b). *Reasoning lived experiences, Human Science for an action sensitive pedagogy*. Athouse: London press, Michigan.

VITZ, P.C. 1990. The use of narratives in ethical development, new psychological reason for an old education method. *American psychologist*, vol.45, no.6, p.709-720.

VON POST, I. 1998. Pre-operative nurses encounter with value conflict, a descriptive study. *Scandinavian Journal of caring Science*, 12, p.81-88. (Medlink) (Cinahl Link) (Context link).

VON POST, I. 1999. A Hermeneutic text analysis of suffering and caring in the peri-operative context. *Journal of Advanced Nursing*, vol.30, no.4, p.983-989.

WURZBACH, M.E. 1999. Acute care nurses experiences of moral certainty. *Journal of Advance Nursing*, vol.30, p.287-293. (Full text link) (Medline link) (CLNAHL link) (Current context link) (Context link).

YUNG, H.H. 1997. Ethical decision-making and the perception of the ward as a learning environment: A Comparison between hospital-based and degree nursing students in Hong Kong. *International Journal Nursing Studies*, vol. 34, no.2, p.128-136.

APPENDIX A

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

TITLE

REALISATION OF ETHICAL DECISION-MAKING IN CLINICAL PRACTICE: A PHENOMENOLOGICAL STUDY USING THE CRITICAL INCIDENT TECHNIQUE

INTRODUCTION

You are invited to volunteer for this research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about what is expected of you.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to analyse ethical decision-making in incidents in clinical practice that posed an ethical dilemma to you.

WHAT IS EXPECTED OF ME DURING THIS STUDY?

You need to describe in written form an incident that clearly illustrates your success or failure in ethical decision-making in clinical practice. Use the guideline provided to structure your story.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study protocol was submitted to the Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences. The committee has granted written approval (S...).

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is entirely voluntary and you can refuse to participate or stop at any time without stating any reason. Your withdrawal will have no effect.

MAY ANY OF THESE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE?

Except for the time to write the critical incident, there is no other known discomfort or inconvenience.

WHAT ARE THE RISKS INVOLVED IN THIS TRIAL?

Except for confidentiality there are no risks involved in participation in this study.

ARE THERE ANY WARNINGS OR RESTRICTIONS CONCERNING MY PARTICIPATION IN THIS STUDY?

Please do not use any names by which you or any other person or institution can be identified.

APPENDIX B

WRITING A CRITICAL INCIDENT

WRITING A CRITICAL INCIDENT

Dear Participant

Please describe an ethical dilemma that you have experienced. This incident is known as a “critical incident” and should clearly reflect what happened. Please do not use names of people or places that may identify them in any way. Use the following guidelines to structure the critical incident that you want to describe. It will help you to keep your story focused.

Thank you for participating in this study.

Gloria Sehume

CORE QUESTION	
Description of experience	<input type="checkbox"/> The here and now experience <input type="checkbox"/> Causal – what essential factors contributed to the experience? <input type="checkbox"/> Context – what are the significant background factors to this experience? <input type="checkbox"/> Clarifying – what are the key processes (for reflection) in this experience?
Reflection	<input type="checkbox"/> What was I trying to achieve? <input type="checkbox"/> Why did I intervene as I did? <input type="checkbox"/> What were the consequences of my action for myself, the patient/family, the people I work with? <input type="checkbox"/> How did I feel about this experience when it was happening? <input type="checkbox"/> How did the patient feel about it? <input type="checkbox"/> How did I know how the patient/others felt about it?
Influencing factors	<input type="checkbox"/> What internal factors influenced my decision-making? <input type="checkbox"/> What external factors influenced my decision-making? <input type="checkbox"/> What sources of knowledge did/should have influenced my decision-making?
Could I have dealt better with the situation?	<input type="checkbox"/> What choices did I have? <input type="checkbox"/> What would be the consequences of these other choices?
Learning	<input type="checkbox"/> How do I feel about this experience? <input type="checkbox"/> How have I made sense of this experience in the light of past experiences and future practice? <input type="checkbox"/> How has this experience changed my ways of knowing?

APPENDIX C

INFORMED CONSENT

SOURCE OF ADDITIONAL INFORMATION

If you have any questions during this study, please do not hesitate to approach the researcher.

Researcher : Ms G G Sehume : (011) 923-2109
Supervisor : Dr C v/d Westhuizen : (012) 354-1784

CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. Data that may be reported in scientific journals will not include any information that identifies you as a participant in this study.

INFORMED CONSENT

I hereby confirm that I have been informed by the researcher, Ms G G Sehume about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details will be anonymously processed into the study report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

Participant's name (Please print)

Participant's signature Date

I, MS G G SEHUME herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study.

Researcher's name (Please print)

Researcher's signature Date

SUMMARY OF THE DISSERTATION

The study was undertaken to establish what nurses in the clinical area experience, regarding ethical decision-making in difficult care situation in their practice. A hermeneutic phenomenological approach was used in this qualitative study.

The critical incident technique was used to collect data, this is an in-depth exploration of specific incidents and behaviors, related to the phenomenon under investigation. A purposive sample of 30 experienced registered nurses was used to obtain information rich critical incidents.

The text was analyzed, utilizing hermeneutic phenomenological method. The narratives were analyzed in three stages:

- Naïve reading: in which narratives were read and re-read, open mindedly to understand the stories;
- Structural analysis: to explain the narratives, which led to a comprehensive understanding of the meaning of the text;
- Ethical decision-making in difficult care situation, led to different feelings and difficulties in action taking, due to the fact that there are no methodological guidelines. There was a complex interplay of thought and action, evident in the narratives. Integration of personal values and beliefs, with knowledge of ethical concepts, approaches and standards of ethical behavior, will become the framework for ethical decision-making.