Toward a Context-Sensitive Theory of Nursing Ethics: Classification and Comparison of Nurses' Narratives from Four Time Periods (1934, 1979, 1989 and 1995)

by

Judith M. Wilkinson

B. S. N., Graceland College, Lamoni, Iowa, 1976
M. A., University of Missouri-Kansas City, 1979
M. S., University of Missouri-Kansas City, 1985

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DEDICATION

To my new grandson,
Mason Christopher Wilkinson, born August 19, 1996
—All my love and, I hope, only my good genes.

To my "old" grandson,
Michael George Katz, who (like me) is a Wilkinson-by-marriage
—I'm so happy that you are a part of our family.

And for my father,
Hubert William Mason, who died March 31, 1997
—I remember and echo what he always said:
"If I felt any better, I'd have to take something for it."

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ABSTRACT

This two-phase, descriptive study used qualitative content analysis of nurses' narratives from 1934, 1979, 1989 and 1995 to determine whether the Wilkinson bifocal model of moral problem construction could account for all the different kinds of moral problems nurses described. Role and culture concepts taken from the literature and identified in the narratives provided a context for grounding and explaining variations in the frequency with which different types of problems occurred in each time period. The Wilkinson model contains two basic problem types: (1) decision problems, in which the difficulty lies in determining the right action to take, and (2) action problems, in which the nurse feels secure in her judgment about what is right, but is prevented from implementing that moral judgment.

Similarities and differences found in the cultural contexts of the four time periods, included the changing status of women and the healthcare environment, and the unchanging condition of nurses as expendable workers whose salaries count against the bottom line. The cultural contexts offered different constraints and supports for nurses to actualize their role perceptions.

Seven major role themes were identified. Advocacy and autonomy themes were strongest in the more recent data. Powerlessness was weakest in the 1934 data and strongest in the 1989 data, in which advocacy was strong and autonomy was relatively weak.

With one exception (in 1934), every problem type described in the bifocal model (moral dilemma, distress, outrage, heroism, judging, uncertainty, weakness, no problem and whistleblowing) was found in each time period. The problems did occur with different frequencies in the data sets. The most striking finding was the overwhelming prevalence of action problems in the 1995 data. More specifically, moral distress was associated with powerlessness, cultural dissonance and role discrepancy with regard to autonomy. Moral outrage and whistleblowing were more strongly associated with an advocacy role conception, either alone or when it occurred with powerlessness.

Because action problems create moral suffering among nurses, this study suggests that researchers, educators, administrators and practitioners should work to change work environments as well as supporting nurses' efforts to cope with moral suffering.

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CHAPTER 1

INTRODUCTION

> (79.46) Mr. A. was a patient . . . [in] a local hospital. Immediately after being diagnosed, he arrested—no heart beat or breathing. [He had] an inoperable aneurysm. The nurses had no order not to resuscitate . . . . I immediately began CPR along with others of the team. Mr. A's doctor arrived and said we should not have tried to revive the patient because of his condition. In spite of our efforts, the patient did die, but we were not aware that his condition was that grave without any hope of recovery. Therefore, we were carrying out what we took to be our duty.
>
> (95.13) 31-year-old male [with] liver failure, hepatitis C. Patient and MD wanted full code; nurses wanted DNR. Patient coded—>big, bloody mess; sent to ICU; one hour later allowed to die. Staff *very* traumatized: Futile care, disrespectful to patient, had to do what they felt was wrong. I started our moral distress group as a result of this case.

Both of these stories were written by the nurses who experienced them; both involved resuscitation of hospitalized patients who were terminally ill; both resuscitation efforts failed. There the similarities end. The nurse in the first story seems comfortable with her actions. The nurse in the second story was so upset that she[1] started a support group as a coping strategy for herself and her peers. What is different in these two incidents? Certainly not the traditional "ethics content." In traditional ethics language, these are both "do not resuscitate" cases involving the issue of the right to terminate or prolong life. Using traditional ethics, the two nurses should be able to use moral principles (e.g., autonomy, beneficence, justice, rights, duties) to analyze both cases and arrive at essentially the same conclusion. Obviously, they did not. Clearly, even when the facts of a story seem the same, each person constructs the problem differently.

---

[1] When gender was known, I used the appropriate pronoun. In other instances I arbitrarily assigned gender to both nurses and clients and referred to them as *he* or *she*. I do not wish to use sexist terminology, but terms such as *s/he* and *she/he* are awkward to read and they feel unnatural to me. I freely acknowledge and welcome the presence of men in nursing; however, the overwhelming majority of nurses in this study were women. Therefore the pronoun *she* is used more frequently than the pronoun *he*.

Nurses do not construct and solve moral problems in a vacuum. They implement or fail to implement their decisions in a complex series of actions and interactions—in particular, personal, interpersonal and cultural contexts. These contexts are inextricably bound up with the manner in which nurses define and solve ethical problems.

> . . . how a person constructs a moral conflict—how she or he defines or interprets the situation, and what she or he focuses on as relevant to the problem—is related to what actions she or he describes and the thoughts and feelings that follow from or accompany this description . . . . *The way in which a moral problem is constructed . . . also depends on the context*, e.g., who is involved, the relationships between the persons involved—their relative power vis-a-vis each other as well as the strength of the connection between them—*where the situation takes place, what role the narrator plays in the conflict, and the personal and cultural history of the narrator*. (Brown, Tappan, Gilligan, Miller & Argyris, 1989, p. 145) [Italics added.]

Lutzen and Nordin (1993) have called for studies to examine moral interaction in health care contexts, and Ray (1994) pointed out the need for "research centering on moral experience rather than solely on principle-based or rule-oriented ethics" (p. 108). This study used nurses' stories to illuminate both the context and process of their moral problem construction. By documenting and abstracting from nurses' stories of their ethical problems, we can begin to objectify their subjective suffering and make it a valid component for moral analysis—as suggested by Rushton (1992). Armed with understanding, we may then be able to create what is now lacking—an ethical practice environment for nurses.

Statement of Purpose and Research Questions

This was a two-phase descriptive study, using qualitative content analysis of nurses' narratives from four time periods: 1934, 1979, 1989 and 1995. The broad aims of the study were to:

1. Expand a grounded, practice-level theory of nursing ethics developed in a previous study (Wilkinson, 1985).
2. Explore the historical-cultural context of nursing ethics.
3. Sensitize both nurses and non-nurses to the moral dimensions of nursing care.

The specific research questions were:

1. What are the similarities and differences in themes of nursing culture, institutional culture and popular culture that are reflected in ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)?
2. What are the similarities and differences in themes of nurses' role conceptions that are reflected in ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)?
3. What are the similarities and differences in the fit between the Wilkinson bifocal model of nursing ethics and ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)?
4. How does the context created by the interaction of culture and role influence the ways in which nurses experience and construct ethical problems in four different time periods (1934, 1979, 1989 and 1995)?

Using nurses' fixed-text stories, Phase 1 examined these questions for the years 1934, 1979 and 1989. Phase 2 examined the questions in the context of the 1995 data and began synthesis and expansion of the Wilkinson bifocal model of nursing ethics, especially with regard to the usefulness of its problem typology.

Background and Literature Review

The purposes of the literature reviewed in this section are to (a) explain the significance of this study for nurses' wholeness and patient care, (b) establish the need for using the Wilkinson bifocal model to classify ethics problems, and (c) establish the relevance of narrative data and method.

Significance of the Study

From both a caring and a pragmatic perspective, the physical, mental, emotional and spiritual integrity (wholeness) of the nurse at the bedside is of vital concern. Moral problems in nursing have implications for the health and wholeness of nurses, for patient care, and for cost containment, turnover and retention. These implications are discussed in this section.

Effects of Moral Problems on Nurses

It is important to reduce the negative effects of ethical problems on nurses, not only for effecting retention and improving patient care, but also as an end in itself. A

profession with values rooted in caring for others must be interested in preserving the integrity of the caregivers who are themselves members of that profession.

Moral problems in nursing have been associated with emotional distress, as well of a variety of specific, painful feelings (e.g., inadequacy, frustration, powerlessness, hopelessness, anxiety, anguish, anger and guilt), culminating in loss of integrity or wholeness (Barr, 1992; Berger, Seversen & Chvatal, 1991; Broom, 1991; Cameron, 1986; Carpenter, 1991; DeWolf, 1989; Fenton, 1987; Haddad, 1993; Hofling, Brotzman, Dalrymple, Graves & Pierce, 1966; Muff, 1988; Rodney, 1988; Theis, 1986; Wheeler, 1994; Wilkinson, 1985; 1987/88; Yarling, 1978). Nurses in DeWolf's study (1989, p. 80) described "being dissatisfied and powerless" when they could not implement a moral decision. Erlen and Frost (1991, p. 403) demonstrated that "inability to affect a resolution to the situation . . . resulted in anger, frustration, and exhaustion"; and Holly (1993) found that nurses experienced "personal feelings of travail when involved in a situation in which they felt powerless to assist their patients or practice in a fully professional manner" (p. 113). Holly referred to these feelings as *anguish*.

Some have suggested that moral problems may even contribute to nurses' physical problems. Nurses have reported, for example, heart palpitations, diarrhea, headache, and frequent illnesses (Wilkinson, 1985); and fatigue, tight muscles, and difficulty sleeping (Meyers, 1994). In a lengthy, unsuccessful whistleblowing incident, McDonald (1994) reported:

> For those nurses who stayed, the emotional trauma caused by the silencing of their concerns took its toll. One unit manager was hospitalized with an ulcer and one for colitis. (p. 24)

Recently, nurse ethicists have been searching for an overarching concept to describe the emotions surrounding moral problems in nursing. Fairbairn and Mead said that the assortment of feelings resulting from moral problems is "similar to a bereavement." Nurses attending their workshops told stories demonstrating "emotions such as anger, pining, confusion and guilt" (1993, p. 38). Rushton (1992) referred to nurses' moral suffering, stating that they "suffer when they are torn between opposing moral responsibilities" (p. 304) and as a result of various other kinds of ethical problems, such as moral distress (see also Villaire, 1994). Meyers (1994) developed the concept of *moral suffering*, which she defined as a context-specific, holistic phenomenon associated with a wide variety of ethical problems. Moral

suffering is a powerful concept that encompasses the variety of specific feelings that others have described.

In discussing the loss of integrity that results from nurses' experience with moral problems, Mitchell (1982) said: "Nurses who stay survive precisely because they sacrifice individual integrity . . ." (p. 176). Over time, frustration has a numbing effect, producing technically competent but morally apathetic nurses (Parker, 1990).

> For compassionate caring to occur, caregivers must be the recipients of compassion themselves. Administrators and health care providers have a responsibility to create an environment where the burdens and suffering of caregivers can be appreciated and addressed in a supportive and constructive manner. (Rushton, 1992, p. 305)

Effects of Moral Problems on Patient Care

Practically speaking, nurses' integrity is important because of the effects it can have on patient care. Counselors Carkhuff and Berenson (1977) stressed that the wholeness of those in helping professions is of paramount importance. They stated:

> Only the fully functioning whole person has the right to be a helper. (p. 246)
>
> Any system is only as good as the helper is whole. (p. 282)
>
> Those who are functioning at low levels . . . simply cannot be turned loose on an innocent public. (p. 252)

Certainly, nurses are helpers. Nursing theorists Paterson and Zderad (1976, p. 27) defined nursing as a "response to a call for help." Their concept of nursing included the nurse's therapeutic use of self in a meaningful, transactional relationship founded on the nurse's existential awareness of self and other (p. 3). This implies a high level of integration and functioning for the nurse—who is a helper.

As shown in the preceding section, empirical evidence indicates that nurses experience stress around moral and ethical problems (Gray-Toft & Anderson, 1981; Jacobson, 1978; Kramer, 1974; Martin, 1990; Oskins, 1979; Wilkinson, 1987/88). There is also evidence that job stress affects the quality of nursing care (Taunton, 1992; Weisman & Nalhanson, 1985). Other studies show that nurses' emotional states can result in such changes in patient care as avoiding patients (Anspach, 1987; Jacobson, 1978; Quint, 1966).

In addition, some studies have *directly* associated changes in patient care with the stress resulting specifically from ethical problems. Nurses in Lamb's study (as

cited in Rodney, 1988) experienced resentment, anger and revenge; and those themes were associated with unsatisfactory patient care. In a study by Candy (1991), informants reported angry responses and severe distress over "do not resuscitate" orders. After the resuscitation, in their efforts to cope with their distress, some nurses avoided patients and others compensated patients by spending more time with them. Fenton (1988) and Rodney (1988) both found that moral distress can evoke both positive and negative patient care behaviors. Some nurses in their studies responded positively by giving support to the family, paying particular attention to the patient's comfort, and being sure to keep the patient informed. Others "described difficulty in giving basic care, wanting to avoid the patient, and inability to respond to the needs of the family" (Fenton, 1987, p. 174; Wilkinson, 1985, 1987/88). A nurse in Holly's 1993 study reported avoiding the patient involved: "I dread going into a patient's room sometimes because . . . I hate having to be involved in continuing the torture" (p. 114). Meyers (1994) found that "the predominant effects of nurses' moral suffering are depersonalization of the patient, inconsistency in provision of care, and non-collaboration with other members of the health care team" (p. 95). Clearly, moral suffering can be detrimental to patient care.

Effects of Moral Problems on Turnover and Retention

Even though many hospitals are making huge cuts in their RN staffs, cost-containment dictates that they retain a nucleus of professional nurses. Since layoffs are an attempt to cut costs, institutions cannot afford to offset those savings with high turnover and constant retraining of new employees. The stress from moral problems may add to burnout and finally leaving the institution. Therefore, it may be financially advantageous to reduce the moral suffering in an organization.

Nurse ethicists have asserted, and researchers have supported, that there are moral and ethical dimensions to nurses' job stress, burnout and leaving the profession (Åström, Furåker & Norberg, 1995; Cameron, 1986; Duxbury, Armstrong, Drew & Henly, 1984; Fenton, 1987; Fowler, 1989b; Jacobson, 1983; Marshall, 1980; Millette, 1993; Mitchell, 1982; Sovie, 1985; Stewart, 1990; Stone, Jebsen, Walk & Belsham, 1984; Wilkinson, 1987/88). For example, nurses in studies by Oberle and Davies (1993) said:

> I don't believe in what we're doing . . . I almost quit nursing over it . . . (p. 72)

> I left under an incredible strain. I felt alone. I stopped, quit nursing for six months . . . . I just realized that it wasn't the place for me . . . I couldn't justify my part in that system. (p. 72)

In a 1984 study of NICU nurses, 70% of the participants said they were not consulted "in a substantial way" before DNR orders were given (Martin, as cited in Savage, Cullen, Kirchhoff, Pugh & Foreman, 1987, p. 370). Probably not coincidentally, that study reported a burnout rate of 65% for the NICU nurses. McDonald (1994) reported a situation in which patients were being treated by methods in opposition to Standards of Nursing Practice and nursing policy and procedure. The nurse manager and several clinical nurse specialists made protracted efforts to get hospital administrators to intervene, but they were unable to correct the unethical situation. Eventually, the nurse manager was fired and the "three nurses resigned their positions rather than struggle with the ethical and moral issues at stake" (p. 24). Indeed this is a dramatic example of staff turnover resulting directly from moral suffering. Mitchell (1981) said: "Almost every week I hear bedside nurses conscientiously, sometimes agonizingly, discuss moral problems . . . . nurses leave nursing because they experience severe stresses which strike at their very sense of self as a moral being" (p. 7).

The Need to Classify Ethics Problems

Throughout American history nurses have experienced stress and anxiety around the ethical problems arising in their practice. Nearly 90 years ago Clark (1906, p. 776) wrote concerning the loyalty of nurses to one another:

> . . . the first years of private nursing are apt to be unsatisfactory and disappointing, *full of anxieties and vexatious problems*. There are many . . . decisions to be made, that were undreamed of in our hospital work . . . . *Duty is not so clear to us* . . . . [italics added]

Nurses continue to document that moral problems in their practice create mental anguish. However, we have made little progress in finding ways to alleviate nurses' moral suffering, or in helping them articulate, much less solve, their ethical problems. The nursing ethics literature, following the lead of medical ethics and bioethics, has focused mainly on difficult questions and dramatic, life-and-death situations. Nurses do not yet have a voice for the true issues of nursing ethics, which arise out of their day-to-day work and work relationships (Bandman & Bandman, 1985; Levine, 1989; Liaschenko, 1993a). This is beginning to change as more

researchers use grounded theory and phenomenological methods to study nursing ethics. However, the nursing and bioethics literature still lack clarity in two important areas: (a) There is no consistent terminology used to describe ethical problems, and (b) distinctions between moral decision and moral action are rarely made. The Wilkinson bifocal model (Appendix A) intends to clarify those points.

Lack of Consistent Terminology

Inconsistent use of terminology is best illustrated by the use of the term *dilemma.* Nurse philosophers, theorists and researchers tend to use the term dilemma in two different ways: (a) to refer accurately and specifically to a difficult decision with no satisfactory answer and (b) to indiscriminately characterize all ethical problems (Curtin & Flaherty, 1982; Jameton, 1984; Levine, 1989).

Many authors do use the term dilemma specifically and accurately to indicate a problem with no satisfactory answer. For example, Broom (1991), Curtin (1982), Davis and Aroskar (1983), Levine (1989) Mayberry (1986), Muyskens (1982), vanHooft (1990) and Wilkinson (1985) used the term *moral dilemma* to mean a problem involving conflicting but equally compelling moral principles. Cahn (1987, p.21) said a dilemma is an "internal, wrenching process of weighing values."

Even though these and other authors have used dilemma accurately to mean difficult decision, not all authors are consistent with their usage. Many have used the term *dilemma* inaccurately to describe problems that are not dilemmas, and interchangeably with a wide variety of other terms to indicate the general concept of *moral problem, issue* or *decision*. Berseth, Kenny, and Durand (1984) and Corley (1992, p. 36) used the word dilemma synonymously with *moral problem* or *question*. McConnell also implied that dilemma and moral problem are synonymous, defining a moral problem as "a situation in which a person has grounds for believing that there are moral reasons to support each of two courses of action, both cannot be done, and one does not know which is more important morally" (as cited in Edgil, 1983, p. 210). This is similar to the classic definition of dilemma; however, Edgil was discussing moral *problems*, not *dilemmas*, so apparently she did not differentiate between the two. Similarly, Holly (1993) used the terms dilemma and *quandary* both to indicate ethical problems in general. Pinch (1985) and Hayne, Moore, and Osborne (1990, p. 11) referred to "a range of various dilemmas," implying that dilemma describes more than one problem type.

The overall effect of this lack of specificity in the literature is that people begin to have the idea that all moral problems are complex and difficult—all dilemmas. This is simply not so. Some moral questions are easily answered (e.g., "Should I take this morphine or give it to the patient for whom it is ordered?"). A dilemma is "a situation in which one feels drawn both to do and *not* to do the same thing. It is inaccurate to refer to *any* morally perplexing situation as an ethical dilemma" (Mitchell, 1990, p. 427). Ethical decisions range from the obvious to the impossible—the true dilemma. White (1983) asserted that "there are simply too many different kinds of confusions, conflicts, and disagreements that are labeled ethical dilemmas in the literature" (p. 40). Levine (1989) believed that nurses confront genuine dilemmas only occasionally; and Cahn (1987) agreed, stating that most of "nursing's ethical dilemmas may not be dilemmas at all, but rather situations of moral distress" (p. 21). Empirical evidence supports these assertions. For example, nurses in Fenton's (1987) study described various kinds of ethical problems, not just dilemmas. Likewise in Meyers' (1994) recent study, nurses reported "being troubled by a wide variety of ethical situations" (p.21).

To compound the confusion, numerous other terms are used when referring generally to moral problems—for example: moral situation, moral conflict, moral disagreement, moral distress, and moral outrage. Unfortunately, these terms, too, are used inconsistently. For example, Murphy (1978) used the term *moral situation*, and Muyskens (1982, pp. 21-24) used the term *moral disagreements* for situations in which people disagree about a particular issue. Case (1991), used the term *moral conflict*: "situations involving a conflict between two or more values, one of which is a moral value" (p. 8).

Most authors (e.g., Cahn, 1987; Corley, 1994; Fenton, 1987; Kerfoot, 1992; Rodney, 1988) used the term *moral distress* in the same manner as I use it in this paper, following Jameton (1984) and Wilkinson (1985); but Buehler (1990) ambiguously referred to moral distress both as the subjective effect of problematic ethical situations and as a type of ethical problem. Other authors used the term *distress* in a general sense, and used the word *moral* as an adjective when the distress results from an ethical situation.

The term *moral outrage*, likewise, is used inconsistently. Andersen (1990, p. 9) used the term to mean the rage that a whistleblower experiences "when a logical attempt to solve a moral problem results in denial of the problem and an assault on the

nurse's integrity and the welfare of patients . . . ." Mahon and Everson (1979) said that "nurses do indeed feel moral outrage [and] desire to constructively deal with nursing dilemmas which generate outrage" (p. 7). Pike (1991) described moral outrage as "an emotional response to the inability to carry out moral choices or decisions," but then said that moral outrage is a product of moral dilemmas (pp. 351-352). These usages are all somewhat different from each other and from the definition of moral outrage used in this study (see Appendix B).

Failure to Distinguish Moral Decision from Moral Action

Nursing literature typically has not differentiated situations in which the nurse experiences difficulty deciding what to do from situations in which the decision is clear but contextual constraints prevent the nurse from acting on the decision. Nursing ethics research, especially prior to 1990, has focused on cognitive development, moral reasoning or the relationship between these concepts and nurses' actions. During that period there were almost no studies examining the impact of the clinical environment on ethical decisions and actions (Gortner, 1985; Ketefian, 1989). The result is a body of literature that advises nurses to cope with moral problems by learning more about moral theory, improving their decision processes, or learning to make ethical arguments. Such literature fails to address the need to change the practice environments that produce nurses' moral suffering.

One example of such advice can be found in the work of Akerlund and Norberg (1985), who implied that nurses would not experience distress when force feeding patients if they could reason more accurately about it. Others also offered similar advice. Fowler (1989a) advised nurses to learn to make ethical arguments; Cassells, Silva and Chop (1990) suggested that nursing service administrators provide an ethical work environment—not by changing the environment but by changing the nurses. They suggested that administrators use strategies to develop the ethical awareness and decision-making skills of staff nurses. Hayne, Moore, and Osborne (1990, p. 10) recommended theory development and education as ways to help nurses "fulfill their mandate of ethical practitioner." These strategies might help nurses who are having difficulty *making* ethical decisions, but they do not help nurses who work in practice environments that prevent them from *implementing* their moral decisions.

Following the same line of reasoning, some authors have more or less advised nurses to "get a grip." Raines admonished nurses of their duty to be courageous and enact "moral agency" (1994, p. 11). Others have suggested that nurses renew their commitment, be more assertive, and learn to communicate better. For example:

> . . . moral commitment or moral motivation involves giving priority to moral values over other competing values so that one decides to do what one believes is morally right. The final component necessary for moral action is implementing the moral decision. This requires the person to have psychological attributes (such as ego strength) and interpersonal communication abilities (such as assertiveness and conflict resolution skills). (Duckett et al., 1992, p. 330)

Still others have recommended that nurses resolve ethical problems by being better "team players"—by engaging in collaborative practice. For example, although Benjamin (1987) admitted the need for radical reeducation of physicians and patients, he nevertheless emphasized that practical ethics is an interdisciplinary undertaking. Stewart (1990), too, said that "decisions need both medical and nursing agreement" (p. 319). Bishop and Scudder (1987), apparently disliking conflict and valuing peace, also urged nurses to collaborate. They implied that conflicts in healthcare were caused by nursing's greed for power. They worried that:

> An excessive concern for autonomy can put health care workers in conflict with each other . . . . Indeed, the focal question in nursing ethics is not autonomy but the promotion of the well-being of patients through communal decisions . . . . When viewed from this moral sense, the in-between situation of nurses, which is such an offense to those who want autonomy, becomes a privileged position for coming to concrete decisions within a team setting. (pp. 40, 43)

Such suggestions do not take into account that the obligation to engage in collaborative practice is directed one-sidedly to nurses. Collaboration is not possible in existing practice conditions unless those in power (i.e., physicians and administrators) agree to it. This was powerfully illustrated by Anspach (1987), who observed that in making life-and-death decisions about newborn infants, the interactive data provided by nurses was devalued, essentially ignored, by physicians (p. 229). A nurse in Wheeler's (1994) study described this incident, wherein a physician completely ignored a collaborative decision that had been made:

> A decision reached at a team meeting was rescinded by the physician, who neither informed nor discussed the matter with staff, but simply

> altered the treatment plan to conform to the newly-arrived-at and independently-made decision. (p. 67)

So although nurses are indeed suffering, it is not necessarily because they lack knowledge or are unable to make good decisions. Studies have shown that in moral situations, nurses experience mental anguish because they are afraid to *implement* the clear decisions they have made, and that they often perceive administrators and physicians as threats rather than supports in moral situations (Andersen, 1990; Bunzl, 1975; Fenton, 1987, 1988; Meyers, 1994; Rodney, 1988; Savage et al., 1987; Wilkinson, 1987/88). Consider the following statement given to a newspaper reporter:

> . . . ethical anguish has become a special weight of the past decade . . . . There may be a very strong, direct conflict between what the nurse thinks should be going on and what she's actually doing . . . . She's got, basically, moral schizophrenia. (Gorney, as cited in Cameron, 1986)

I do not mean to detract from previous ethics work. It has heightened awareness and laid some groundwork. Nevertheless, what nurses need now are not prescriptions for coping with their moral suffering, but prescriptions for changing the system. As long as 15 years ago, Mitchell (1981) pointed out the incongruity of the get-a-grip reasoning—apparently to no avail. Commenting on the work of bioethicists and nurse ethicists of the time, she said that their prescriptions for moral behavior did nothing to enable nurses to act morally within the existing system. It is time now to differentiate between decision problems and action problems and to examine the contexts in which they occur. The Wilkinson model offers clear, precise terminology and a typology that may help to achieve that end.

Beginning Classifications

A practical framework for categorizing nursing ethics problems is long overdue. As long ago as 1979, Gadow lamented the trend to reduce nursing ethics problems to a common denominator. She urged that approaches be found for identifying and sorting the "plethora of ethical issues" confronting nurses, and suggested that problems might be differentiated according to whether they arise more in relation to the consumer or the provider (see also Aroskar, Gadow, Neumann & Giovinco, 1979, p. 93). However, she did not elaborate her suggestion as a model, nor attempt any such classification of moral problems.

The philosopher, Andrew Jameton, first sorted moral problems in hospital nursing into three categories: moral uncertainty, moral dilemma, and moral distress (1984, p. 6). Jameton defined and gave an example of each of these categories, but did not clarify why the distinctions should be made nor elaborate further on the topic. Building on Jameton's definitions and distinctions, I qualitatively described the problems of moral distress and moral outrage (Wilkinson, 1985, 1987/88). My 1985 moral distress work has stimulated studies by several other researchers (Augustine, 1991; Corley, 1994; Fenton, 1987; Meyers, 1994; Rodney, 1988; Wheeler, 1990, 1994), and it has been cited in numerous articles in the nursing ethics literature (e.g., Andersen, 1990; Buehler, 1990; Cassells & Redman, 1989; Fenton, 1988; Haddad, 1991; Holly, 1993; Jameton, 1993; Kerfoot, 1992; Millette, 1993; Quinn, 1991; Rushton, 1992, 1994, to name a few).

In 1993, I proposed a model for categorizing ethics problems according to whether their source of difficulty arises in making or implementing the decision (Wilkinson, 1993). That model was expanded in Phase 1 of the present study (see Appendix A). It provides a framework for distinguishing among different kinds of ethical problems, thereby enabling nurses to conceptualize them more clearly. Clarity and distinction are essential because, as noted in the preceding section and in previous work, decision problems and action problems require very different approaches for their resolution (Cahn, 1987; Wilkinson, 1993).

Rationale for Narrative as Data and Method

I used the perspective of narrative ethics in this study to examine nurses' stories about ethical problems encountered in their practice. Narrative is studied across several disciplines (e.g., anthropology, education, ethics, linguistics, medicine, philosophy and sociology). Therefore there cannot be a "standard" methodology for narrative analysis (Bertaux & Kohli, 1984, p. 233). Narrative is more a form of the data than it is the form of the analysis. Narrative analysis is about interpretation and making sense of the story. And interpretation depends on the context of the study, the history of the researcher, and the theoretical lenses through which the stories are viewed (Liaschenko, 1993a, p. 124).

I chose narratives as the data source because: (a) They are believed to closely represent the lived practice experience for which the bifocal model is intended, (b) they provide a foundation for nursing ethics by providing information about culture

and context, and (c) stories of practicing nurses may help to sensitize those outside the profession to the nature of nursing care, and thereby provide hope for creating a more humane health care environment. The literature reviewed in this section elaborates these reasons.

Types of Thought and Discourse

Bruner (as cited in Astington, 1990) said there are essentially two modes of thought and discourse: paradigmatic and narrative. *Paradigmatic discourse* treats physical reality and deals with issues of truth and objectivity. Using language similar to that of mathematics and logic, it abstracts, verifies, argues, and draws conclusions. *Narrative discourse*, on the other hand, is concerned with psychic reality and issues of human experience. Using the language of drama and story, it deals with beliefs. A good story simultaneously recounts reality (events and actions) and participants' perceptions of that reality. Narratives provide orientation to the who, where, and when of the events and fulfill two other distinct functions: reference and evaluation (Peterson, 1990). *Evaluation* conveys emotional information, meaning and the reasons for telling the story. *Reference* refers to a sequence of specific, chronologically ordered events.

Another way to conceptualize narrative is as "discourse organized around the passage of time," usually including clauses about events and states of being (Polanyi, 1985, p. 10). In addition to its temporal organization, the fact that narrative has a *point of view* also distinguishes it from other types of discourse, such as description (Westlake, 1992).

Gustafson (1990) distinguished narrative discourse from ethical discourse. *Ethical discourse* abstracts from experience. *Narrative discourse* is descriptive, and provides concrete, specific details of experience—or extended context. The nurses' stories that constitute the data for this study are narrative discourse. This report, which abstracts from and interprets those stories, represents paradigmatic and ethical discourse.

Narrative as a Record of Lived Experience

Because the bifocal model is intended for use in the concrete world of nursing practice rather than in the abstract and rational world of the classroom, it is essential to understand ethics problems as they are experienced by the nurses who live them. Lived experience is private, though, and cannot be understood from the outside.

According to Dilthey and Ricoeur, experience, if it is to be understood, must first be expressed and then interpreted (as cited in Tappan, 1990). Expression can be oral or written. Written narratives are a "representational medium for culture and cognition" (Chafe, 1990, p.102). As a form of symbolic action and as an expression of nurses' lived moral situations within cultural contexts, narrative representation holds the possibility for interpreting and understanding nurses' moral experiences.

Narrative as Ethical Foundation

The purpose of purely ethical discourse is to decide how one ought to act in particular situations; it frames and solves problems by rational application of concepts and principles. Narrative discourse, on the other hand, is descriptive; rather than prescribing precise conduct, it illumines one's choices in a particular situation by providing details about the situation.

Sher (1987, p. 179) said that moral problems should not be seen as "a math problem with humans, but as a narrative of relationships that change over time." By reflecting the social practices, assumptions, and human emotions that underlie an ethical situation, narratives provide *extended context*, within which the circumstances of particular clinical choices may be understood (Gustafson, 1990). Context is an important concept in the bifocal model because it is the context of nursing practice that creates the distinction between decision-focused and action-focused problems. When a nurse has made an ethical decision, it is the practice context that may prevent implementation of that decision—the key antecedent to an action-focused problem (see *Wilkinson Bifocal Model* in chapter 2).

Although ethical discourse and narrative discourse are different in operation and purpose, both forms are important in ethical analysis and decision making. For example, an ethicist might abstract an argument from a story containing affective and descriptive overtones; but because context frames specific moral choices, isolating the ethical aspect would lead to an incomplete understanding of the problem being addressed. Theory development necessitates abstraction; and abstraction is always needed to organize an otherwise unmanageable maze of complex particulars into useful patterns. By moving back and forth between the nurses' stories and the abstractions therefrom, I hoped to ground the bifocal model solidly in the practice it attempts to describe, and which it may eventually help to explain and guide.

The Culture-Narrative-Ethics Relationship

In addition to the personal meaning they convey, nurses' narratives should also illuminate the ethics of larger cultural entities, for example: institutions, the nursing profession, and the wider society. Suggesting a narrative foundation of ethics, Kemp (1988) said that any story is always embedded in the story of the larger culture. Stivers (1993) maintained that because the language people use to tell about themselves is communal, there is nothing completely idiosyncratic about a single narrative.

As the context for nursing ethics problems, cultural assumptions shape issues and conflicts. One important function of nursing stories is that they can help nurses to identify their own assumptions and illuminate the assumptions of the institutional culture. Only when nurses (and others) begin to notice and question their assumptions can moral problems be handled with sensitivity and integrity.

Narratives for Sensitization

Because of the length of this report, I could not quote extensively from the nurses' stories. However, I included as many of their words as possible in order to fulfill one of my research purposes: awareness of and sensitivity to nurses' ethical experiences. The details and language of the nurses' stories evoke emotion and understanding in a way that is not possible in my theoretical discussion. For that reason, nurses' stories (narratives) are central to this, and any, account of nursing ethics (Parker, 1990).

According to Boykin and Schoenhofer, "Stories call to mind the commonalities of nursing situations as well as the beauty and uniqueness of each" (1991, p. 246). Because stories are particularly engaging, some believe that stories of nurses' moral struggles can increase sensitivity to the moral nature of care, "thereby linking care concerns with nursing ethics" (Cooper, 1991, p.30). Gustafson agreed that stories can not only sensitize, but shape values and moral viewpoints: "We are members of moral communities, and the outlooks, values and visions of these communities are shaped by their stories . . . . our own moral outlooks and values are shaped by its narrative" (1990, p. 137).

Although not all the narratives in this study were fully developed stories, they were all stories in the sense that they are "a moment in time caught forever," and that they involved both the patient and the nurse (Boykin & Schoenhofer, 1991, p. 246).

Stories and narratives are different from case studies or reports, although they have some similarities. A case study focuses on the patient and his needs, while stories and narratives also involve the nurse. The case study tends to separate the nurse from the patient, while a story is more intimate. A story provides weighted, evaluative information, as opposed to a report, which—like a case—is a factual account of events (Polanyi, 1985).

Although some authors differentiate between story and case study, the terms *story* and *narrative* often are used interchangeably (e.g., Havelick, as cited in Chafe, 1990; Gustafson, 1990), as in this report. Stories and narratives are alike in that they (a) reflect lived experience, (b) enhance understanding through their richness of detail, and (c) arouse intuitive and emotional, as well as intellectual, responses (Boykin & Schoenhofer, 1991).

Assumptions

The following are the underlying assumptions of this study:

1. Nurses' written or oral stories of their experiences, although given from recall at a later time, are representative of the situation as they experienced it.
2. In addition to the personal meaning they convey, nurses' narratives also illuminate the culture and ethics of larger entities, for example: institutions, the nursing profession, and the wider society.
3. Different periods of history constitute different cultural contexts, even within the same geographic locale.
4. The various problem constructions can be differentiated by their antecedents and defining characteristics (or dimensions).
5. Any moral problem, however constructed, can produce moral suffering.
6. Nurses fixed-text narratives, regardless of how the data are accessed, are representative of the cultural context in which they were constructed, because the language they use to tell about themselves is communal (Stivers, 1993).

Limitations

The following are the limitations of this study:

1. The quantity of text analyzed precluded the use of other data gathering techniques, such as participant observation or interviews by the

researcher. This could be addressed by designing another study using interviews to confirm the findings of this study.

2. Many inferences were made in interpreting the data and classifying the moral problems. Therefore, problem classifications and role and culture themes may not have been identified with 100% accuracy. This limitation was addressed by performing tests of interrater reliability on randomly selected narratives and by using two readers to independently code and then interpret by consensus.
3. Data from 1934, 1979, and 1989 were, of necessity, examined from the perspective of the researcher, who lives in the present. I made an effort to learn about the sociohistorical context of each of those three periods and to try to adopt the appropriate perspective for each period by asking questions such as, "Would this have been so unusual at that time?"
4. The demographics of the participants could not be described completely, therefore generalizability of the findings is limited to this degree. The general source of all narratives was known (e.g., nursing students at a Catholic school of nursing). However, for the 1934 and 1979 data there was little demographic information about the individual story writers. More information was available for the 1989 and 1995 data, and fuller description was given. Additionally, the cultural context of each period was well described, so findings can be generalized to the extent that contexts are similar rather than to the extent that individual nurses, themselves, are similar.
5. Because a random sample was not used, it is possible that some of the stories were told by nurses who chose to participate because they wanted to ventilate negative feelings. However, this could not be true for all the stories because some (for example, the entire set of 1979 narratives) were not optional. All of the R.N. participants of that particular ethics class were required to keep journals for a semester. Also, this is less of a concern because of the large total number of stories analyzed. In addition, the researcher looked for patterns in the data rather than single incidents, and qualitative methods to ensure rigor were employed (see chapter 3).
6. All the stories were told from recall, so it is possible that some may have been distorted by the passage of time. Again, the methodology and the

> large number of stories counterbalance this concern. Furthermore, regardless of the "facts" as they occurred at the time, the nurse's later perception at the time of telling does constitute his/her most current experience of the event. It is the perceived reality of the past event—not the factual accuracy of the event—that continues to influence the nurse's present experience.

Summary

This chapter has stated the purpose, questions and background of this study, and has discussed literature to support (a) the significance of the study, (b) the need for a typology to classify ethical problems, and (c) the use of narrative as data and method in this study. Chapter 2 will present a literature-supported theoretical framework for the study, which integrates the Wilkinson bifocal model with concepts from role and culture theories. Chapter 3 will present the research design and methods. Chapters 4-6 will concurrently present and discuss study findings related to (a) culture themes in chapter 4, (b) role themes in chapter 5, and (c) Wilkinson model problem constructions in chapter 6. Chapter 7 is a synthesis of chapters 4-6 and explains how role and culture interact to influence the different patterns of problem construction found in the four historical periods. Chapter 8 will briefly summarize the study and suggest its implications for nursing practice, education and research.

CHAPTER 2

THEORETICAL FRAMEWORK

The literature reviewed in this chapter explains the theoretical framework for the study, which is formed by integrating the Wilkinson bifocal model with concepts of role and culture. This framework posits, generally, that moral problems are constructed by the people who live them, within a context in which the problems and the people are situated (this assertion is discussed in more detail in the next section, *Wilkinson Bifocal Model).* Further, the structure of a moral problem, or the way in which it is formulated by an individual, is determined in part by the interaction of person and culture. Some factors are unique to the person, others are specific to the culture or context. In support of this line of thinking, Ray (1994) concluded from her research that cultural contexts and the persons involved (as active agents of moral experience) shape experience, including ethical decisions, and that the decision makers are shaped by each other in moral interaction.

As a discipline, ethics has in the past relied heavily on logical, principles-based reasoning. However, it has been expanding to include consideration of meaning, value and context, as expressed through narratives. Liaschenko and Davis (1991) said:

> Our ethical lives are not a matter of making a decision about the logical priority of one principle over another. Rather, they are a matter of the kind of people we want to be, the way we want to live, and what is of value and concern to us. This is a matter of cultural discourse on the meaning of our lives, not logical decision making. (p. 269)

Jameton (1990) held that ethics *must* be studied in a social context. Because morality is a part of culture, he asserted, moral principles have no truth value and no social value apart from culture. Citing both Habermas and Sullivan, Waterman also said that "The emergence of any moral viewpoint must be understood in terms of the cultural and historical contexts within which it is formulated" (1988, p. 293). Hogan defined morality as systems of rules designed to guide behaviors in social contexts and said, "In the final analysis, moral behavior typically comes down to either following or disregarding a social rule of some sort" (1973, p. 219).

Wilkinson Bifocal Model

This section first discusses factors that influence the making and implementing of moral decisions: constraints and supports. It then presents the problem typology of the Wilkinson model as it existed prior to Phase 1 of this study.

In the Wilkinson bifocal model, the way in which a nurse experiences a particular moral situation (how he/she constructs the moral problem) is characterized in terms of the status of the moral decision and resulting moral action. For example: (a) Did the nurse know the right thing to do? (b) Was she focusing on her own actions or those of others? and (c) Were there constraints to her actions? When a person makes a moral decision it does not automatically result in a moral action. For many reasons, nurses may not carry out their moral decisions (see the section, *Factors Influencing Moral Actions*, beginning on page 22).

Philosophers and psychologists have almost taken for granted the distinction between moral decision and moral action. Kant's philosophy, for example, requires that for an action to be moral it must be freely chosen, based on duty and put into motion by the will. The very notion of willing an action presupposes that judging and doing are separate and must be linked by some phenomenon (i.e., the will). Examples of other philosophers who distinguish between deciding and acting are Sokolowski (1985), Jameton (1984), Robins (1984), Wetterstrom (1973) and Unamuno (1921).

Psychologists making the decision/action distinction have debated whether and how various psychological stages or cognitive processes relate to moral action. That literature is too extensive to cite here, but a few examples are found in Asch (1952), Blasi (1983), Candee and Kohlberg (1987), Gilligan (1977), Haan (1978), Kupfersmid and Wonderly (1980), Ward and Wilson (1980), and Waterman (1988).

Unlike philosophers and psychologists, nurses are only beginning to recognize the decision-action distinction. A few who have mentioned but not focused on separating decision and action are Allen (1974); Åström, Furåker, and Norberg (1995); Duckett, et al. (1992); and Pinch (1985).

Factors Influencing Moral Decisions

Various characteristics of the context and the nurse affect problem construction by influencing either the moral decision or the subsequent moral action. Contextual factors that affect moral decisions include but are not limited to cultures and subcultures, the facts (or type) of patient case, and situational supports and constraints. Individual differences in biology (e.g., brain chemistry), cognition (e.g.,

knowledge and problem-solving abilities), and emotion (e.g., moral motivation and empathy) undoubtedly also contribute to nurses' moral decisions. Such factors influence the decision about what is or is not good/right.

For a problem construction to exist, the nurse must first be aware that the situation involves a moral issue and needs ethical analysis, and that she is responsible for deciding (philosophers refer to this as moral autonomy and moral motivation). This resembles Lutzen and Nordin's grounded theory of *structuring moral meaning*, which is a spontaneous process that occurs prior to action, and which includes the processes of perceiving, knowing and judging (1993, p. 177). As they defined the concepts, perceiving is a cognitive function; knowing is similar to experience, knowledge and decision-making; and judging is similar to applying moral frameworks and values in the Wilkinson model. Jos (1988) also mentioned the cognitive functions of awareness and reasoning. He said that doing what is right requires ". . . awareness and sensitivity to the moral implications of a situation," and "the ability to reason . . . through a process of conscious critical deliberation" (p. 327). Empirically, cognitive variables such as critical thinking and intelligence have been found to be positively related to moral reasoning, especially by deJong (1985), Fleeger (1986), and Mustapha (as cited in Ketefian, 1989).

Context in the bifocal model functions more obviously as a constraint to action than as an influence on decisions. However, context undoubtedly affects decisions—as well as actions—to the extent that people are socialized, because socialization itself directly affects cognitive and moral development and awareness (Kohlberg, 1971). Supporting that idea, Omery (1986) found a mode of moral reasoning, which she called *accommodating reasoning*, in which nurses reconciled their reasoning to fit what they perceived to be the group norm. And finally, Shipps (as cited in Chafey, 1992, pp. 92-93) interviewed 41 staff nurses and found that 3 of the 8 factors used by the nurses in their moral reasoning about truth telling were related to the practice environment (e.g., whether the medical plan was clinically justified, head nurse's expectations, and legal responsibilities).

Factors Influencing Moral Actions

To reiterate, a moral decision does not necessarily produce a moral action. Once the nurse decides what is right to do, she must decide whether and how to do it. For example, although 87% of the nurses in Martin's (1989) study considered themselves to be patient advocates, only 20% indicated that they would go up the

chain of command to remedy what they considered to be inappropriate treatment decisions. Some of the same contextual and individual factors that influenced the initial decision also affect the nurse's ability to implement the decision. There is ample nursing literature (see chapter 1) regarding situational constraints on nursing action. Individual differences in biology, cognition and emotion also appear to contribute to the nurse's ability to translate her moral decision into action. For example, factors such as knowledge and empathy influence the extent to which nurses can overcome situational constraints.

Nurses with limited skills in managing ethical situations are more likely to experience action problems. Citing a 1993 study that used the Dreyfus' et al. theory of skill acquisition in unstructured problem areas, Åström, Furåker and Norberg said:

> The nurses disclosing limited skills . . . seemed imprisoned in their situation and their main problem was not in understanding what was good and right, but being able to act in accordance with their conviction. (Åström, Jansson, Norberg & Hallberg, as cited in Åström et al., 1995, p. 1079)

The nurses who experienced action problems exhibited the following characteristics: powerlessness, fear of other people's opinions, inferiority, disappointment, willingness but lack of time, relation-dependent decisions, bearing traumatic experiences, avoiding the patient, and uncertainty (Åström et al., 1995, pp. 1075-1076).

Constraints can be perceived or actual. More experienced and knowledgeable nurses are more aware of their rights within the system and appear to have a more realistic perception of the likelihood and severity of any consequences to themselves, and may therefore perceive fewer constraints to their actions. The amount of experience and the knowledge of available options also affect the degree to which the nurse can circumvent constraints and implement the moral decision (Wilkinson, 1985, 1987/88).

Although they used different language, support for the preceding line of reasoning can be found in Rest (1983) and Schlaefli, Rest and Thoma (1985). Rest conceptualized four requisite elements to produce moral behavior. Two of those (moral sensitivity, and making the moral judgment) relate to the moral decision; the other two (motivation and moral character) relate to the moral actions. *Motivation* and *moral character* are, respectively, the desire to be moral and the persistence and know-how to actually carry out the behavior. Schlaefli et al. did not address contextual

constraints and supports, except as can be implied from the notion that motivation and moral character are needed in order to produce moral behavior.

Constraints and Supports

Constraints are those internal and external factors that inhibit/prevent moral action; *supports* are those that facilitate moral action. Contextual constraints are important in the bifocal model because their presence is one of the necessary conditions for producing the four most troubling action problems for nurses: moral distress, moral outrage, moral heroism and whistleblowing.

Ashley (1976) and Kramer (1974) documented the organizational pressures operating in the hospital setting, but made no direct connection between organizational pressures and moral decision making. However, at about that same time, the nursing literature began to point out that nurses were often unable to carry out their moral decisions. In a poll of its readers, *Nursing Life* ("How Ethical are You?" 1983) found that of the 5,000 nurses responding, 83% had found it necessary to compromise their moral values in their clinical practice. Benjamin and Curtis (1981) pointed out, in general terms, that "the nursing context is characterized by a number of constraints that frequently make the exercise of autonomy problematic" (p. 23). Mitchell (1982) also said, "The constraints upon nursing integrity are a major factor in the well-documented dissatisfaction and 'burn-out' phenomenon noted in the nursing profession" (p. 175). And finally, Haddad (1993) said, "To a degree the nurses in all the cases cited previously [in her study], are prevented from doing what they have decided is right" (p. 8). Those authors did not elaborate on specific constraints.

Internal constraints.

Internal constraints consist of various biological, cognitive and psychological/emotional factors (e.g., moral frameworks, perceptions, role conceptions, awareness, personality and motivation). Those factors are encompassed in what Rest (1983) and Schlaefli et al. (1985) call moral motivation and character. Internal constraints are influenced by formal socialization and developed within the context of powerful cultural influences.

Although internal constraints are culturally influenced, their specific combination is unique to each individual. According to Jos (1988), "internal obstacles [to moral judgment and action] range from obvious physiological impairments to less obvious psychological weaknesses that may undermine the degree to which the

individual is capable of self-direction" (e.g., mental illness). The constraints more commonly are that "we experience a loss of control when overwhelmed by our emotions and passions"; we become "a slave to our instincts or selfish desires" (p. 323), and "individuals often suppress any awareness of unethical practices in the workplaces . . . . Personal loyalty to fellow workers or superiors will often override moral conviction" (p. 325).

One study identified personality characteristics that undoubtedly could function as constraints to moral decisions and actions. Mauksch (1977) demonstrated that nurses had a low need for risk-taking and a high need for succorance, submissiveness, order, and avoidance. Crisham (1981) identified cognitive and emotional factors that functioned as constraints, but she did not describe them or explore them in depth. Using hypothetical moral dilemmas, she asked staff nurses to make decisions and then interviewed them to see what factors had influenced their moral reasoning. Nurses indicated that their judgments were altered by the following internal pressures: "opposing loyalties to the nursing profession, the hospital, and the patient" and "confusion about the most effective way to utilize the vast and expanding body of professional knowledge" (p. 110).

Nurses in a previous study (Wilkinson, 1985, pp. 81-82) named most frequently as internal constraints (a) their background and experiences and (b) lack of initiative because of the futility of past actions. They spoke of a variety of other specific constraints: (a) self-doubt ("I was thinking I might be wrong—that maybe I'm biased"), (b) hope for a miracle, (c) concern for reputation (". . . get a reputation . . . of being a troublemaker, or not have the respect of that doctor"), and (d) lack of courage ("Maybe I didn't have the backbone to refuse"). It seems apparent that although those hopes, concerns and attitudes are internal to the nurse, they would have been shaped in part by professional socialization and organizational culture, which are discussed in the next section, *External Constraints*.

External constraints.

External constraints consist of the cultural context and environment (specifically including cultural expectations, socialization and threats of sanctions, for example). These powerful forces both influence and are mediated by personality and other characteristics of the individual. The literature contains a myriad of external constraints conceptualized in various ways and at various levels. I have tried to

organize them into the following relatively concrete categories: (a) organizational culture and socialization, (b) physicians and administrators, (c) laws, policies and licensing, (d) past experiences, (e) families and patients, and (f) other nurses.

Organizational culture and socialization. It is well documented that the institutional culture frustrates the ability of nurses to carry out their decisions—including those involving moral issues (Ashley, 1976; Augustine, 1991; Crisham, 1981; Erlen & Frost, 1991; Fenton, 1987; Ketefian, 1981; Kramer, 1974; McShea, 1978; Wilkinson, 1987/88). Actions open to nurses in carrying out moral decisions are severely limited by the organizational bureaucracy (Davis & Aroskar, 1983; Jameton, 1984; Murphy, 1978).

Among the first to discuss institutional constraints were Davis and Aroskar (1978). They included the power imbalance between nurses and physicians, the nurses' employee status, and the fact that nursing is a *semiprofession* made up predominantly of women. A semiprofession is:

> more bureaucratic and subject to numerous rules governing not just the central work tasks, but extraneous details of conduct on the job. Semiprofessionals do not have a strong reference group orientation to colleagues . . . . Therefore they become more willing to accept an administrative superior as [a source of norms]. One reason given for this pattern in the semiprofessions is the prevalence of women, who seem to be more amenable to administrative control than men, less conscious of organizational status, and more submissive in this context than men. (Davis & Aroskar, 1978, p. 56)

Gilligan (1977) commented that women's lack of power makes them vulnerable and reluctant to take a stand on moral matters—to the extent that women perceive themselves as having no choice, they excuse themselves from the responsibility for decision making.

Physicians and administrators. Nurses fear physicians and administrators because of their power over them in the work setting. Because of the employee status of most nurses, whether they have a job or not is controlled to a great extent by physicians and administrators. There is evidence, much of it empirical, that nurses often perceive administrators and physicians as threats rather than supports in moral situations. Their mental anguish then occurs because they are afraid to implement the clear decisions they have made (Andersen, 1990; Applegate, 1984a, 1984b; Bunzl, 1975; Fenton, 1987, 1988; Meyers, 1994; Rodney, 1988; Savage et al., 1987; Wilkinson, 1987/88). Aikens (1929) provides an early example:

> Not infrequently, a nurse is torn between her desire to be loyal to the patient's interests, and not be disloyal to the doctor, who has it in his power to turn calls in her direction . . . . nurses should understand how physicians look at the matter and proceed cautiously in doubtful situations. (p. 184)

One of the peculiarities of the nursing practice context is that nurses are subjected to a dual system of authority, in which they must respond to demands of both physicians and administrators of the employing organization. Physicians, as clients of the hospital, are usually in a more advantageous decision-making position than nurses, who are employees of the hospital. Actions open to nurses in carrying out moral decisions are severely limited by lack of clarity about their responsibilities and conflicting expectations of those in authority (Crisham, 1981; Davis & Aroskar, 1983; Jameton, 1984; Murphy, 1978). Curtin (1978) said:

> The nurse is commonly placed in the paradoxical situation of knowing that even if (or most particularly if) she/he practices her/his profession responsibly in accord with established standards, she/he is quite likely to suffer recrimination, possibly job loss. (p. 9)

Shelp and Ternes (1980) stated that external constraints may make it dangerous for nurses to use an appeal to conscience to preserve their integrity—the cost may be too great:

> An appeal to conscience as a basis for refusing to commit a proposed act may serve to guard the moral integrity of the nurse but perhaps not without some other cost to the nurse (e.g., loss of job, reassignment, failure to receive a pay raise or promotion, etc.) (p. 6)

Griffiths (1993) related an actual incident in which a physician retaliated against a nurse. A cancer patient asked the nurse to recommend a holistic physician. The nurse provided that information, and when the patient went to the new physician, the patient's general practitioner called to ask what was going on.

> [The nurse] repeated the patient's request and explained her response . . . . [She] thought the matter was resolved; the GP apparently did not. A call from the hospital administration informed [her] that a letter had been written criticizing her for giving her patient information about another physician. The letter had gone to three administrators and an oncology radiologist. (p. 25)

Physicians were by far the most frequently mentioned constraints in the original Wilkinson (1985) study of moral distress. While the study in no way proved that all or many physicians are actually as powerful or vindictive as the nurses

portrayed them, the nurses in that study certainly viewed them in that manner. Whether realistic or not, their perceptions functioned as a strong constraint to their moral actions. In related studies, Davidson et al. (1990) and Jannson and Norberg (1989) reported that 40% of their subjects indicated they would change their positions on feeding a terminally ill patient if the rest of the nursing team disagreed with them, or if the physician so ordered.

Policies, laws, and licensing. Nursing practice is subject to regulation by various bodies, for example: professional organization standards of practice, state nurse practice acts and licensing laws, hospital policies, and state and local laws governing such subjects as living wills, libel, slander, and regulation of narcotic medications. In addition, there hovers the threat of civil action via a lawsuit by a patient or patient's family. All of these, and more, function as constraints to moral action.

Nurses in Rodney's (1988) study said that "situational constraints such as physicians' orders and hospital policies were interfering with their ethical obligations to their patients" (p. 10). A physician speculated that nurses' autonomy is limited by a "litigation-conscious nursing administration shackling its own professionals . . . . The nurse . . . finds herself handcuffed by a wild proliferation of procedure codes telling her what she can*not* do" (LeMaitre, 1981, p. 1487). Noting the proliferation of policies in the 1980s, Jameton (1984) asserted that the bureaucratic form of management had become as much of a hazard to autonomy as were physicians. Staff nurses in Crisham's (1981) study reported that they were constrained by "hospital policy which conflicted with their own concepts of fairness" (p. 110).

Perception is an important factor in this type of constraint. Nurses seem very conscious of legal constraints, even though few actually ever experience legal sanctions. This may be because legal sanctions, when they do occur, can be very serious. Also, nurses may feel more threatened than protected by the legal system. Most nurses work without an employment contract, so when they are required by an employer to perform an act that conflicts with their professional duty to their patients, "nurses must choose whether to risk their job or fulfill professional obligations of patient advocacy" (Kraemer, 1993, p. 9). They are caught in a legal double bind. "If nurses follow the employer's directives, the state's Board of Nursing may initiate an action against them for violating the . . . nurse practice act" (Kraemer, 1993, p. 9). Kraemer noted that courts have only rarely supported nurses who try to take action

against the employer for wrongful termination, even when following the employer's directive would have caused the nurse to violate the state's nurse practice act.

Past experiences. Childhood experiences, formal education and professional experiences can all create constraints to moral action. Many nurses have been taught at various levels of their education first to obey the law, and next to follow orders. Those who are inexperienced and unsure of how to make things happen in the practice arena have more difficulty implementing their moral decisions (Wilkinson, 1985, p. 80). Nurses in Cahn's (1987) study mentioned being constrained by years of tradition and professional socialization.

Anspach (1987) observed that in making life-and-death decisions about newborn infants, the interactive data provided by nurses was devalued, essentially ignored, by physicians. Being exposed to such experiences over time can lead to lack of initiative because of feelings that action is futile. Fenton (1987) found that nurses' inability to effect their advocacy role produced disillusionment and subsequent withdrawal from the ethical decision-making process.

Families and patients. Families and patients can function as constraints because of the ever present threat of lawsuits. However, there is more to it than that. Nurses sometimes participate in what they believe to be immoral actions, in the sense that they are harmful to the patient, in order to meet the needs of a family, not because they fear the family. For example, nurses may suffer moral distress from participating in life-prolonging treatments because the family "isn't ready to let go" (Wilkinson, 1985).

Other nurses. Nurses have mentioned peers, head nurses and supervisors as constraints to their moral actions (Wilkinson, 1985). Another study showed that neonatal intensive care nurses' intentions to resuscitate were "modified by their perception of what others [including their peers] expected them to do, or the subjective norm" (Savage et al., 1987, p. 373). Other theoretical literature agrees. Guillemin and Holmstrom (as cited in Cunningham & Hutchinson, 1990, p. 237) stated that "peer group pressure—pressure to conform, the belief safety is located in consensus and protocol militate against ethical creativity"; and describing his experiences with peers in medical school, a physician said:

> Psychologically, the safety of the norm is even more important and ubiquitous. You *feel* safe, not just legally but morally, to the extent that you do what everyone else is doing. (Konner, 1987, p. 366)

Rodney's (1996) most recent study added to the list of external constraints the history of relationships and decision processes among nurses on a unit. She conceptualized moral agency as being enacted within a matrix of interdependent relationships and noted that the relational matrix can be either supportive or problematic in terms of a nurse's ability to do what he/she believes to be good for a patient. In Wilkinson bifocal model terminology, that would mean that the history of relationships and the current relationships on a unit sometimes function as a contextual constraint, preventing nurses from implementing their moral decisions.

Typology of Problem Constructions

Given the same set of "facts" and the same context in an ethical situation, different people will construct different problem types. For example, in a previous study of moral distress, some nurses responded to a Do Not Resuscitate (DNR) order with moral distress, while for others it represented no problem (Wilkinson, 1985). Similarly, Akerlund and Norberg (1985) found that staff nurses in one institution experienced the force feeding of patients in different ways. Categorizing according to the ethical rule nurses used to guide their behavior, they found four different groups of nurses:

- Group #1 consisted of nurses who force fed patients, did not view their feeding method as violence, and did not experience anxiety.
- Group #2 force fed patients, perceived they were causing the patient to suffer, and were very anxious they might choke the patient.
- Group #3 viewed keeping the patient alive as a task, focused on that, and had few fears of choking patients.
- Group #4 focused primarily on the rule, "Don't cause suffering," were emotionally distant from their patients, and experienced much difficulty with their work.

Although their data were not analyzed in bifocal model terms, clearly the nurses encountered a similar issue in a single context and experienced it in different ways. If in a particular situation, different nurses construct the problem in different ways; then logically, it would also seem that the same nurse would construct a particular issue (e.g., DNR) differently in different sociohistorical/cultural contexts.

Assuming that moral problems are constructed individually and are therefore varied, the Wilkinson model includes a typology of different problem constructions for the purpose of differentiating among the various types of problems. In the Wilkinson model, moral problems in nursing sort into two broad categories: decision focused ("What is the right thing to do?") and action focused ("What is it possible for me to do?").

Decision-Focused Problems

Decision-focused problems are those situations in which the difficulty lies in determining the right action to take. The central question is: "What *is* the right thing to do?" Decision-focused problems consist of two sub-types: (a) moral uncertainty and (b) moral dilemma. The model used as a framework for Phase 1 is shown in Figure 2.1.

Moral Uncertainty

Moral uncertainty occurs when one is not sure what principles or values apply, or perhaps cannot even clearly identify the nature of the problem (Jameton, 1984). For example:

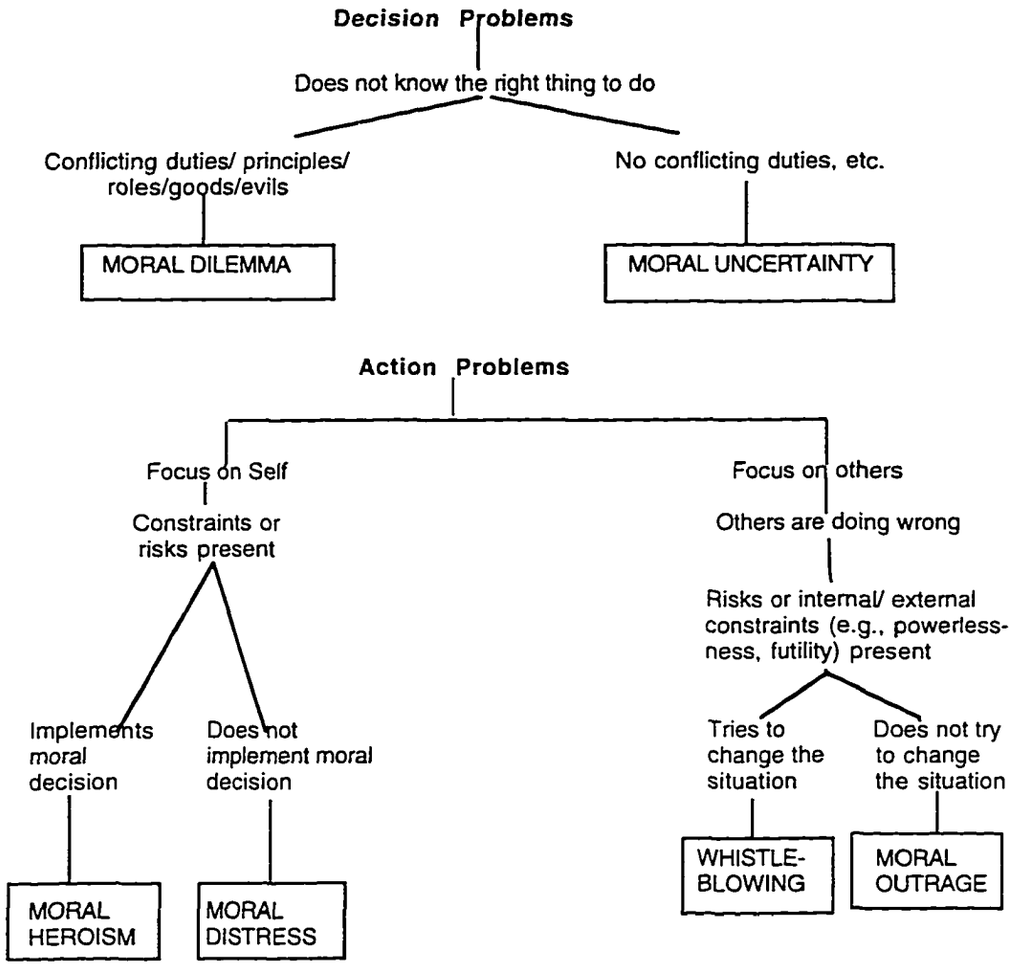
> I was asked to do nothing to prolong or shorten the life of a 4-5-month-old fetus once it was delivered into a surgical pail
>
> . . . . At birth the fetus was emaciated and unresponsive with an Apgar of 2 and 3. I baptized the child. It was a boy . . . . I checked it from time to time and I noticed he moved around a little in the pail. About two and a half hours after his birth, the boy died. The mother left the hospital six hours after her delivery. I cried. I am crying now as I write this. (Haddad, 1993, p. 9)

Moral Dilemma

A moral dilemma occurs when two or more moral principles clearly apply, and the principles call for mutually inconsistent actions (Jameton, 1984). One cannot carry out both actions, or both actions are equally unsatisfactory (Levine, 1989); so no matter what one does, an important value must be sacrificed. For example:

> Because a nurse is committed to the principle of relieving suffering, he wants to give as much morphine as possible to a dying patient. Yet, because he values the principle of sanctity of life, he wants to give a smaller dose because he fears he will fatally depress the patient's respirations. The nurse is not comfortable with either choice, but can see no other alternatives. (Wilkinson, 1993, p. 4)

Figure 2.1. Wilkinson Bifocal Model of Nursing Ethics Prior to Phase 1



Action-Focused Problems

Action-focused problems are those in which the nurse feels secure in her judgment about what is right, but is prevented from carrying out that moral judgment. The central question is: "What risks am I willing to take in order to do what is right?"

At the beginning of this study action-focused problems included four sub-types: moral outrage, moral distress, moral heroism, and whistleblowing. Three new sub-types emerged from the data during Phase 1 and were added to the theoretical framework for Phase 2: moral judging, moral weakness, and no problem (see Appendix B for definitions of problem sub-types; see chapter 6 for discussion of the new sub-types that emerged in Phase 1).

Moral Outrage

Moral outrage occurs when the nurse believes that others are acting immorally, but feels powerless to stop them. The nurse, who does not participate in the act and who does not even consider that intervening is possible, consequently does not feel responsible for the situation. The resulting painful feelings (usually anger) are directed at the "immoral others" (Wilkinson, 1985; 1987/88). For example:

> A physician . . . . entered a note which was placed between other attending physicians' notes throughout the previous week which would indicate he visited the patient each day when we nursing staff knew that he had not seen the patient in one week even though he had been frequently paged and his office notified. What worried me about this particular situation is other nurses and physicians knew about this and nothing was said or done by the physicians or nursing supervisor. I was told it was "medical politics." (Haddad, 1993, p. 7)

Moral Distress

Moral distress occurs when the nurse knows the right thing to do, but cannot pursue the right course of action because of institutional or other constraints (Jameton, 1984; Wilkinson, 1985, 1987/88). The nurse focuses on his own actions in the case (in contrast to moral outrage, where the focus is on the actions of others). For example:

> A respirator-dependent, premature newborn was never able to exist apart from life support equipment. After more than six months in the neonatal intensive care unit it became apparent that the infant had no "reasonable" hope for survival and would most likely be neurologically impaired. Considering the lack of hope for the baby, the cost already incurred by the prolonged treatment, and the suffering of the baby, the family, and the caregivers, the nurses believed that life support should be terminated. However, this was not done, and the nurses had to continue caring for the infant. Some of the nurses experienced distress to the point that it affected their care. One said: "In the end I refused to look at that baby—I couldn't stand her. . ." (Adapted from Anspach, 1987, p. 226.)

In her philosophical dissertation Cahn (1987) referred to moral distress as "a sense of moral surety as to what is right or wrong, coupled with the inability to act appropriately because of external constraints" (p. 9). Wheeler's (1990) concept analysis agreed essentially with the Cahn and Wilkinson (1985) definitions. Using my definition, Fenton (1987) and Rodney (1988) described cases of moral distress.

Moral Heroism

Moral heroism occurs when the nurse is confident of having made the right moral decision, and carries out that decision regardless of the presence of constraints or threats. In this type of problem one is concerned with one's own actions rather than the actions of others. Cahn's (1987) philosophical examination of moral heroism forms the basis for the definition of moral heroism in the Wilkinson bifocal model. Moral heroism is identical to moral distress in that the focus is on one's own actions and there are contextual constraints to implementing the moral decision. The difference is that a moral hero carries out the moral decision despite the constraints, whereas in moral distress the nurse fails to implement the decision.

Whistleblowing

In the Wilkinson model, whistleblowing is considered a special case of moral heroism, in which the nurse believes that other health care providers (either individuals or organizations) are doing wrong, believes she has a personal responsibility to make a disclosure (usually a public disclosure) of the wrongdoing, and implements this decision despite personal risk or threat. It differs from moral heroism in that the nurse focuses on others' actions rather than on her own actions.

Whistleblowing frequently is done to expose negligence, abuses, or dangers to the public welfare, but may also be done to expose personal victimization, as in the case of sexual harassment (Andersen, 1990; Theodore, 1986). Typically, but not always, the whistle-blower exhausts all sources for problem resolution before "going public" (Petersen & Farrell, 1986).

Whistleblowing is identical to moral outrage in all dimensions, except that whistleblowers carry out their moral decision. They start constructing the problem by focusing on the immoral actions of others (moral outrage), and then begin to feel personally responsible for stopping those actions. At that point the moral outrage evolves into whistleblowing.

Special Relevance of Moral Distress

Because of the imbalances in socio-economic-political power and the place of nurses in the hierarchical structure of the system in which they work, I anticipated prior to Phase 1 of this study that nurses would be especially likely to experience moral distress as compared to other types of moral problems. Jameton (1984) had also made this speculation. Cahn (1987, p. 21) said that most of nurses' moral

problems "may not be dilemmas at all, but rather situations of moral distress;" and Haddad observed that "to a degree the nurses in all the cases cited previously [in her study], are prevented from doing what they have decided is right" (1993, p. 8).

It is well documented that institutional culture frustrates nurses' ability to carry out decisions (an antecedent to moral distress), including those involving moral issues (Ashley, 1976; Augustine, 1991; Crisham, 1981; Erlen & Frost, 1991; Fenton, 1987; Ketefian, 1981; Kramer, 1974; McShea, 1978; Rodney, 1988; Wilkinson, 1987/88). It seemed likely, therefore, that moral distress would be the type of ethical problem encountered most frequently by nurses, especially those working in hospitals.

Role Theory

One statement from the Wilkinson (1985) study is that nurses' role conceptions are linked to the manner in which they experience moral situations. For example, the definition of moral distress requires the making of a moral decision as a necessary antecedent. Therefore nurses who do not conceptualize autonomous decision-making as a part of their role could not experience moral distress because they would have no moral decisions to implement. Role theory supports this as an assumption of the bifocal model, maintaining that "when the social structure is a source of vague, difficult, or conflicting role expectations, role occupants may experience tension, frustration, and anxiety" (Hardy & Conway, 1978, p. 108).

Hardy and Conway (1978) also theorized that *role stress* is created by *role ambiguity* (disagreement about which norms are relevant to a role) and *role conflict* (role expectations that are contradictory or mutually exclusive). For example, role ambiguity would occur when nurses and employers disagree on the degree of autonomy appropriate to the nursing role; role conflict would occur when nurses hold the role expectation that they are patient advocates, but also hold that they must follow hospital policies and medical orders. Meyers (1994) identified role ambiguity as one of the factors associated with the moral suffering of critical care nurses.

Murphy agreed that nurses' role conceptions affect the way they function in moral situations. She said that there is a "historical sense of being trapped in restrictive role definitions, powerless to help patients, families or other nurses" (1993, p. 3). She urged nurses take a proactive approach to ethical decision-making, by changing their role definitions to include responsibility and independent judgment.

Framing nursing ethics in a philosophical foundations approach, nurses' ethical actions would emanate from the views they hold about the nature of nursing,

including their role conceptions. It may well be that a nurse's role conception is one of the strongest factors in determining her reaction to and construction of a moral problem. "It matters very little what moral theory or moral principles a nurse may hold if the nurse's role conception forbids acting on those beliefs. For this reason, a discussion of various views of the nurse's role are of utmost importance for nursing ethics" (Pence & Cantrall, 1990, p. 1).

Empirical work supports the conjecture that role conception affects moral functioning. Typically, such studies present a story of a realistic nursing dilemma, followed by a series of questions that ask nurses what ought to be done and what, realistically, they would actually do in the situation. Although the construct of ethical practice has not been consistently defined in the literature, investigators have attempted to measure the relationships between certain variables, including role conception, and moral behavior (ethical practice). Kramer's (1974) classic study of reality shock suggested that nurses' role conceptions and discrepancies between ideal and actual values affect the manner in which nurses practice. Ketefian (1985) found that a *professional categorical* (actual) role conception was correlated positively (r = .30) with moral behavior as measured by her instrument, "Judgments About Nursing Decisions." A *professional normative* (ideal) role conception was correlated negatively (r = -.13). with moral behavior, as was a discrepancy between actual and ideal roles. Whatever other conclusions may be drawn from that study, it is safe to say that role conception and the congruency between actual and ideal role conceptions do affect nurses' experience of moral situations. Kim (1989) also demonstrated that in addition to the work environment, nurses' professional and service role conceptions were important predictors of their ethical decision-making.

Importance of Autonomy and Advocacy

Nurses' role conceptions may include many concepts. On the basis of previous research (Wilkinson, 1985) and a review of the literature, I posited and supported in Phase 1 of this study that autonomy and advocacy were especially important role concepts in determining problem construction. They are of particular interest because of (a) the ways in which the two concepts are related and (b) the difference between nurses' role conceptions and their ability to enact them in practice.

Autonomy, as a part of a nursing role conception implies (a) that it is appropriate for nurses to make decisions, including ethical decisions, and (b) that nurses should have some degree of independence and accountability. *Advocacy* is the

articulation and defense of the rights and interests of another. Since the 1970s, advocacy has been the dominant metaphor for nursing found in the literature (Winslow, 1984). For many, advocacy has assumed the stature of a moral duty. The ANA *Code of Ethics for Nurses* instructs nurses to advocate for their patients, and nurse philosopher Sally Gadow (1989) said that "advocacy is the *moral commitment* to enhance patients' autonomy" (p. 535) [italics added]. Current research confirms that advocacy is an important dimension of nurses' role conceptions (e.g., Wlody, 1994).

Relationship Between Autonomy and Advocacy

As a rule, one must possess some degree of autonomy in order to function as an advocate (see *Definitions of Terms* in Appendix B and discussion of advocacy in chapter 5). Logically, it seems that nurses who have a strong role conception of advocacy and autonomy would be likely to experience conflict when they encounter ethical situations that prevent their fulfilling these role requirements. Support for this line of reasoning is provided by Winslow's (1984) classic discussion of advocacy as a metaphor for nursing, in which he argued that nurses who adopt the role of advocate are bound to be torn by conflicting interests and loyalties. Pinch (1985) also said:

> It was believed that the possession of professional autonomy to so implement one's decision would affect the kind of action taken in the professional role. If autonomy was not part of the role, or restrictions existed in the work setting that prevented autonomous action, then anxiety from the ethical dilemma might result . . . from the inability to implement the desired solution. (p. 372)

There is some empirical support for this line of reasoning, as well. In an investigation of moral reasoning of nurse practitioners, Murphy (1979) identified and categorized nurse-patient relationships as patient advocate, physician advocate, or bureaucratic. In that study, autonomy was clearly a dimension of the patient advocate model, in which the nurse:

> . . . considers her moral authority to be as great as any other health professional and sees her first responsibility to and for the patient as a unique human being . . . to help facilitate the patient's efforts to obtain whatever care is needed, even if it means going against the doctor or the hospital administration. (p. 19)

Meyers, too, concluded that if the profession of nursing "embraces patient advocacy as the central purpose of its existence, then nurses are vulnerable to the possibility that this purpose may be frustrated, it may be an end they fail to meet or a possibility that may never be realized" (1994, p. 74).

Role Conception vs. Practice Reality

Traditionally, autonomy and patient advocacy were not a part of the nursing role. However, in the 1960s and 1970s, with the changing roles of women and the shift to baccalaureate and higher nursing education, nurses began to rethink their roles to include these concepts (Benjamin & Curtis, 1987; Murphy, 1984; Winslow, 1984). The concept of advocacy has even been incorporated into nursing codes of ethics such as that of the American Nurses Association (1985). Nevertheless, many have questioned whether nurses, especially those who work in hospitals, actually have the autonomy needed to function as patient advocates (Benjamin & Curtis, 1987; Cahn, 1987; Miller, Mansen & Lee, 1983; Trandel-Korenchuk & Trandel-Korenchuk, 1990; Winslow, 1984; Yarling & McElmurry, 1986a; Zusman, 1990). Some authors have even denied the need for an autonomous, professional nurse (Newton, 1981; Packard & Ferrara, 1988).

There is evidence that the degree of autonomy nurses perceive as appropriate to their role is different from what they actually experience in practice. Studies such as Blegen's (1993) and Pinch's (1985) have shown autonomy to be moderately related to job satisfaction, suggesting that many nurses include autonomy in their role conception. In a study by Case (1991), pediatric nurses told passionate stories about violations of their autonomy when physicians interfered with or obstructed the nurse's care of a child. In a study by Collins and Henderson (1991), nurses perceived that they were expected to practice autonomously, but most felt little support for doing so within their hospital work environment.

Nurses' Preferences for Autonomy

Although autonomy is a part of the role conception of most nurses, individual nurses differ greatly in their desire for autonomy. For example, although most nurses in the study by Blegen and associates (1993) supported nurse autonomy, a sizable minority did not. In their review of the literature, Dwyer, Schwartz and Fox (1992) reported that previous research actually tended to support the preference of nurses for other-centered decision making. The results of their study, however, indicated that

individual nurses differ greatly in their need for autonomy. This seems reasonable since *preference*, by definition, is an individual matter. The possible explanations for differing preferences for autonomy are probably innumerable, but to mention two that may be relevant to this study: (a) Cassidy and Oddi (1988) found a significant effect for educational levels on nurses' attitudes toward autonomy, and (b) Fenton (1987) found that some nurses pull themselves out of the ethical decision-making process after becoming disillusioned when their lack of autonomy prevents fulfillment of their advocacy role conception.

Culture Concepts

In this study culture is important because, as the context for moral problems, it influences nurses' role conceptions and moral problem constructions, and can constrain or support their ability to act morally. Kemp (1988) has said that any story is always embedded in the story of the larger culture; and Jameton (1990), in treating the relationship of morality and ethics to culture, held that ethics must be studied in a social context.

Culture is the set of shared values, beliefs and meanings within society and organizations that is transmitted among people from one period to the next and used to define reality (Geertz, 1973; Reilly & DiAngelo, 1990). Culture includes expected behaviors (behavioral norms): "Each culture consists of specific values and behaviors, which are melded together in a unique pattern that is different from that of any other group" (Coeling & Simms, 1993, p. 47).

Within cultures, there are *subcultures*—social groupings with clusters of beliefs, values, relationships and practices that identify them. For example, nurses and physicians as different subcultures have different beliefs and values—hence the "caring vs. curing" characterization of nurses vs. physicians in some of the literature (Jameton, 1990). In this study, healthcare culture, organizational culture, and the nursing culture were all considered as subcultures of the American (United States) culture.

Organizational Culture

Organizational culture is the "taken-for-granted and shared meanings people assign to their work surroundings" (Fleeger, 1993, p. 39). According to Schein, organizational culture is "the pattern of basic assumptions and shared meanings (values) that a group develops to survive their tasks and that works well enough to be

taught to new members" (as cited in Coeling & Simms, 1993, pp. 46-47). Common to those two definitions are the concepts of work and shared meanings.

Subcultures within an organization include work group culture, professional cultures, managerial culture and unit cultures. Subcultures develop because "different groups have different work to do; hence they need different survival strategies to cope with their jobs" (Coeling & Simms, 1993, p. 48).

Culture, and specifically organizational culture, is an important determinant in nurses' reactions to moral situations. Corley and Raines (1993) noted that "the influence of the organization can be more powerful than the nurse's commitment to the patient" (p. 68). Binder (1983) concluded that there is a need to integrate "personal or more universally held values into an organizational/technologic environment"; and further said that modern organizations are based on "dispensability, specialization, malleability, obedience, planning and paternalism" (p. 116, 118). Organizations insure centrality of decision making by requiring that low-ranking employees accept decisions reached by employees higher in the hierarchy. They structure employees' decision-making environment by imposing rules to limit their discretion, by taking decision making out of their hands entirely, by controlling the communication system and flow of information, and by encouraging the employee to internalize the values and decision rules of the organization through training and indoctrination. The effect is that employees are not allowed to make decisions, do not believe they should make decisions, and probably could not decide effectively if they were asked to make decisions (Murphy, 1978).

Jos's (1988) philosophical analysis supports Murphy's assertion, as well as the notion that culture influences role conception and moral problem construction. He held that modern organizations encourage self deception and diminish the individual's capacity for "moral sensitivity, understanding, and courage" (p. 328). Jos said that:

> Organizations . . . foster conformity and dependence, and "they erode the individual's *capacity* for independent thinking and decision making . . . . organizations not only require workers to do things they might not otherwise do . . . they undermine the capacity of workers to make their own judgments about what they should do. By uncritically deferring to others, workers may become party to immoral or illegal activities and policies. In short, it is the worker's *autonomy*, his status as a chooser, that is at stake." (p. 323)

The Interaction of Culture and Role

I assumed for this study that moral decisions are contextual and that culture is an important dimension of context. Furthermore, even though role conceptions are psychological and internal, they are developed in and influenced by one's culture. For example, Surbone (1992), an Italian, commented that respect for autonomy has become virtually a moral absolute in the United States. The cultural emphasis on autonomy and independence in the United States has undoubtedly created a context in which many nurses would develop a role conception of nursing autonomy. That many do not have an autonomous role conception, may also be due to another aspect of our culture—which tends to reward autonomy and independence in men but not in women. This example of culture and autonomy illustrates that culture must be considered when analyzing role conceptions.

In extending and refining Vygotsky's work in sociohistorical psychology, Carl Ratner argued that psychology—including such processes as logical reasoning, memory, perception and emotions—is profoundly dependent upon the social environment. Ratner (1991) accounted for individual variations (e.g., role conceptions in this study) by explaining that individuals are not passive recipients of stimuli, social or otherwise. They are active agents, seeking for meaning. In so doing, they selectively draw from their culture. The individual is always somewhat different from the social influences that act on him because he incarnates them (fleshes them out), totalizes them, and reflects upon them.

Feminist theorists, too, (e.g., Campbell & Bunting, 1991) hold that knowledge is socially constructed and exists only inside the context in which it is created. Adopting a life-course perspective, Giele (1993) pointed out that because later events are shaped by earlier events, different age cohorts tend to experience the same historical events in different ways. Therefore, in order to understand human behavior (or in this study, problem construction) one must understand both personal meanings (which include role conception) and communally agreed upon meanings (cultural norms). This reaffirms the notion that role and culture are interrelated and work together to influence problem construction.

Culture and the Bifocal Model

Another assumption of this study is that moral problems are not a priori entities that exist "out there," like new viruses, waiting to be measured and observed. They are, as are other realities, socially constructed. "Each culture provides people

with a way of seeing the world. It categorizes, encodes, and otherwise defines the world in which people live. Culture includes assumptions about the nature of reality" (Spradley, 1979, p. 10). Speaking generally, therefore, one would expect culture to influence problem construction.

Applying this idea specifically to decision-making in the neonatal intensive care unit, Anspach (1987) acknowledged the contribution of sociology in revealing medical decision-making as a social process. Anspach demonstrated empirically that "the organization of the intensive care nursery as a work environment structures the perceptions of those who work within it" and that the practical circumstances of the work shape the decisions of the health professionals (p. 216).

Speaking to the same point, Davis (1994) noted that physicians and nurses define situations differently. She said:

> Ethical reasoning and decision making occur within specific social contexts and these contexts establish norms of dominance and legitimation. Such norms determine what is discussed, how it is discussed, and by whom. (p. 14)

To illustrate the point, Davis compared a seven-country cross-cultural study on active voluntary euthanasia (Davis, Davidson, Hirschfeld, Lauri & Lin, 1993) to an Australian study (Kuhse & Singer, 1992). She speculated that the two studies differed in their findings because the variations in the relationships and social situations of the groups caused differences in how a patient's request for euthanasia would be viewed by nurses. In the terminology of the present study, that would be similar to differences in the way the nurses constructed the problems/realities.

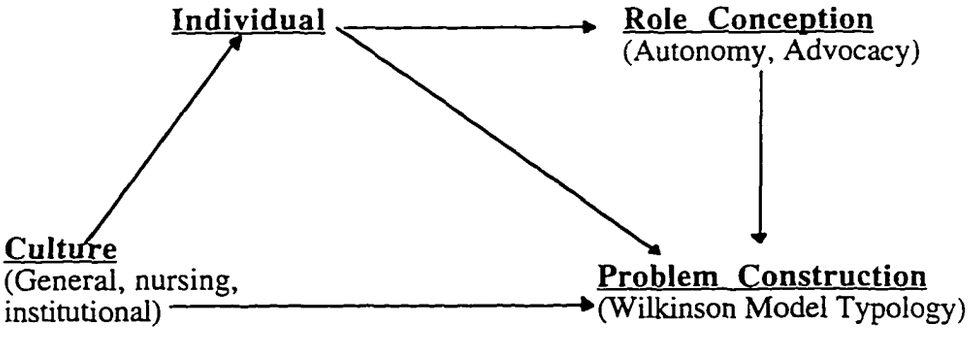
The concept of *cultural dissonance* may also be helpful in explaining the fit of the Wilkinson bifocal model to the data from different time periods. In her study of organizational culture, Fleeger (1993) said that cultural dissonance exists when two or more cultures operate in conflict rather than harmony. In the Wilkinson model, cultural dissonance might be operating when nursing culture directs the nurse to advocate for the patient, but the hospital culture directs the nurse to follow a hospital policy that precludes such action. Binder (1983) noted that "caring values of nurses . . . do often conflict with administrative values and orientations based on efficiency, standardization, and proceduralism" (p. 117). And finally, Berger and colleagues' (1991) general conclusion supports the notion that cultural dissonance may be present for nurses and affect the manner in which they experience moral problems:

> The difficulty with nursing ethics is that nursing practice is a clinical art with moral overtones which is carried out in a bureaucratic setting constrained by institutional policies, where there is great potential for a clash between professional cultural values and corporate values. (p. 519)

Summary

This study adopted a sociohistoric perspective and used narrative ethics to examine nurses' moral problem constructions in 4 different historical contexts. Concepts from theories of role and culture, together with the Wilkinson bifocal model and typology, formed the theoretical framework for the study. That is, individual factors interact with role and culture to effect problem constructions. The cultural context influences problem construction, and individual nurses within a culture do not all have the same role conceptions. There are variations in what different nurses perceive the ideal nursing role to be. The cultural context influences role conceptions and either facilitates or inhibits the nurse's ability to enact his ideal role. This dynamic interplay is a major factor in how the nurse constructs a lived moral problem. The basic theoretical framework stating these relationships is summarized in Figure 2.2.

Figure 2.2. Theoretical Framework



This theoretical framework was used both to guide study design and to facilitate interpretation of findings—for example in explaining similarities and differences in problem construction in the 4 different sociohistorical contexts, 1934, 1979, 1989 and 1995.

CHAPTER 3

RESEARCH DESIGN AND METHODS

This chapter describes the overall study design as well as the procedures and rationale for data collection and sampling, data processing and management, data analysis, data interpretation, rigor, and protection of human subjects.

This was a two-phase, descriptive study using qualitative content analysis of existing narrative data, as defined by Morgan (1993). In Phase 1, I used data from three different time periods (1934, 1979 and 1989), to clarify concepts from a previously developed ethics model (Wilkinson, 1985, 1993) and to test the model on new cases for its usefulness in categorizing nursing ethics problems (Wilkinson, 1994). As the research questions in chapter 1 imply, this meant specifically that the analysis was intended to determine whether the Wilkinson bifocal model problem typology could account for all the different kinds of problems nurses identified in their narratives from the different time periods. Role and culture concepts taken from the literature and identified in the narratives provided a context for grounding and explaining variations in the frequency with which different types of problems occurred in each time period. In phase 2 the same process and procedures were used on contemporary (1995) rather than historical data, and the two phases were then synthesized.

Because context is an important concept in the bifocal model, qualitative content analysis was especially useful. Content analysis is a method of inquiry into the symbolic meaning of messages, which provide vicarious information about phenomena other than those directly observed. It is useful for comparing messages from different situations or from different communicators, and making replicable and valid inferences from data to their context (Krippendorff, 1980, p. 21). According to Berelson, one of the uses of content analysis is to "reflect attitudes, interests, and values ('cultural patterns') of population groups" (cited in Krippendorff, 1980, p. 34). In this study, I sought cultural understanding not as an end in itself, but for the influence it has on nurses' role conceptions and moral experiences. I used a combination of preselected and emergent categories to perform the content analysis for identifying moral problem constructions and themes of culture and role.

Data Collection and Sample

The sampling unit in both phases of the study was a fixed-text narrative of nurses' experiences with and questions about ethical issues. Although all data were fixed-text narratives, they were obtained from a variety of sources. This section describes the data and provides rationale for choosing those sources.

This study assumed that reality is constructed; therefore, nurses' words are especially appropriate as data. Language, even spoken language, is a means for constructing reality, not just communicating it (Spradley, 1979). This study was concerned with nurse's constructed realities—their experiences and perceptions of events—not with establishing the formal, objective "truth" of those events—so again, analysis of language was fitting. According to Krippendorff, "Anything connected with the phenomena of interest qualifies as data for content analysis" (1980, p.171). Personal documents, such as diaries, have been mentioned specifically as a type of data suitable for content analysis (Hays, cited in Krippendorff, 1980, p. 42-43).

Because this study examined social phenomena (e.g., moral problems, role enactment), and because I expected that context would affect the manner in which narratives sorted into the bifocal model, I chose narratives from different periods of history in order to assure some differences in context. This is in keeping with Tuchman (1994), who maintained that social phenomena must be understood in their historical context. See Table 3.1 for the total number of participants and narratives in each data set (1934, 1979, 1989 and 1995).

Phase 1 Data Collection

The Phase 1 narratives were obtained from (a) a 1934 master's dissertation, (b) a 1979 published collection of journal entries, and (c) unanalyzed raw data collected in 1989 by another researcher. Narratives in all three Phase 1 data sources were written by the nurses themselves, but retyped by the original researchers.

1934 Data Source: Description and Rationale

The 1934 data were taken from a master's dissertation from The Catholic University of America (Vaughan, 1934). Vaughan's study contains 524 narratives of 527 incidents of moral problems, recorded as brief entries in diaries kept for the express purpose of that study. Student and graduate nurses from 39 schools located in 15 states "were requested to keep a record in the form of a diary of the moral problems arising in their daily professional and social life over a period of three

Table 3.1. Number of Participants and Narratives from Each Time Period

Year	Number of Nurses	Number of Stories
1934	95	527
1979	Not reported	215
1989	185	209
1995	98	124
Total	>378	1,075

months" (p. 18). Vaughan recruited nurses through Catholic schools, but both Catholic and non-Catholic nurses participated in the study. A total of 95 nurses returned diaries. These were brief entries, usually two or three sentences in length.

I chose the 1934 master's thesis because it is very likely the first empirical study in nursing ethics. Nursing research of any kind was rare during the first half of the century. I manually searched 4 nursing indexes covering the years 1900-1940, using the subject headings, *ethics, ethical problems, moral, morale, distress, autonomy, advocacy, nurses* and *nursing*. Most of the references under the ethics heading were either (a) not actually written by nurses, (b) ethics texts, and/or (c) concerned with the need for a code of ethics. As can be seen in Table 3.2 on page 47, Vaughan's study was the only research found.

1979 Data Source: Description and Rationale

The 1979 data came from a published collection of journal entries (Carroll & Humphrey, 1979). Nurses enrolled in two philosophy classes and working toward a bachelor's degree were asked to "keep a journal of moral problems they had encountered in the past or during the course of the semester" (p. 1). Carroll and Humphrey did not report the number of nurses keeping journals; however, the collection includes 202 entries yielding 215 stories. These entries were in the form of stories or cases, and were often a page or more in length.

I chose the 1979 collection because it represents one of the earliest published sets of nursing narratives in the "new" era of nursing ethics, perhaps even the first. As such, it contains the earliest narratives that might differ appreciably from the 1934 data.

Table 3.2. Ethics References in Selected Indexes of Nursing Literature, 1900-1940

Indexes Searched	No. of Ethics References	No. of Research References
Henderson's *Nursing Studies Index (1900-1929), Vol. I*	120	0
The American Journal of Nursing Cumulative Index, Volume 21-30 (October 1920 - December 1930)	51	0
Henderson's *Nursing Studies Index (1930-1949), Vol. II*	33	1
The American Journal of Nursing Cumulative Index, Volume 31-40 (January 1931 - December 1940)	79	0

Biomedical ethics actually began in the 1970s after the Council for Philosophical Studies conducted a summer Institute in Moral Problems in Medicine at Haverford College (Benjamin, 1987; Smith & Davis, 1980). Attempts to deal with nursing ethics in a philosophical way also began in the 1970s (Stenberg, 1979)—Mila Aroskar and Anne Davis were among the first to differentiate nursing ethics from biomedical ethics (Aroskar et al., 1979; Davis & Aroskar, 1978).

1989 Data Source: Description and Rationale

The 1989 data were unanalyzed raw data from a study by another researcher (Haddad, 1989). These data consist of 209 ethics stories obtained from 185 nurses who responded to an anonymous survey sent to a probability sample of 1,400 nurses throughout the United States. The final open-ended question on the survey instrument asked the nurse to "share a short written description . . . of a problematic ethical dilemma that impressed you the most during your professional career and how it was resolved" (Haddad, 1993, p. 6).

The 1989 narratives were chosen to represent contemporary nursing experiences in 1993 and 1994, when Phase 1 was conducted. Because the bifocal model and an ultimate practice theory are intended for application to current practice, it was important in each phase to include contemporary data. In 1993, the 1979 narratives were too old to represent current practice; and the 1989 narratives, while

older than I preferred, were temporally distant enough from the 1979 data to provide at least slightly different context. Because of the limited time and resources available in Phase 1, it was necessary to use data that were in the public domain, so it was not possible to obtain narratives written after 1989. Because of lag times in publication, published narratives are always at least a year old, and more likely two or three years old. For example, the narratives quoted in Haddad's 1993 article were actually collected in 1989.

Phase 2 (1995) Data Collection: Description and Rationale

Phase 2 data are fixed text narratives written in 1995. They were obtained from a snowball sample of various published and unpublished sources. There are 124 stories collected from 98 nurses. The data sources are described in Table 3.3 on page 49. The Phase 2 data differ from the Phase 1 data in that some of the stories were initially presented orally rather than written by the nurses themselves. However, they had been transcribed by the original researchers and were sent to me in the form of fixed text—the same as the Phase 1 data.

Again, because the bifocal model is intended for use in contemporary nursing practice, I thought it essential that the most current data be collected and analyzed, in order that the final synthesis of data would reflect current as well as historical themes. The 1989 data could not be said to reflect the context of nursing practice in 1995, when Phase 2 began—much less in late 1996, when study completion was projected. For example, in 1989, workplace redesign and widespread use of unlicensed assistive nursing personnel were just being instituted. Today, they are commonplace. In 1989, the nursing shortage was just ending; today nurses are having difficulty finding jobs they want or feel prepared to do (Joel, 1995). Meyers (1994) found that nurses in her study were working in organizations that were reconfiguring delivery systems and downsizing their nursing staff, and that these nurses were intensely concerned about the "finiteness of resources for health care" (p. 17).

Colleen Scanlon, Director of the American Nurses Association Center for Ethics and Human rights, related that the telephone calls they receive from nurses now pertain to very different issues than in 1989 (personal communication, September 20, 1995). She said that nurses now identify the number one issue as cost containment measures that jeopardize patient well being; they talk now about quality of care issues and are much less focused on bedside, clinical dilemmas such as abortion and termination of life support. Echoing those comments, a 1993 survey stated that "40%

Table 3.3. Phase 2 Data Sources

Type of Data	Sources of data
Published narratives and interviews that are in the public domain	M. A. Homann (1995), *A Multiple-Case Study Examining Ethics Teaching and Learning Models in Baccalaureate Nursing Education Programs.* Complete transcripts of all cases analyzed for the dissertation.
	T. Savage (1995), *Nurses' Negotiation Processes in Facilitating Ethical Decision Making in Patient Care.* Excerpts from the researcher's interviews, quoted at length in the body of the dissertation.
	E. J. Sandelin (1995), *The Ethical Decision Making Process of Community health Nurses Caring for Patients with HIV/AIDS.* Excerpts from interviews with two of the participants, quoted at length in the body of the thesis.
Class papers or journals from students in RN-BSN or MSN programs	Journals from RN-BSN students at a midwestern state college, analyzing the moral problems they experienced in their practice in 1995-1996.
	Formal papers from MSN students at 2 eastern and 1 midwestern universities.
Unpublished raw data obtained from other researchers for secondary analysis	Complete transcripts of interviews of 5 participants, originally analyzed for E. J. Sandelin's (1995) dissertation, *The Ethical Decision Making Process of Community health Nurses Caring for Patients with HIV/AIDS.*
	Responses to an open-ended question on an anonymous questionnaire administered by D. W. Raines (1995) for her dissertation, *Values Guiding Nursing Practice Behavior.*
Questionnaire responses to an open-ended question designed for this study	Nurses in 4 midwestern hospitals.
	Nurses attending a week-long nursing ethics institute in the midwest.

of the respondents cited a nurse-client ratio that was too high to provide for the safety and well-being of clients" (Roach, as cited in Tunna & Conner, 1993).

Cyndy Hylton Rushton, a nursing ethics consultant at Johns Hopkins Childrens Center in Baltimore, also indicated that the stories she hears from nurses now are very different than they were five years ago. Nurses today are disempowered

by the ways administrators respond when they raise questions about patient care and safety—for example, telling them that they are simply inefficient. Dr. Rushton said that in the present chaotic work environment, job security is threatened and nurses are afraid to act as patient advocates. There have always been barriers to advocacy—some real, some perceived—but now there are more real barriers, she said (C. H. Rushton, personal communication, October 4, 1995).

Another important way in which the 1995 context is different is that nurses' perceptions of their practice autonomy may be changing. A primary nursing care delivery system has been shown to positively influence nurses' perceptions of their autonomy (Alexander, Weisman & Chase, 1982). However, primary care is rapidly becoming extinct in the present flurry of workplace redesign. It seems likely that nurses in 1995 may believe they have less autonomy than did the nurses in 1989. One might speculate that since hospitals have worked hard to "sell" staff on the virtues of workplace redesign, nurses' conceptions of the degree of autonomy appropriate to their roles may even have changed as well. This has the potential for altering the fit of the narratives to the bifocal model, since autonomy is thought to be an important determinant in problem construction.

Phase 2 Sampling Strategies

Phase 2 data were obtained by the snowball process. Finding current, fixed-text narratives for the Phase 2 data proved to be difficult and time consuming, requiring nearly a year to complete. In order to find narratives written after January 1, 1995, I had to use unpublished material, and I concluded that such material would most likely be found in unpublished manuscripts or in raw research data.

The intent in qualitative research is to do purposeful sampling for information-rich cases. Therefore, the people I contacted were those deemed most likely to yield information about moral problems (Sandelowski, 1995). I started the snowball process by telephoning three main groups of nurses: (a) researchers, primarily graduate students, who had used my earlier moral distress study in their work, and with whom I had previously corresponded; (b) nurse ethicists I had met at various meetings and conventions during the past several years; and (c) authors of recent journal articles taking a qualitative or narrative approach to nursing ethics. I began with a list of approximately 20 names and, through a chain of referrals, eventually acquired a list of 85 names from which to solicit data. While generating the list of names, I created forms to organize and track conversations and referrals.

For those who promised data, I created a form to track permissions, telephone calls, receipt of data and so forth. This form also served as the key to the codes for identifying the Phase 2 data sources (e.g., "96Sandelin.4"). It was important to track these data carefully because of the various types of sources being used—some required new permissions, some did not; some came in one batch from the researcher, some came separately from individual subjects; some required a formal letter requesting data, some did not.

When I was unable to obtain enough stories from the 85 nurse researchers and authors on my list, I elected to place questionnaires in 4 hospitals, and to request permission to use a mailing list from a nursing ethics workshop. Interfacing with two Minnesota hospitals was facilitated by two colleagues I had located using the snowball technique described previously.

In keeping with the principles of emergent design, the number of narratives needed depends on the richness of the narratives; and the number of sources depends on the number of narratives produced by each source. Several of the narratives were quite long and provided very rich sources of information. As data collection and analysis were occurring simultaneously, I stopped searching for new data when I had enough narratives to achieve some informational redundancy and to achieve adequate variation among cases.

Demographics

This section will describe common and unique characteristics of the narratives and of the nurses who provided them. Some demographic data were obtained from the narratives themselves, some from the researchers or others from whom narratives were obtained, and some were inferred from knowledge of the situation or era that produced the narratives.

Description of the Participants

The demographics of the nurses within each period differed slightly. Compared to the other 3 data sets, nurses in the 1934 data were the most homogeneous in terms of age, marital status, living arrangements, education, work setting and actual job assignment. They were probably younger and had less education than nurses in the other data sets (Melosh, 1982). They were almost exclusively bedside nurses in hospitals, and all had about the same amount of nursing experience. It is unlikely that any were married, male, or over 30 years old. Nearly all

were students in Catholic schools of nursing, but not all were Catholic; and a very few were recent graduates rather than students. The schools were located in 15 different states, but nearly all the nurses lived in the nurses' dormitory at the hospital where they worked and went to school (Vaughan, 1934). They were all given the same task: to keep a journal of the ethical problems arising in their professional and social life.

Nurses in the 1979 data set were less homogeneous, but still had much in common with each other, especially in terms of work background, education and geographical locale. They were all RNs enrolled in an ethics course, studying to obtain a bachelor's degree in nursing. They all lived in the same geographical area and were, or had recently been, bedside nurses. A few, however, were head nurses and a few were working in non-hospital settings (e.g., clinics, schools). Their ages, amount of nursing experience and marital status probably varied, although it was not possible to conclude definitely from the narratives. In 1979, it was not unusual for RNs attending baccalaureate completion programs to be married and have children. Like the 1934 nurses, they were all given the same task: to keep an ethics journal.

There was scant information about the nurses in the 1989 data set, but it was possible to infer that there was more heterogeneity in that set than in 1934 and 1979. Many of the nurses were supervisors and managers, but some were bedside nurses. Some had graduate degrees and were in advanced practice roles and/or working in non-hospital settings. These nurses lived throughout the United States and constituted a random sample in the study in which they provided primary data (Haddad, 1989). They were all given the same task: to write a description of an ethical dilemma.

The 1995 nurses were varied in about the same ways as the 1989 nurses. They represented a variety of ages, education, work experience, geographical location, work settings and marital status. There was a slightly higher proportion of nurses in this group with advanced degrees and in advanced practice roles. The main lack of homogeneity within this data set is that these nurses were *not* all asked to respond to the same task. For example, some were asked to respond to an open-ended questionnaire and others were interviewed by a researcher. Also, several of the nurses had not been asked to "describe a moral problem." The 1995 stories were gathered by several different people, primarily researchers, for a variety of purposes. Some nurses were asked specific questions, such as "Tell me about an ethical dilemma that occurred during your care of a patient with HIV/AIDS." Others were asked questions

such as, "How do you teach ethics to your students?" Such questions occasionally resulted in a story about a moral problem the participant had experienced, even though that was not the intent of the question.

Except for the 1934 data, I did not use stories from nursing students. I wanted stories to reflect practice, and believed that students' perceptions would be different from those of licensed nurses. I did, however, use stories from RNs who were students in baccalaureate nursing programs (RNBs). RNB students are already licensed RNs, and usually work while they are in school. Most of the 1934 narratives were written by students who were in hospital based diploma programs. At that time nursing students actually staffed the hospital floors and managed and gave the nursing care—as do RNs in present-day hospitals. Therefore, their experiences and perceptions would be similar in most ways to those of registered nurses who had graduated. Graduate nurses were, at that time, more likely to be doing private duty, home care, or community health. Care in hospitals was delivered mainly by students.

In all four data sets, the majority of nurses worked in hospitals; however, this was not true of all the nurses. For this reason, the contextual confirming data from the literature was not limited to nurses in hospitals.

Description of the Narratives

In order to preclude introducing new and different trustworthiness concerns, Phase 2 used fixed-text data, the same as Phase 1. The Phase 1 and 2 data sets were alike in that they included the narratives of nurses from a variety of traditional specialty areas, such as obstetrics, medical-surgical and psychiatric nursing. However, the Phase 2 data differed from the Phase 1 data in several respects:

1. The data for each time period (1934, 1979, and 1989) in Phase 1 came from a single source; the Phase 2 (1995) data were obtained from several different sources in order to produce enough narratives.
2. I solicited some of the data in Phase 2 directly, albeit anonymously, from participants specifically for this study; none of the Phase 1 data were obtained in this manner.
3. Some of the Phase 2 data are transcribed interview data rather than stories written by the nurse participants.

Data Analysis

This section provides the rationale and procedures used for data analysis in this study. It also reports the procedures used for data processing and management.

Rationale for Data Analysis Methods

In this analysis, human social constructions were both studied and made. Therefore, in both phases, data analysis proceeded within the paradigm of constructivist (also called *naturalistic*) inquiry, in which meaning is always rooted in context, and the search is for meaning rather than "ultimate truth" (Crabtree & Miller, 1992). Content analysis methods vary along the quantitative-qualitative continuum from applying statistical procedures to assigning words to categories and drawing conclusions based on those categories (Krippendorff, 1980; Morgan, 1993; Tesch, 1990). According to Morgan, qualitative content analysis is appropriate when "research goals call for the advantages of content analysis in describing what patterns are in the data as well as the advantages of grounded theory in interpreting why these patterns are there" (1993, p. 119). That was the case for this study: Chapters 4, 5 and 6 describe the patterns found in the data; chapter 7 interprets why the patterns are there.

I believe, with Morgan (1993) and others, that qualitative content analysis does not preclude all counting. It is difficult to describe the "what" in textual data without at least implicitly quantifying (e.g, "*most* nurses said" or "*few* mentioned that . . ."). Morgan has suggested that explicit counting improves on such impressionistic judgments (p. 118). Ball and Smith (1992) agreed that qualitative research "does not eschew measurement altogether" and that characterizations such as *often* or *rarely* are, in fact, "measurement judgments even though they are not statistically expressed" (p. 30). In this study, counts were done only for the purpose of identifying stronger versus weaker patterns in the data and sometimes for illustrating relationships visually. I did not use frequencies to assign decontextualized meaning or to imply generalizability.

I did not count the qualitatively developed role and culture themes, with this exception: Themes that were identified a priori (see *Theoretical Framework* in chapter 2) or that seemed to be of special theoretical importance in Phase 1 (i.e., advocacy, autonomy, obedience, powerlessness, and subservience) were counted. Because the intent was to evaluate the fit of an existing model, I performed careful counts of the ethical problem categories. However, this was done primarily to make it possible to

illustrate in graphic format the relationships between role themes and problem constructions. These relationships were intricate and difficult to track using only verbal explanations.

Procedures Used in Data Analysis

The unit of analysis when categorizing moral problems was a single story (some narratives contained more than one story). For identifying role and culture themes, the unit of analysis was sentences or phrases. According to Mishler (1986) and Briggs (1986), it is important in textual analysis to avoid decontextualization. To make it easy to move back and forth from a single decontextualized phrase to the complete narrative I created a page layout in a database program that included both the separated phrases and the complete narrative.

In an effort to elicit meaning from the texts, analysis went beyond mere counting of word occurrences. Inferences were made about the type of moral problem (e.g., moral dilemma, moral distress) represented by each narrative and about the cultural and role themes present. For example, I inferred themes of nursing culture from comments nurses made about their work, professional relationships, caring and authority.

Both structured and unstructured coding were used. I used predetermined codes and criteria to first sort narratives into broad categories of culture, role and problem type (see *Sorting Rules/Criteria* in Appendix C). Then I used unstructured second and subsequent level coding to identify emerging, more specific, themes of role and culture. A combination of structured and unstructured coding was used for identifying ethical problem constructions. Sorting rules and criteria (Appendix C) were based on the definitions provided in Appendix B. The definitions all assumed that each narrative pertains to a patient-care situation and involves an ethical issue.

Bifocal Model Sorting

I first sorted each journal entry or story by time period (1934, 1979, 1989, and 1995), and then a decision tree was used to sort each story into the appropriate bifocal model categories and sub-categories (see Appendix D). Problems were first sorted into the broad categories of decision problem or action problem, and then into the subcategories of: moral uncertainty, moral dilemma, moral distress, moral outrage, moral heroism, whistleblowing, moral weakness, judging, no problem, and

unable to categorize. Moral weakness and no problem emerged during the first coding in Phase 1; judging emerged during the final analysis of Phase 1.

Some of the narratives were extremely long, and contained more than one story. The narrator would move back and forth between stories, as well, so it was difficult to keep the events of the story in mind. As suggested by Polanyi (1985), for such narratives I made a five- or six-sentence summary of each story, listing the main story events. With the shorter, paraphrased story, it was easier to follow the decision tree used for categorizing.

As a final step, I tabulated frequencies for each category and subcategory in the 1934, 1979 and 1989 data. I followed the same process in Phase 2 and merged the frequencies with the Phase 1 frequencies.

Because the four data sets did not have equal numbers of narratives, I converted the frequencies to percentages in order to obtain a standardized metric for comparing the data sets. The percents are merely the frequency of a particular type problem divided by the total number of problems. They are not meant to imply the "amount" of any variable in the population. For example, a 47% for moral uncertainty in the 1934 data does not mean that 47% of nurses experienced moral uncertainty nor that moral uncertainty represented 47% of the moral problems of the time. It means that of the 951 problems in the 1934 data set, 47% of them were coded as instances of moral uncertainty.

Role Coding

Because I assumed that role conceptions affect the manner in which nurses experience ethical problems, I anticipated in Phase 1 that nurses' role conceptions would be important to future theory development. Therefore, after sorting by model categories, I analyzed the data for broad themes of role and culture, with special attention to autonomy and advocacy. Because autonomy and advocacy were not mentioned in the literature as a part of the role conceptions for nurses in the 1930s (Kalisch & Kalisch, 1987; Reverby, 1987; Winslow, 1984), I did not limit examination of role themes to those concepts, but allowed other themes to emerge in the analysis. The initial sorting of role perceptions used the following categories: autonomy, advocacy, rules, and other role themes.

Autonomy and advocacy were theoretically preselected themes; the theme, *rules* (later changed to *obedience*), emerged almost immediately from the data and therefore functioned essentially as a preselected theme during most of Phase 1.

Usually, several role themes could be identified in a single narrative. As a result, approximately 30 themes were identified on the second coding in Phase 1. An additional difficulty was that several of the themes that emerged from the 1934 data were not present in the 1979 and 1989 data, and vice versa (e.g., morality was a theme only in the 1934 data). Therefore, in Phase 1, a third pass was made through the data in order to collapse themes and make a shorter list that would fit all three data sets. That list (see chapter 5) was used as preselected themes to begin coding the 1995 data in Phase 2.

Finally, in Phase 1, I tabulated frequencies and percentages for five role themes that seemed to be especially important in explaining problem construction (see chapter 5): advocacy, autonomy, obedience, subservience, and powerlessness. I followed the same procedure in Phase 2 and those frequencies were merged with the Phase 1 frequencies. I present only the most frequently occurring themes in this report (in chapter 5).

Culture Coding

After role coding in Phase 1, the narratives were coded for the following broad themes of culture: nursing culture, institutional culture, popular culture, and other culture themes. As with the role themes, an unwieldy list developed on the second (emergent) coding; so a third pass was required to collapse themes. The qualitatively developed themes from Phase 1 were used as preselected categories for initial coding of the 1995 data in Phase 2. Some new themes emerged from the 1995 data as well (see chapter 4).

As expected, there was considerable overlap between role and culture themes. Although culture is based on values, it manifests itself in behaviors (Coeling & Simms, 1993)—not in isolated behaviors, but in patterns of behavior. Therefore, to identify culture themes, I looked for patterns of reported behaviors or inferred values and beliefs in the narratives. Coding instructions provided consistency in differentiating role from culture (see Appendix C).

Data Processing and Management

Content analysis uses a consistent set of codes to designate data segments that contain similar material (Morgan, 1993). The codes in this study were the model category and sub-category labels, role perceptions, and cultural themes (see *Sorting Codes* in Appendix E).

Within each data set (1934, 1979, 1989, and 1995), I assigned each narrative a unique code identifying its data set (year) and general source, so that it was always possible to locate a sorted phrase or page in the original narrative. The numbering was slightly different for each data set, because of the differences in organization of those original materials. For all data, the first two numbers in the code represented one of the four data sets from which the data came (34, 79, 89 or 95). For the 1934 data, that number was followed by the number of the page of Vaughan's dissertation on which the story was located (e.g., 34.1). The 1979 stories were located by page number, and also by the case number assigned by the authors of that work (e.g., 79.51.Case25). For the 1989 stories, the year code was followed by the 4- or 5-digit code assigned by original researcher (e.g., 89.0041). Because the 1995 data came from a variety of sources and arrived at different times, I numbered each narrative sequentially in the order received. The year code was followed by the name of the general source, and then by the numerical sequence number (e.g., 95Smith.16). I filed the hard copies of the 1995 stories in numerical order.

Phase 1 Data Management

I scanned printed text and typed handwritten text into a Macintosh computer. I used a database, FileMaker Pro©, for coding and categorizing and counting significant role and cultural themes, as well as for sorting the narratives into model categories. I created a separate file for each of the three data sources, and a separate record for each narrative. Each record contained fields for the complete narrative, the codes, quoted phrases to verify codes, and theoretical notes and comments.

Phase 2 Data Management

I typed all Phase 2 data into a word processing program, Microsoft Word. Scanning was not done because much of the data were hand-written, and also because this set was smaller than the other data sets. I chose a word processing program instead of a data base program for Phase 2 data for two reasons:

1. With this small data set, I did not need the sophisticated sorting capabilities of a data base. The "sort" function of Microsoft Word was adequate for these data.

2. With the data base program used in Phase 1, it is difficult to print the data in a format that is convenient to use for hand coding. It was important to print out the Phase 2 data because I used a second reader and we hand-coded all these data before

entering codes into the computer, whereas I coded primarily on the computer in Phase 1.

As the narratives arrived I typed them into the computer and then printed hard copies of the entire set. Coding was done on hard copy for ease of discussion and comparison. After we arrived at consensus, I transferred our final codes into the computer file so the narratives could be later sorted for analysis and counting. Exact codes had to be used consistently because they were used for computer counting and sorting later in the analysis (see *Sorting Codes* in Appendix E).

When obtaining counts, I used the table function of Microsoft Word—one column for the story's identification number, one column for the role code, one column for the culture code, and so on, but omitting the narrative itself. To find out how many stories contained autonomy, for example, I simply used the "sort" command and sorted the role column. The role codes then appeared in alphabetical order, with all the autonomy stories (for example) appearing together—so they were easy to count. The other kinds of codes appeared beside them in other columns, so I could see what kind of bifocal model and culture codes appeared with each role code in a particular problem (see Appendix F). To examine further or to find examples in the narratives, I looked up that particular story's identifying number in the text file. In this way it was easy to move back and forth between the abstract, decontextualized codes and the stories from which the codes had come. When margin notes, such as rationale for a particular code, were written on the printed copies, I typed these into the computer file, too, to retrieve in later analysis as needed.

Data Interpretation

After analyzing the data and obtaining the desired frequencies and percentages, I looked separately at the patterns of culture, role, and problem construction themes by comparing each across time periods. Finally, I examined the possible relationships among themes of role, culture, and problem construction. This section explains the manner in which the literature was used to aid in interpretation.

Establishing Sociohistorical Context

Sociohistorical context was established through consulting primary and secondary sources and references. As a part of the interpretive process, I examined literature from each of the 4 time periods in the study in order to achieve a perspective from which to understand the nurses' experiences of moral problems.

Secondary Sources

In sociohistorical research, secondary sources are "books and articles written by historians and social scientists about a topic" (Tuchman, 1994, p. 318). The following secondary sources were among those used to establish the culture and context of the different periods.

Kalisch, P. A. & Kalisch, B. J. (1987). *The changing image of the nurse*. Menlo Park, CA: Addison-Wesley.

Melosh, B. (1982). *"The physician's hand": Work culture and conflict in American nursing*. Philadelphia: Temple University Press.

Reverby, S. M. (1987). *Ordered to care: The dilemma of American nursing, 1850-1945*. Cambridge: Cambridge University Press.

Winslow, G. R. (1984, June). From loyalty to advocacy: A new metaphor for nursing. *The Hastings Center Report, 14*, 32-40.

Primary Sources

Even in pure historical studies, distinctions between primary and secondary sources may be fuzzy. In discussing whether books and journal articles should be classified as primary sources, Tuchman (1994) said that primary sources "are most often the . . . documents or practices of the period one is trying to explain" (p. 318), including books and articles of the period. The assumption is usually that articles and books are considered to be primary sources only if written more than 50 years ago. Nevertheless, I am using Tuchman's definition to classify the materials discussed in this section as primary because they are all books and articles that are documents or practices of the periods under study (1934, 1979, 1989 and 1995).

For information about nursing and organizational culture, I used the *American Journal of Nursing* for all four time periods because (a) it was thought to reflect the practice context of all four periods, and (b) original journals are conveniently located in the Dykes library on campus. I used articles found under the terms *ethics, role* and *nursing* in the *AJN Cumulative Index for January 1931-December 1940*, as well as scanning visually all *AJN* journals for the years 1934 and 1979. The terms *role, nursing* and *ethics* were searched in Henderson's *Nursing Studies Index for 1930-1935* for possible sources, and for an indication of the amount and type of ethics literature during the period. The same procedure was followed for 1979. Nursing ethics texts published between 1930 and 1939, were also used.

I searched for the terms "ethics" and "moral" in the *AJN Cumulative Index for January 1931-December 1940.* I read all ethics-related features in the 1930-1939 *AJNs* (e.g., "Questions," "Letters to the Editor," and "Ethical Problems," which appeared at intervals during that period). Because the 1934 data were obtained by a Catholic researcher from students in Catholic schools, I also used Catholic ethics texts and Catholic nursing journals. The *Appendixes* and *Conclusions* from the Vaughan study also offered insight into the 1934 data. Vaughan's appendixes included the rules and regulations from five different schools of nursing.

Because the 1989 and 1995 data are so recent, there was much more literature available. The problem for those periods was to limit and focus the search rather than to identify as many sources as possible, as was done for the 1934 and 1979 periods. Recent institutional (healthcare) and nursing culture were reflected in the literature of nursing management, healthcare reform, and workplace redesign.

For popular culture, I scanned magazines, such as *TIME* and *The Ladies Home Journal,* and local newspapers, for the period 1930-1934, and for 1979. Author comments and appendixes to the 1934 and 1979 data were also helpful in determining cultural themes. Historical studies of women's roles (secondary sources) were also used to establish the cultural context of the 1930s and the 1970s. Because I have recently lived and experienced the cultures of 1989 and 1995, interpretations of that data were of necessity made through those lenses. However, I relied on other information from and about each period in order to adopt the appropriate perspective as much as possible when interpreting.

Ensuring Rigor

For naturalistic inquiry, Lincoln and Guba (1985, p. 290) posit four dimensions of trustworthiness that parallel the concerns of validity and reliability in the conventional paradigm: credibility (truth value), confirmability (neutrality), dependability (consistency) and transferability (applicability). These will be addressed in this section. Because this was a content analysis, reliability and validity issues will also be addressed from that perspective, after Krippendorff (1980), Miles and Huberman (1984) and Wilson (1989).

Credibility

For Lincoln and Guba (1985), credibility is the criterion for the conventional question of truth value. They suggested that credibility is improved by contextual

validation and by using multiple theories. In this study, I compared themes and problem constructions to the literature of the relevant period to determine that themes in the data were consistent with the literature. In addition, I interpreted the data within a multiple-theory framework, using culture, role and ethics theories.

Even though analytical techniques assume close correspondence between the story and the experience, life-as-lived is not the same as life-as-told. Stories are expected to change in retelling, so the concepts of consistency or stability are not especially useful in establishing their "truth." Stories, and this study, are concerned not so much with "pure objective truth" as with the way in which experience is endowed with meaning. This follows the position of Sandelowski (1991) that the distinctions between truth and fiction are artificial and that stories can be judged for their "coherence" and "narrative fidelity"—that is, they should make sense and be consistent with past experience and stories.

Validity in Interpretation

Validity in interpretation involves a "dialectic between guessing and validation" (Ricoeur, as cited in Brown et al., 1989, pp. 161-162). In order to fully maintain this dialectic, I trained a second reader for the Phase 2 coding and interpretation.

> In practice, the "logic of validation" is operationalized most clearly when readers are able to discuss their respective interpretations of the same interview text. Ample opportunity exists at that point for alternative interpretations to be entertained, and for the relative probabilities of each to be considered . . . . [and] ways of choosing between [different interpretations] or reconciling them in terms of a new interpretation can be considered or created. (Brown et al., 1989, p. 162)

Training of second reader.

An experienced nurse enrolled as a master's student was chosen as a second reader. To begin preparing, she read the interim research report for Phase 1 of this study and the proposal for Phase 2. She reviewed the graphic representation of the Wilkinson bifocal model of nursing ethics (Appendix A) and the *Decision Tree* for the bifocal model (Appendix D). In addition, she read relevant articles on qualitative content analysis and narrative ethics. After she had become familiar with the bifocal model and the process of narrative analysis, she used the study definitions along with the *Sorting Rules/Criteria, Decision Tree* and *Sorting Codes* (Appendixes C, D and E)

to independently code two different samples of Phase 1 data. We then met to compare and discuss our codings and arrive at consensus.

During the three weeks following the first training session, we again performed independent codings of another sample set of Phase 1 data. We met again to discuss those codings and reach consensus on our interpretations. By this time, I had received the first 62 stories from the Phase 2 (1995) data sources, and in the following weeks, we began separate and independent coding of those. We met several times to compare and discuss our coding of the Phase 2 data.

Both readers read and discussed the entire set of 1995 narratives, as well as 20% of each of the Phase 1 data sets. In this way differences in interpretation were addressed and reconciled, a variety of inferences were considered, and consensus was reached on satisfactory interpretations. I found, as did Miles and Huberman (1984, p. 60), that "definitions get sharper" when two readers code and discuss the same data set. In many instances, the second reader's fresh perspective provided me with an insight or understanding I had not previously brought to the narrative. With discussion we were able to reach 100% consensus on all moral problem codings.

Validity of the Categories

The validity of a content analysis requires, in part, that categories be clearly defined, appropriate to the data, relevant to the research question, and supported by rationale (Wilson, 1989). The preceding sections of this chapter were intended to fulfill those requirements. Wilson also said that the researcher must illustrate the fit with which the data can be coded into the categories. That fit should be evident in the presentation and interpretation of findings, to follow in chapters 4-6. In addition, the categories and themes in this study meet Wilson's criteria of inclusiveness and mutual exclusiveness.

Inclusiveness has been achieved when "the categories include every possible aspect of the variable without reverting to a catchall category such as *mixed* or *miscellaneous*" (Wilson, 1989, p. 475). This criterion was met for the bifocal model categories. Out of the total 1,075 narratives comprising the data, 65 (6%) could not be classified into the broad categories of decision problem and action problem. The difficulty with classifying those narratives was not that the model lacked a category for them, but that the narratives contained insufficient information to identify the problem construction, or in a few cases, that they simply made no sense. Consider the following examples from the 1934 data:

(34.3)"Time off" seems to be the topic of the day.

(34.30) Patient admitted with diagnosis of pneumonia. Very confidentially gave me his history of Lues and G.C. I did tell the doctor and so made an enemy of the patient.

In #34.3, it is impossible to infer what the nurse believes is right, what she did or didn't do, or whether she is talking about herself or someone else. In #34.30, the nurse's action is clearly stated, but there is not enough evidence to infer whether she thinks she did the right thing.

An additional 55 problems (5%) could be classified into either the decision or action category, but not into a subcategory. Again, that was primarily because the narratives contained insufficient information; but also because the distinctions are finer and the sorting criteria far more complex for the subcategories than for the two main categories.

I did not attempt to achieve inclusiveness for the role and culture themes, because the intent was not to identify *all possible* themes. For example, the themes presented in chapter 5 do not include "every possible aspect" of the role variable (Wilson, 1989, p. 475). Because of the quantity and richness of the data an almost infinite variety of themes might have been generated, but I was interested only in themes that were relevant for explaining bifocal model fit.

Categories are *mutually exclusive* if they are "separate and independent" and if responses cannot reasonably be coded into more than one place (Wilson, 1989, p. 476). The bifocal model categories meet this criterion, although this was difficult to achieve. The difficulties around mutual exclusivity in this model and this study emanate from two sources: (a) The sorting criteria were complex, and (b) individual narratives provided only partial information about the sorting criteria, so many inferences had to be made.

The sorting criteria were complex because the phenomena of concern are multidimensional. Moral problems are identified on the basis of the eight dimensions in Table 3.4, on page 66, which were derived from the Wilkinson bifocal model and the definitions and defining criteria found in Appendixes B and C. Each problem has its own specific combination of dimensions, and problems were categorized on the basis of whether dimensions were present or not present. Two difficulties arose:

1. Some of the discriminations are very fine because some of the problems differ on only one dimension, as can be seen in Table 3.4 (on page 66).

For example, the main difference between moral distress and moral outrage is in whether or not the narrator focuses on his or her own actions, and in many stories this focus was difficult to determine.

2. Some of the dimensions are not truly dichotomous in practice, although they are in theory. In an interview, one could question a respondent to obtain dichotomous information on a dimension. However in fixed text, some of the dimensions were "more or less" present—for example, focus on self and personal responsibility. In some stories, the words were about moral outrage (focus on other), and yet the nurse was present in the story and was feeling "more or less responsibility" for her own actions, not simply "responsible" or "not responsible." In fixed text it is sometimes very difficult to determine whether the focus is more on self or other.

As already mentioned, the narratives frequently did not contain information on which to make a decision about the presence of all eight dimensions. Because, unlike an interview situation, text cannot be probed for additional data, many inferences were made.

Confirmability

Along with philosophers and scientists in a variety of other fields, I recognize that truth does not exist apart from the observer; and therefore that pure neutrality cannot be obtained. Anatole France (1971) said, "There is no such thing as objective criticism any more than there is objective art . . . . we speak of ourselves every time we have not the strength to be silent" (p. 671). Echoing France, philosophers Augros and Stanciu (1984) said that in what they call the new science, "Truth has vanished. Only viewpoints remain" (p. 128). Sociohistorical psychologist, Carl Ratner (1991), said that "the belief that culture contaminates objective observation is . . . . an unfounded myth propagated by logical positivists" and that "human perception is always socially mediated" (p. 182).

According to Lincoln and Guba (1985), objectivity is not so much a question of intersubjective agreement, but of the characteristics of the data—are they confirmable? The emphasis is less on the objectivity of the researcher, and more on the confirmability of the data. The 1934 and 1979 narratives used as data were from published sources so they are, in a sense, "fixed" and available for inspection. The 1989 data could be confirmed by the researcher who initially collected those

Table 3.4. Eight Dimensions for Identifying Moral Problem Constructions

	Problem Type								
Dimensions	**Moral Uncertainty**	**Moral Dilemma**	**No Problem**	**Moral Heroism**	**Moral Distress**	**Moral Weakness**	**Moral Outrage**	**Whistle Blowing**	**Moral Judging**
Decision difficult	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Can identify issue, principle, duty, etc.	no	[1]yes	yes	yes	yes	yes	yes	yes	yes
Conflicting values, principles or duties	no	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Decision made	[2]**no**	[3]**no**	**yes**	**yes**	**yes**	**yes**	**yes**	**yes**	**yes**
Decision implemented	**n/a**	**n/a**	**yes**	**yes**	**no**	**no**	**no**	**yes**	**no**
Focus on self	n/a	n/a	n/a	yes	yes	yes	no	no	no
Personal responsibility	n/a	[4]n/a	n/a	yes	yes	yes	[5]no	yes	no
Constraints to action present	n/a	n/a	no	yes	yes	no	yes	yes	no

Key:

n/a -Dimension not necessarily, but may be, present.
yes -Dimension must be present in this problem construction.
no -Problem construction can not contain this dimension
1 -Principles/duties are not always explicitly stated; may need to infer
2 -Actions can be taken without actually making a moral decision.
3 -May take action without ever knowing what is "right" to do.
4 -Dimension not necessarily present, but frequently is
5 -Rarely explicitly stated; may be unclear

narratives. The 1995 data were obtained from various individual sources—some are published and others not, but all are identified in this report and could be tracked. In addition, I retained computer files and hard copies of all the raw data, codings, analyses, theory and process notes, and a variety of counts and sorts. The data collection process and sources were also retained.

Dependability

Lincoln and Guba posited dependability as the criterion for consistency. These concepts approximately parallel reliability in the conventional paradigm. However, Lincoln and Guba held that if a study can be shown to be credible (valid), it ought not be necessary to demonstrate dependability separately (1985, p. 317). In practice, one way to deal with dependability is to use "overlap methods." In this study that meant using multiple theories to interpret the data and confirming my interpretations with some historical research. The other validity enhancing procedures outlined in the previous paragraphs (e.g., interpretation by consensus) should also serve to assure dependability and consistency.

Reliability

This study proceeded within a naturalistic paradigm from the perspective of narrative interpretation, so a demonstration of validity should be sufficient to establish reliability, as discussed in the preceding paragraph (Lincoln & Guba, 1985). Nevertheless, the study did use content analysis as method; and according to Krippendorff (1980), *replicability* is a reliability requirement for a content analysis because not all interpretations are equal. Qualitative analysis exists on a continuum from completely emergent coding to a structured content analysis procedure using preselected categories and category counting. This study seemed to fall midway on that continuum—between the more structured and quantitative approach of Krippendorff and the completely naturalistic approach of Lincoln and Guba. I have tried to compromise by satisfying the rigor requirements from both ends of that continuum. Therefore, I have conceptualized reliability as *interpretive agreement.* Interpretive agreement refers to the ability of two or more readers to agree independently on the interpretation of a particular narrative or to read the same narrative "in more or less the same way" (Brown et al., 1989).

Phase 1 reliability.

To achieve interpretive agreement in Phase 1, a nursing doctoral student, using the written sorting criteria and definitions, sorted 26 randomly chosen narratives, approximately nine from each time period, into the model categories. She also examined the narratives for culture and role themes. She had only a 30-minute training session, using 6 sample narratives. Interrater reliability was 50% for the bifocal model categories (e.g., moral dilemma, moral distress) and 46% for the broad role themes. However, when the narratives were discussed, it was possible to reach nearly 100% agreement on the coding. The low percent agreement was not surprising. According to Goodwin and Prescott (1981), "The larger the number of choices available to the raters (or the finer the distinctions possible), the higher the probability that exact agreement will not occur" (p.330). Additionally, Krippendorff (1980) said that all coders should be experts in the area of the data. The nature of this data and the complexity of the model did indeed require that a coder be very familiar with the model, with nursing ethics, and with the data. I believed that low interrater reliability in Phase 1 was due to the rater's lack of experience with the content of the study, as well as a lack of structure for coding decisions. Therefore I developed a decision tree for coding problem construction, and a second doctorally prepared rater used it to code 25 stories. This rater was more familiar with the Wilkinson bifocal model than the first one, who had had no previous exposure to it. For her 25 cases, 83% agreement was achieved. Using Krippendorff's (1980) "conditional reliability," which considers all decisions in the tree rather than just the final code, agreement was 94%. Phase 1 interjudge reliability percentages are summarized in Table 3.5 on page 70.

To arrive at agreement on the final classification of a single moral problem, researchers had to agree on decisions for each of the eight dimensions in Table 3.4 on page 66. Even when there was disagreement on the final classification in the bifocal model (e.g., moral distress versus moral hero) there was usually disagreement on only one of the eight dimensions required to classify the problem.

Phase 2 reliability.

For the predetermined categories of the study (Wilkinson model problem types, autonomy and advocacy), interjudge reliability was established during Phase 2 by having two trained readers use the sorting rules and decision tree (Appendixes C

and D) to categorize randomly chosen samples of the narratives from each of the four time periods. Interjudge agreement was calculated as follows (Miles & Huberman, 1984):

$$\text{reliability} = \frac{\text{number of agreements}}{\text{total number of agreements + disagreements}}$$

Reliability percentages were calculated at three different times during Phase 2. They are shown in Table 3.5, along with the figures from Phase 1. The first Phase 2 calculations were done after the second reader, a nursing master's student, completed preliminary readings (see *Training of second reader,* beginning on page 62), but before discussing any narratives with me. The second set was done after 3.5 hours of discussion and coding with the second reader. The final set was calculated on a sample of 1995 narratives, after several coding and discussion sessions had been held.

According to Miles and Huberman (1984), no more than 70% intercoder reliability is to be expected initially. I believe reliability figures were better on the 1995 data because the narratives were more complete; therefore fewer inferences needed to be made. In addition, the 1995 narratives were coded and calculated last, after the second reader had gained more experience. As noted in the section, *Validity in Interpretation,* beginning on page 62, we were able to reach 100% agreement on all moral problem codings after discussing them.

Intrarater reliability.

In Phase 1 of the study, I randomly selected 30 items from the three earlier time periods and coded them twice at an interval of 10 weeks. I obtained an intrarater agreement of 94% when classifying problems into the two major categories, decision and action. Intrarater reliability was 70% when classifying problems into sub-categories. I recoded the same data two years later, and obtained matches of 89% and 67% with the previous, Phase 1, coding.

Similar to the interjudge reliabilities, these percentages are probably slightly low because of the many inferences made in categorizing the problems. As previously illustrated, each narrative required that an inference be made about nearly every sorting criterion or dimension; and although criterion sorts may be replicable, inferences frequently are not. Since "inferences do not justify themselves"

(Krippendorff, 1980, p. 172), I used primary and secondary sources to justify and enhance the reliability of my inferences.

Table 3.5. Interjudge Agreements

Description of Testing Conditions	No. of Stories	Major Categories (Decision vs. Action)	Sub-categories	Role Coding
Phase 1 Samples from 1934, 1979 and 1989 data. Doctoral student after 30-minute training session. Without decision tree	26	Not done	.50	.46
Samples from 1934, 1979 and 1989 data. Ph.D. nurse familiar with the model and using the decision tree.	25	Not done	.83	Not done
Conditional reliability		Not done	.94	Not done
Phase 2 Samples from 1934, 1979 and 1989 data. MSN student before training session. Using decision tree and coding criteria.	51	.88	.61	.67
Samples from 1934, 1979 and 1989 data. MSN student after 3.5 hours of training.	40	.92	.76	.67
Sample from the 1995 data. MSN student after 3.5 hours of training + 2 prior sets of reliability coding + beginning coding of 1995 data.	10	.92	.92	.91
Combined reliability for all Phase 1 and Phase 2 tests.	152	.90	.73	.79

Transferability

The naturalistic researcher sets out "working hypotheses together with a description of the time and context in which they were found to hold" (Lincoln & Guba, 1985, p. 316). After the recommendations of Lincoln and Guba, this study makes no claims for generalizability to contexts other than those described in the study. It does provide information about time, context and demographics that potential appliers can use to make their own judgments of transferability; and it does suggest that the model is applicable to other contexts to the extent that those contexts are similar to those described in the model (for example, work environments that do or do not promote nursing autonomy).

Conclusions Regarding Trustworthiness

Although I read the texts several times in Phase 1, it is a limitation of the study that only one reader was used in that phase. In Phase 2, I sought a better interpretation of the narratives by using two expert readers, after the method of Ricoeur (1979), Udén, Norberg, Lindseth and Marhaug (1992), and Brown, Tappan, Gilligan, Miller, and Argyris (1989). I believe we did achieve a good interpretation.

I present the findings of this study with a moderate amount of confidence. First, paradigm cases were found that clearly illustrate each of the problem types (Jonsen, 1991). Second, some of the problem types are beginning to appear in current literature in the way they are described in this study (e.g., moral distress, moral heroism, moral outrage, moral dilemma and whistleblowing). Third, I obtained similar results in a historical study of the period from 1900 to 1990, which examined the relationships between moral problem types and nurses' role conceptions of advocacy and autonomy (Wilkinson, 1992). Fourth, adequate intra- and interrater reliability figures were achieved. Fifth, two expert readers were used and consensual interpretation achieved for all the Phase 2, and a representative sampling of the Phase 1, data. Sixth, all inferences were validated by primary and secondary source literature. And finally, only strong patterns were considered in interpreting the data.

Most important though, this was a qualitative content analysis using 1,075 narratives. The intent was not to provide accuracy in coding a single problem, but to determine whether problem types existed in all time periods and to locate patterns in the data. It is not so important for independent raters to categorize a particular problem as a moral dilemma or to count exactly the same number of moral dilemmas, for example. What matters most is that they both note a stronger pattern of, for example,

moral outrage than of moral dilemma in the data. I make no claims for the statistical significance of any frequencies. They are provided in subsequent chapters only to indicate patterns.

Human Subjects Protection

Phase 1 used existing, published text exclusively except for the 1989 data. Anonymity was assured, since the names of the nurses providing the narratives were not known by or available to me. The narratives were published and therefore in the public domain, implying consent of the narrators. In addition, for the 1989 narratives, I obtained written permission from the researcher for secondary analysis of her data. Phase 2 data came from a variety of sources, so different procedures were taken to protect anonymity and confidentiality, depending on the source.

Data Collection Procedures to Ensure Protection of Human Subjects

Data sources discussed in this section were cited fully in Table 3.3 on page 49. Appendix G contains samples of the types of request letters, informed consent forms and participant instructions sent to data sources and participants. Content of those documents varied slightly because procedures varied depending upon the source and type of data. Copies of actual letters and materials sent to all data sources and participants were retained in my files. Procedures used to ensure protection of human subjects for each of the types of data in Phase 2 are elaborated under the following bold-type headings:

- **Published narratives and interviews that are in the public domain**

Stories of this type were located in two dissertations and one thesis (Homann, 1995; Sandelin, 1995; Savage 1995). The Homann data consisted of transcripts of her case studies, which were quoted in their entirety in her dissertation appendix. Data from the *Results* section of Savage's dissertation were excerpts quoted from her interviews of nurse educators. Some of the Sandelin data were taken from interview transcripts that she quoted in her thesis. Because all of these data were found in published materials, they are in the public domain and no permission was required from either the authors or from the nurses who provided the narratives.

- **Papers or journals of RN-BSN or master's students**

RN-BSN students at a midwestern college were offered the opportunity to participate in this study by keeping a journal in which they described and analyzed the moral problems they experienced in their nursing practice during the 1995-1996

school year. Participation was entirely voluntary and did not affect the student's grades. I requested institutional permission to use those journals from the chairperson of the department of nursing. The class professor distributed information/informed consent sheets to the students, and they mailed their journals directly to me to assure anonymity..

Three professors of nursing at other schools agreed to request students from former ethics classes to submit, anonymously, papers they had written for an ethics class. Students had already received their grades for these classes, and neither the professors nor I know who responded to the requests.

- **Unpublished data from other researchers**

Emily Joyce Sandelin, M.S., provided full transcripts of the interviews of five participants in her master's research. Because the transcripts were not in the public domain, I obtained permission for secondary analysis of data both from Sandelin and from her five participants. To protect their anonymity, I did not contact them. Sandelin obtained their written permissions for secondary analysis and maintains those in her confidential file.

Deborah A. Raines, Ph.D. provided raw-data responses to an open-ended question on anonymous questionnaires she administered for her doctoral research. Neither Dr. Raines nor I knew the identity of any of these participants. Approval for secondary analysis was obtained from the Committee on the Conduct of Human Research for Raines' study at the Virginia Commonwealth University School of Nursing.

- **Questionnaire data from nurses working in four hospitals**

Stories were requested from nurses at two Minnesota hospitals and two Kansas Hospitals. A nurse from each of the Minnesota hospitals agreed to act as liaison and to facilitate distribution of information sheets and data requests at their institutions. I obtained permission from the appropriate officer at each of those hospitals. Because participants were instructed to send stories voluntarily and by mail, there was no possibility that I or anyone at their places of employment would learn their identity.

I obtained permission from the chief nursing officers of the two Kansas hospitals. I attended one of their regularly scheduled meetings of nurse managers to explain the study and distribute packets of instructions, questionnaires and stamped,

self-addressed envelopes. Nurses were instructed to return questionnaires by mail so their participation would not be known and their replies would be anonymous.

- **Questionnaire data obtained from nurses on a Midwest Bioethics Institute mailing list**

Nurses attending the October, 1995, Midwest Bioethics Nursing Ethics Institute were asked by the staff to sign their names if they wished to be included on a mailing list which would, among other things, be used to request their participation in a study. Permission was obtained from the President and CEO of Midwest Bioethics Center to use this mailing list for purposes of this research. Instructions, a questionnaire, and a self-addressed, stamped envelope were then mailed to each person on the list. They were informed that participation was voluntary and that they should not use any identifying names of places or put their name on the questionnaire.

Confidentiality

As raw data were received, I removed identifying names and places and assigned an identifying code to each story. For the questionnaire data, an accompanying form included directions to help participants maintain their anonymity. I destroyed the envelopes in which the stories arrived. And finally, the second reader did not see any of the data until after I had removed names and retyped it. Neither she nor anyone else has access to the data in its original form (except, of course, for the 1934 and 1979 data, which are published and in the public domain).

Exempt Status

No harm to subjects was expected and none has been reported. No human subjects were directly involved in Phase 1 of this study, although they were involved to the extent that they wrote a narrative at a time previous to this study. In Phase 2, some participants were asked to write an anonymous narrative specifically for this study (e.g., nurses from the two Kansas hospitals). Both phases of the project were reviewed and granted exempt status by the University of Kansas Medical Center Human Subjects Committee.

CHAPTER 4

CULTURE THEMES: PRESENTATION AND INTERPRETATION

This chapter addresses the findings for Question 1: What are the similarities and differences in themes of nursing culture, institutional culture and popular (United States) culture that are reflected in ethics narratives of nurses from four different time periods: 1934, 1979, 1989 and 1995? In answer to that question, this chapter contains cultural information available from the narratives and from primary and secondary sources. Quotations from the Vaughan (1934) study are preceded by "(34.xx)"; from the Carroll and Humphrey (1979) book, by "(79.xx)"; from the Haddad (1989) data, by "(89.xxxx)"; and from the Phase 2 data, by "(95.xx)." This convention continues in all subsequent chapters.

In this study culture is relevant because it shapes the context in which role conceptions are formed and moral constructions made. This chapter presents only those culture themes that have the most obvious effects on moral problem construction: for example, aspects of the culture that affect nurses' awareness of ethical issues, role perceptions, and willingness or ability to make and/or implement moral decisions.

Culture is the set of shared values, beliefs, meanings and behaviors within society and organizations that are transmitted among people from one period to the next and used to define reality (Reilly & DiAngelo, 1990). Although acknowledging the analytical distinction between cultural knowledge and cultural behavior, Spradley (1972) and Coeling and Simms (1993) pointed out that both cognition (including values) and behaviors (including communication) are a part of the concept of culture. Therefore, I identified cultural themes from patterns of common behaviors and from patterns of stated beliefs and values in the data that I could infer to be shared rather than individual or idiosyncratic.

Organizational culture is the "taken-for-granted and shared meanings people assign to their work surroundings" (Fleeger, 1993, p. 39), or "the pattern of basic assumptions and shared meanings (values) that a group develops to survive their tasks and that works well enough to be taught to new members" (Schein, as cited in Coeling & Simms, 1993, pp. 46-47). Elements of organizational culture include power relationships within the group, the work group's priorities, peer relationships,

support systems within the group, and the group's preferences for stability versus change (Coeling & Simms, 1993). Organizations have "a deep structure of meaning which . . . [involves] symbols, meanings, myths, and ideologies" (Reilly & DiAngelo, 1990, p. 129). Therefore, hospital culture is "reflected in policies and practices related to dress, personal appearance, social decorum, physical environment, communication, and status symbols" (del Bueno & Vincent, 1986, p. 16). *Subcultures* within an organization include work group (or unit) culture, professional culture, managerial culture, and so forth (Coeling & Simms, 1993).

The United States Culture

The popular culture provided the context for nursing and organizational subcultures. From the narratives alone, it was possible to gain a fragmented picture of the economy, the status of women and nurses, and the effects of laws and policies on nurses' decision making in the time periods examined. I have used references to the literature to make this picture more complete

The Economy

Every decade of this century has experienced cyclic variations in such phenomena as the value of the dollar, unemployment and the stock market. However, the 1930s were more dramatically shaped by the economy than the most recent three decades in this study because of the effects of the 1929 Great Depression. The economy dominated the news during the 1930s. For example, 5 of the top 10 national stories in *Time Magazine* during the 1930s were reports on the economy. Their titles were: "Depression," "Banking Crisis," "The New Deal," "Rights for Workers," and "The Dust Bowl" ("Top stories of the 1930s," 1994). During the depression, 1 in 7 adults were out of work; foreclosures of houses, farms and businesses were common (Kalisch & Kalisch, 1987). The Social Security Act was not passed until 1935, so there were no funds for welfare or unemployment insurance. Families that would once have been too proud to allow their young women to work became grateful for the services of any family member who could get a job. Many young women went off to nursing school in order to not be a burden to their family.

By 1927, the economic decline, together with hospitals' almost exclusive use of student labor, had caused serious unemployment of graduate nurses, as shown in this example from the 1934 data:

> (34.80) When I see the nurses who are out of work, I get frantic. I can't go home and I don't want to be dependent on my relatives.

Students, at least, were fed and housed by the hospital, where they lived and worked. Graduate nurses had to find work, and the competition for private duty cases was severe ("The American Journal of Nursing 1900-1940," 1940).

The National Industrial Recovery Act was passed in 1933 as a part of President Roosevelt's "New Deal," to help businesses recover from the depression and to put people back to work—but it did little to help nurses. The plan primarily provided relief for banks, farmers and small homeowners to prevent mortgage foreclosures. Additionally, it provided jobs that were traditionally reserved for men ("Top stories of the 1930s," 1994). This, too, is illustrated in the 1934 data:

> (34.94-97) Why does not the N.R.A. affect nurses? This question is asked by many patients.

> (34.89) I haven't a cent to my name. I have no winter clothes at all. I hate to ask my people for money.

By comparison, the 1970s, 1980s and 1990s were economically tame. During the decade of the 1970s, only 2 of the top 10 national story topics in *TIME Magazine* were related to the economy. They were: "Fighting Inflation," and "Recession and Shortages" ("Top Stories of the 1970s," 1994). The 1980s and 1990s experienced bouts of inflation and unemployment—and even a stock market crash in 1987—but never so prolonged and dramatic as in the 1930s (*The new Grolier*, 1993). This is reflected in the data from those periods, which contain few references to the economy.

Although it was not typical of the entire American culture in 1995, there were pockets of poverty at least as devastating as conditions in 1934. The difference is that in 1995 true poverty was isolated to certain communities rather than being pervasive nationwide. From the 1995 data, one community health nurse remarked that where she worked:

> (95.19) Situations in the community are not ideal . . . [there is] a 98% poverty level; many single parents, teen parents, grandparents raising children. More pressing problems for parents than being present at the school for immunization.

In comparing 1934 to the other 3 time periods, it is apparent that the national economy affected healthcare in all periods; but it was only in the 1970s that the opposite occurred—healthcare began to have an impact on the national economy! In

the 1970s technology advanced rapidly, clinical practice became specialized, and costs began to increase (Christman, 1973). Initially, insurance shielded consumers from these costs, so there was great demand for and usage of healthcare. From a mere 6% of the gross national product (GNP) in the 1960s, healthcare expanded rapidly through the 1970s and 1980s (Kalisch & Kalisch, 1987) until by 1990 it accounted for 12% of the GNP (Grace, 1990).

In terms of the Wilkinson model, the state of the economy can support or constrain nurses' willingness to act morally. When jobs are scarce and the nurse is the only family breadwinner, she may be less inclined to stand on principle if there is a risk of losing her job.

Status of Women and Nurses

This theme refers to the status of women and the image of nurses in the community. Because nursing is primarily a profession of women, the status of nurses and women is intertwined. Individual and institutionalized values and attitudes toward women affect not only role perceptions but role enactment in the Wilkinson model. Viewed from a modern perspective, the women in the 1934 narratives did not enjoy high status. And yet the nurses telling those stories did not complain about their status more than the ones in the recent narratives. As the status of women improved through the years, expectations also became higher, so the chasm between the ideal and the reality remained.

During the 1930s, the proportion of married women who were working increased from 12 to 15 percent, and women were frequently the family breadwinners (Kalisch & Kalisch, 1987, p. 78). Still, that was low compared to the 1970s, 1980s and 1990s. The lives of American women have changed dramatically since the 1920s, when most working nurses were single, and about half were under thirty years old (Melosh, 1982).

By the 1960s, contraceptive use had become widespread, so sexuality no longer had to be linked to reproduction. The feminist movement was strong in the 1970s, empowering many women to begin taking on nontraditional roles. For example, about 7,500 women served in the military in the Vietnam War (Scannell-Desch, 1996). By 1977, many gender differences had disappeared and women had more personal freedom and were not so closely guarded by their families as they had been in the 1920s (Bahr, 1980). Bahr also noted that for the residents of the town

they studied, the median years of school completed for females 25 and over had increased from 9.0 to 11.6 from the 1920s to the 1970s (p. 49).

In a *Nursing74* survey, 52% of the respondents reported, though, that they thought the feminist movement had had little or no effect on nursing ("Nursing ethics: The admirable," 1974, p. 66). Furthermore, advertisements and other mass media accentuated female domesticity and characterized women as dependent on men, less competent, and more passive and emotional (Kalisch & Kalisch, 1987).

Domestic relationships were transformed during the 1980s, as women became increasingly able to control their lives. Many women were challenging the beliefs that they preferred and needed to be self-sacrificing (Kalisch & Kalisch, 1987). But in 1989, women who worked full time still earned only 66 cents for every dollar earned by men. One reason was that women tended to work in low-paying jobs, either because they were not educated for other jobs or because such jobs were more compatible with child rearing. Among FORTUNE 500 companies, fewer than 2% of top executives were female. A 1989 study of 50 middle-class, two-career couples noted that the women performed 75% of the household tasks (Wallis, 1989). One of the 1995 narratives provides an example of the multiple roles that many women assumed (e.g., employee, student and homemaker):

> (95.60) I graduated from a community college with an Associate Degree . . . I was also a single parent and managed a fourplex, so . . . the energy required at work and at home filled up my life.

By 1990 half of all workers in the U. S. were women and in 1/6 of American families a woman was the head of the household. Most women now finish high school and over 30% have some college education (Giele, 1993, p. 32). Nevertheless, women, even now, seem willing to give up their equality in the home. A frivolous, but interesting, example is a study which reported that women willingly allowed their men to control the television remote control. This was despite the fact that the women held jobs and despite the fact that most couples watched television together for an average of three hours a day. "Channel-surfing men rule the roost, systematically driving their wives and girlfriends bonkers. Yet they put up with it" (McCall, 1996, p. E12).

Public Opinions of Nurses

Kalisch and Kalisch indicated that during the 1930s the public was beginning to view nursing "as a worthy, important profession that enabled women to earn a

respectable living . . . requiring training, discipline, and skills" (1987, p. 81). Narratives in all four time periods indicate that patients were comfortable with nurses and readily approached them with their questions and concerns. For example, from the 1995 data:

> (95.91) . . . he said . . . he didn't want [the physician] to know, because he didn't want to involve him in it. He didn't want the physician to be in a position other than total ignorance, in case there were any legal ramifications to the physician . . . . At the time I thought, "Gee, I wish you'd thought the same thing with me," but he was really sharing this on a very personal level . . . and I felt, given what he was telling me, he did trust me.

This seems to have been particularly true in the 1930s, when a physician's work was considered more important than that of a nurse, who was thought of as a mere "Girl Friday." People believed, with some justification, that women took up nursing as a means to catching a man—and then quit work as soon as they accomplished that goal (Kalisch & Kalisch, 1987). Although nurses in the 1930s were trying to set themselves apart by behaving "professionally," it is likely that one reason patients treated them with familiarity was because they saw them as similar to themselves in status and education.

> (34.30) While out socially a nurse is frequently confronted with problems that really pertain to a physician. Friends will ask her the cause of certain ailments, also what remedies might be used.

The 1934 narratives mentioned that families of hospitalized patients used the nurses' telephone and kitchen facilities. Some patients even asked home care nurses to do housework. Apparently the public perceived nurses to be workers, not professionals.

> (34.66) Should a nurse stay on a case after a patient has died to do ordinary housework if asked?

Other indications of familiarity in the narratives were that patients gave gifts to nurses and asked nurses personal questions about their boyfriends.

The 1934 narratives indicate that at least a segment of the population had a low opinion of nurses. There were numerous comments about public criticisms of nurses, for example:

> (34.2) I have heard several patients complain that a nurse gives the best care only to those from whom she expects to receive money as a reward for her care . . . . That seems to be the general impression of nurses.

A 1940 *AJN* article commented that during the 1930s, although nurses were underemployed and poorly paid, they were, nevertheless, criticized for the poor care they gave ("The American Journal of Nursing 1900-1940," 1940):

> The serious discrepancies between adequate provision of care for patients and inadequate incomes for the "many" nurses became distressingly and increasingly apparent. (p. 1090)

The public's negative perception was deserved in some instances. The proliferation of hospitals had led to a decline in the quality of the hospital-controlled schools. Because student nurses were an inexpensive source of labor, nearly all hospitals had started their own training programs. That trend resulted in a lack of uniformity in the quality of nursing education. Nursing leaders generally agreed that nurses tended to be materialistic, to demand much and to give little. Some leaders blamed the lowering of admission standards in order to fill the schools. For example, they commented, "Concessions . . . have permitted the acceptance of relatively large numbers of immature and, all too frequently, poorly prepared students" ("Professional ethics: Some replies," 1922, p. 885).

By 1976, half of all American mothers and 43% of women with preschool children were working—perhaps because only 40% of the nation's jobs paid well enough to support a family. Oddly, despite the growth of feminism and the number of working wives in the 1970s, the media continued to portray nurses as sexual playthings or as malicious and domineering (Kalisch & Kalisch, 1987). Nursing, traditionally women's work, offered low wages and part-time work, which no doubt helped to define the perception of nurses as workers rather than professionals. Public perception, in this instance, was probably more accurate than the perception most nurses had of themselves as autonomous professionals.

In the 1980s public perception had changed only slightly. Weiss found "a continuing public image of nurses as a mere extender of functions performed by the physician" (1983, p. 138). A 1985 study of nursing students found that 51.4% of the freshmen in the study indicated a role orientation toward "supporting the physician in his relationship with the patient, and interacting with the patient on the basis of institutional rules" (Pinch, 1985, p. 375). Because freshmen had not yet been socialized to nursing, their "ideas of role fulfillment came from family, school and society, not from the process of professional education" (p. 375). Non-nurses saw the physician as the leader and did not recognize the need for the nurse to act as a

patient advocate nor to ensure that patient rights were recognized. But there were those within the healthcare system who did believe that patient rights needed protection, even if the general public was not aware of that need. The American Hospital Association published a *Patient Bill of Rights* in 1972, beginning a movement away from the professional dominance model of health care.

By 1990, more nurses were becoming career nurses, whose goals included self-realization as much as supporting the family. Nevertheless, the media still portrayed nurses as physicians' helpers during the 1980s. Kalisch and Kalisch (1987) maintained that the media offered a distorted image of nurses as young women who dedicate their lives to humanity and assist physicians, but only until they marry. People in general still did not perceive nurses as having much power (Morrow, 1988). Some families in the Erlen and Frost (1991) study viewed nurses as experts, but the nurses were not able to implement that role: "When nurses exercised expert power, they met resistance, as physicians dominated the decision making" (p. 404). A continuing problem in the United States is that caregiving, which is the work of nursing, is thought of as "women's work" and is, therefore, not valued in the same way as work that is associated with men (Benoliel, 1992; Melosh, 1982).

Gender Discrimination in Nursing

The theme of gender discrimination goes beyond general societal attitudes to include, specifically, harrassment and/or discrimination on the basis of gender. Although it occurs in healthcare settings, gender discrimination is at least as much rooted in the U. S. culture as in the healthcare and nursing subcultures. In the Wilkinson model, the hostile environment created by discrimination and harrassment can function as a constraint to (a) nurses' motivation to be involved in moral issues, (b) their confidence that their contributions will be heard and valued, and (c) their ability to implement the decisions they do make.

In the case of nurses, it is difficult to separate sexism from economic exploitation of the working class. What appears to be sexual discrimination can just as easily be exploitation of a disadvantaged person who needs work. Unfortunately for nurses, they have qualified for both categories during most periods of United States history. An economic class imbalance is implied in the following narrative (as indicated by "one of our most exclusive rooms"):

> (34.58) I went into one of our most exclusive rooms to see how the patient was . . . . he suddenly put his arms around me and kissed me

> several times. As soon as I could free myself, I said nothing and left the room. I never mentioned the incident to anyone.

No wonder the nurse was afraid to object. Who would have believed that an upper class man would kiss a working class woman or that she could dare to refuse!

As previously mentioned, the National Industrial Recovery Act offered little help to unemployed nurses in the 1930s. Most of the public works jobs were manual labor, such as clearing brush and mending roads, and it was expected that men would do this work. President Roosevelt was quoted as saying, "I estimate that 250,000 *men* [italics added] can be given temporary employment . . ." ("Top stories of the 1930s," 1994).

Women were vulnerable to scandal, which could ruin them personally. If sexual harrassment occurred, the woman was obliged to not make a scene—to avoid scandal. In fact, it was the woman's responsibility to be "careful of her ways" so as not to cause men to take advantage of her, as in the following example from the data:

> (34.59) Most male patients seem to have little respect for nurses. How can this be overcome? While many nurses are careful in manner, speech, and dress, they are classed with those who are not.

Many of the rigid institutional rules and admonitions to use professional demeanor were meant to protect the nurse from sexual advances of male patients (Melosh, 1982, p. 54). Nurses were told to maintain professional distance by avoiding familiarity such as telling patients their first names (Spalding, 1939). A similar concern—that nurses need to be protected from male patients—appeared in the *AJN* "Ethical Problems" column:

> Should student nurses . . . be obliged to prepare male patients for genito-urinary surgery or assist the doctors with these operations?
>
> [Reply] The student nurse of today is too young and there is too much sex consciousness openly avowed and cultivated to make such work a matter of routine. It would be only in an extreme emergency . . . . (1932, p. 1199).

The 1934 narratives do, in fact, contain stories of nurses being sexually harassed by male patients and male acquaintances:

> (34.82) With men I find you can't go too much out of the way to be nice to them and too much attention is not beneficial to them for they take advantage of it but not in the way it is meant. So great care must be taken to be very careful of our ways.

Nursing schools emphasized strict discipline and deference and loyalty to the physician (Reverby, 1987), thereby promoting obedience and subservience. "Hospital schools provided both a structural and a functional arrangement whereby the medical profession and male officials in the hospital could claim the right to exercise control over women" (Ashley, 1976, p. 76). In the 1934 narratives, physicians, even more powerful than male patients, harassed both female nurses and female patients. At that time, the women were more concerned about what people would think of them than about asserting their rights:

> (34.58) How should one take a doctor when he fools with you? If you laugh too much, he thinks you are bold or that your reputation is none too good . . . . This creates a very unpleasant feeling as well as nervousness which prevents you from show [*sic*] your best in front of them.

Even though gender discrimination was present as a theme only in the 1934 narratives, I did find incidents of sexism in the literature. In a survey conducted by a 1974 nursing journal, 32% of the 11,000 nurses responding said that they had experienced seductive or sexual advances from patients. Forty-three percent more had had that experience "once or twice" ("Nursing ethics: What are your," 1974, p. 43). Compared to nurses in 1934, these nurses did not appear to be helpless victims. Their responses indicated that nurses should and could discourage sexual advances from patients. In general they believed that there was nothing wrong with sexual involvement between doctors and nurses so long as it did not interfere with their work, and so long as there was mutual affection and agreement.

Cleland (1971) claimed that sex discrimination was nursing's most pressing problem during the 1970s, especially as it related to the doctor-nurse relationship. The *doctor-nurse game* described a form of communication in which the submissive female nurse makes recommendations to the dominant male doctor in the guise of hints and questions. In order for the physician to preserve the appearance of superiority, he must appear to have initiated the recommendations (Stein, 1967). Nurses were expected to take initiative and make important recommendations, but at the same time they had to seem passive.

By 1990, sexism between doctors and nurses had "receded somewhat in importance" (Pence, 1994, p. 3). Nevertheless, current literature reflects that nurses still experience gender discrimination and sexual harassment, although in perhaps more subtle forms. In a 1992 survey of nurse managers and administrators, 70%

thought that sexist attitudes sometimes or often prevailed, and 54% had observed gender bias. Seventy-five percent of these nurse managers and executives did say that they would confront an administrator who was making sexist remarks (Blancett & Sullivan, 1993). The following is one of several similar statements from a 1996 study:

> I saw other nurses being touched in ways that were just totally inappropriate. Physicians' feeling that they had a right to do that . . . . but I just knew how to maneuver and get away from them. (Smith, Droppleman & Thomas, 1996, p. 26)

In the same study, a nurse faculty member said:

> In my . . . work situation we women are absolutely in the minority . . . in a very paternalistic system. It's a "good old boy" system. It's Southern, it's male-dominated, we are referred to as "the girls." (Smith et al., 1996, p. 29)

And finally, Meyers (1994) speculated that male nurses' concerns and objections may be given more weight and thus their more frequent inclusion in decisions regarding patient care would decrease the likelihood of their experiencing moral suffering" (p. 91).

Legal Concerns

As a theme, legal concerns refers to comments about laws, state boards of nursing, licensing, and lawsuits. In the Wilkinson model, as noted in chapter 2, legal considerations frequently function as constraints to nurses' moral actions.

There was only 1 mention of legality in the 527 narratives from 1934. However, nurses in the other data sets frequently mentioned being concerned about lawsuits—for themselves as well as for the institution and the physician. For example:

> (89.00932) Many units . . . are not adequately staffed or almost completely staffed with new, inexperienced personnel. This is an unsafe practice. I don't think a courtroom would accept that the nurses were too busy or short-staffed. This worries me.

Research literature from the 1980s and 1990s indicates that nurses in those periods were afraid of lawsuits or of losing their license to practice (e.g., Case, 1991; Wilkinson, 1985). Attorney Sheryl Feutz explained:

> The establishment of nurse practice acts, standards of care, and the code of ethics have altered the legal status of nurses in malpractice actions. Whereas previously nurses were not named in malpractice

> lawsuits because they lacked professional status and recognition, today they are held personally accountable for their actions. (1989, p. 4)

This is congruent with the 1995 narratives, in which the nurses had a heightened awareness of legal and policy concerns. Nearly 20% of the 1995 narratives mentioned the effects of legal concerns on nurses' moral experiences. They named a variety of issues, such as lawsuits, legal guardianship, living wills, durable power of attorney, standards of practice, public defenders, nurse practice acts, legal competence, laws regarding assault, the Patient Self-Determination Act and institutional policies. The following are two examples:

> (95.23) . . . all nursing home patients have to have a durable power of attorney or make some of these decisions ahead of time; and we spend quite a bit of time talking about that.

> (95.88) What kept me from doing what I thought was right was the . . . fear of having assault charges placed upon me.

Miscellaneous

In this section, I have included a theme that affected moral problem construction, but which did not fit well into any of the other culture themes—that is, the focus on outward behaviors as an indicator of a moral character. This theme was important only in the 1934 data set, which would be expected, since the ethics literature of that period focused on prescribing which behaviors were and were not moral.

One researcher found that people "place a premium upon a clean personal life, respect for public property and honesty" (Dudycha, 1930, p. 200). Another study, involving the attitudes of women, demonstrated that for the general public, questions of morality were concerned with such practices as smoking, drinking, petting, marriage, and literary taste (Blanchard & Manasses, 1930). The following is an example from the 1934 narratives:

> (34.65) Has the Nursing Bureau the right to refuse to keep nurses on their list who drink and smoke to excess only while off duty, otherwise very good ones?

Literature of the time confirms that nursing viewed morality in much the same way as did the broader culture. In 1932, Paul Limbert, Ph.D., said that "nurses confuse professional ethics with personal morality." Evidence of the similarity

between nursing and popular culture is also shown by the nurse's attitude in the following narrative—the idea that people who sin deserve to suffer.

> (34.56) While relieving on a ward I noticed that a patient suffering with Deliriums Tremens was not receiving the same care that the other patients did. I mentioned it to the student and she said, "It's good enough for him, he deserves to suffer."

The nursing subculture did hold that nurses who broke rules should be punished; however, in honoring the value of caring, the nursing culture would undoubtedly have made some exceptions for patients. This idea was more likely from the popular culture, where it was commonly illustrated by such aphorisms as, "You made your bed, now lie in it," "If you want to dance, you have to pay the piper," and "His chickens have come home to roost."

Healthcare Culture

During analysis, this concept expanded beyond just the organization to include broader societal and policy issues. The concept of organizational culture still fits in the analysis, however, because even nurses who are not delivering care within the walls of an institution are still influenced by the culture of their employing agency when doing home care or community work. Furthermore, most of the narratives were written by nurses working in hospitals. Jameton (1990) noted that an institution's culture is revealed by the most basic assumptions of those who work there. He argued that many nursing ethics problems "would not arise or would arise differently if nurses were contractors working in the home independent of medical supervision and centralized control, or if hospital policy were controlled primarily by nurses rather than physicians and professional managers" (p. 444). Findings are presented in this section under the headings: Institutional Rules and Control, Resource Allocation, Patient Decisions, Heroic Measures and Letting Die, Ethics Committees, and Quality Assurance Committees.

Institutional Rules and Control

Most of the following discussion is taken from the rich information on this subject found in the narratives. To conserve space, I have not cited literature for individual points; however, this entire section can be confirmed by Reverby (1987) and Melosh (1982).

In 1934, nurses' first loyalty was to the institution and second to the physician. Institutions and physicians expected that a nurse would do as she was told;

nurse administrators and educators expected that a nurse would do as she was taught. Apparently no one, including the nurse, expected that she would *decide* anything, except which of the plethora of conflicting rules to follow.

The institutional culture in 1934 included the belief that students and nurses had to be controlled, watched and policed in order to get them to fulfill their duties and responsibilities. A rule existed for nearly every activity (see Appendix H for a list of rules from one of the schools in Vaughan's 1934 study). Many of the ethical problems in the narratives were about whether a nurse should "turn herself in" or whether she should report one of the other nurses. They reported equals and subordinates, but not physicians or superiors in the nursing hierarchy. Institutional expectations were that incidents such as careless work, smoking and rule breaking would be reported:

> (34.64) I knew certain girls were smoking in their rooms. Should I have reported it? I didn't.

It was expected that rule-breakers would be punished. One punishment was to "have your time taken away," which meant the nurse would have to continue working for the hospital for a while after graduation, or would have to work some days with no pay. There were instances of lying and taking covert actions in order to circumvent the rules and escape punishment.

> (34.51) This nurse forgot to give [a medication] for three consecutive hours. What should she do? If she reported to the supervisor she'd have her time taken away, it would go on her report at the end of the month and the supervisor would not trust her again. Should she chart the medication as given or report it?

Expectations of obedience were very strong. When, for example, teachers and senior nurses gave conflicting instructions, the reaction was not "What is the right thing to do" but "Who was I to obey?" Even when ordered to do something wrong, the tendency was to obey.

> (34.42) Our teacher told us never to take a medication into a patient's room, leave it stand and go out, trusting the patient to take it herself. The supervisor insisted that I take a medication into a room as calomel to be taken every 15 min. and leave it there. Who was I to obey?

The controlled environment and rigid adherence to rules produced a variety of reactions. In some cases nurses resorted to subterfuge, finding a variety of ways to

subvert the rules, e.g., giving medications and not charting them, or recording vital signs when they weren't taken. There was no evidence of open defiance.

> (34.52) Today a nurse was to give a patient a hypodermic of morphine. She lost the solution and rather than report it she gave the patient sterile water.

A pattern of subverting institutional rules continued through the 1979 and 1989 data. However, all three of the more recent data sets differ from 1934 in that the more recent rule-breaking was done primarily in order to fulfill the nurse's function as patient advocate rather than as a way to escape punishment. For example:

> (89.00932) Up until recently . . . our hospital refused to allow Do Not Resuscitate orders. Therefore, we frequently must care for brain dead patients . . . . This would include delivering of vasopressors to maintain a BP. There have been times when I would pour a portion of the drug down the sink to account for use of the medication.

The pattern of reporting others, still a common behavior for nurses, also changed in character. The 1979, 1989 and 1995 narratives are different from 1934 in two ways: (a) The nurses began reporting physicians instead of just reporting themselves and other nurses, and (b) they reported others mostly for doing things they believed harmful to the patient, not just for breaking the institution's rules. The focus and emphasis for *why* they are reporting was different than in 1934. This is illustrated by the following two narratives:

> (34.64) I knew certain girls were smoking in their rooms. Should I have reported it? . . .

> (79.53) During the surgery, the patient's bladder was accidentally injured . . . . the operating room supervisor . . . discovered that the surgeon had omitted any reference whatsoever to the accidental injury. . . . the surgeon . . . said he had no intention of changing the record. The nurse went to the administrator. The doctor was called on the carpet and also lost hospital privileges. The patient sued and recovered.

By 1979, institutions were occasionally insisting that physicians, as well as nurses, conform to institutional policies. The institution-physician alliance was not as strong as in 1934 because the institutions had become as powerful as physicians. Hospitals had begun to be concerned about their relationships with patients as well as with physicians.

Nevertheless, the 1995 narratives (as in 1979 and 1989) indicated that results varied when nurses reported physicians whom they believed to be unethical or

incompetent. Physicians were still powerful, but the nursing culture was by then accepting of reporting physicians, and the nurses apparently had some protection from the hospitals. The narratives indicated that hospitals sanctioned physicians only when the malfeasance was so blatant that it was undeniable, when they broke important hospital rules, or when the institution's fear of a patient lawsuit was greater than the fear of loss of revenue generated by the physician. Note the difference in the two following narratives. In the first, the hospital acted; in the second (in which the patients are all unconscious), it did not:

> (79.52) . . . She was instructed by him to take the infant out of the isolette immediately and follow his instructions of disposing of the body. The nurse refused to do so and reported the incident to the hospital authorities. The doctor was forced to comply with hospital regulations.
>
> (89.02552) I . . . found one of the anesthesiologists to be very negligent in his protection and treatment of patients bodies when they are asleep. . . . he would begin anesthetics with no monitoring, flop patient's head when trying to place head strap himself, drop patient's arms that were not on armboards. He also violates pts. right to privacy by throwing all blankets, gown, etc. off pt. no matter what the procedure is . . . . I have always felt very intimidated by him . . . . my supervisor . . . . said she would speak to the doctor - but I never heard another thing about it. I did notice that I am assigned to work in his room as little as possible - which is fine with me.

As society and the healthcare system changed, different institutional rules and policies reflected those changes. For example, only the 1995 nurses mentioned rules and policies to address risk management and advance directives; and unlike the 1979 and 1989 nurses, they seemed to take for granted that Do Not Resuscitate policies would be in place.

Resource Allocation

Undoubtedly the Patient Self-Determination Act of 1991 and the concern for scarce resources have been important influences on the cultural context for moral problems, especially those concerning the end of life. The concern about resource allocation first emerged in the 1989 data. It was expressed by the nurses as concerns about (a) cost control measures (e.g., staffing patterns) that were harming the quality of patient care on their unit or in healthcare in general, (b) instances in which resources were wasted by unnecessary or futile treatments, and (c) the allocation of healthcare resources on a broader scale. Similarly in the literature, nurse respondents

to a survey (Berger et al., 1991) indicated that inappropriate resource allocation was the third most frequent ethical issue they encountered.

Staffing and Workplace Redesign

The historical pattern is that regardless of the supply of nurses, hospitals chronically understaff. Even in the 1934 narratives, there were a few complaints about being overworked and understaffed—but without the concern about resource allocation:

> (34.37) When you know your floor is being overworked, no time off given, and the night nurses must be relieved, should the offense be taken or plug along?

Nurses in the 1970s also complained about unsafe staffing patterns. The 1979 data do not strongly reflect this, but a 1978 nursing ethics text quoted a nurse and described the following story as "typical":

> A nurse told of a shortage of nursing personnel on the evening shift in the intensive care unit where the nurse had . . . six patients on ventilators in three separate rooms. This nurse spent about 15 minutes with one patient who was hemorrhaging and then returned to another room where the patient had accidentally disconnected himself from the machine, arrested, and died. (Davis & Aroskar, 1978, p. 57)

In the 1989 narratives, nurses began to report that cutbacks in financing had resulted in staffing patterns that diminished the quality of patient care and made working conditions intolerable.

In the late 1970s and 1980s, understaffing was a result of an undersupply of nurses (Secretary's Commission on Nursing, 1988); but in the 1990s it occurred because hospitals were trying to cut costs. The wave of reorganization of the late '80s and early '90s began a pattern of downsizing. Hospitals eliminated nursing positions, hired more unlicensed personnel, and "'empowered' their remaining staff to take on extra responsibilities" (Brider, 1993). A 1993 survey of hospital nurses reported that "40% of respondents cited a nurse-client ratio that was too high to provide for the safety and well-being of clients" (Roach, as cited in Tunna & Conner, 1993). A nurse quoted in the Smith, Droppelman and Thomas (1996) study expressed her dissatisfaction as follows:

> It is like a rat race. We are here to push pills and drugs, but no time to do patient care . . . . It seems I always fall behind on time and that

> makes me angry . . . . It is like you are pulled in 20 different directions. (p. 30)

Colleen Scanlon, Director of the American Nurses Association Center for Ethics and Human Rights, related that telephone calls they now receive from nurses identify as the number one issue, cost containment measures that jeopardize patient well being. Nurses feel they have no voice in changes, such as using fewer licensed caregivers, which they view as unsafe and inappropriate. Worse, they do not feel free to articulate their concerns about patient safety because they are afraid of losing their job if they become identified as a source of complaint (personal communication, September 20, 1995).

The 1995 narratives echo the literature—that nurses are upset about understaffing and restructuring and are worried about their job security:

> (95.60) I was . . . told, "Due to organizational and management changes you no longer have a job". . . . was told to get my belongings . . . to go home. I was not to talk to anyone . . . . I felt like the rug had been pulled out from under my life . . . . I felt very poorly treated by a hospital and profession I had worked so hard to improve.

Actually, compared to the 1995 and 1996 literature, the 1995 narratives do not reflect as much concern as might be expected, given the massive structural changes that have occurred in healthcare. Downsizing is widespread, pay gains have slowed appreciably, and many nurses have difficulty finding jobs they want or feel prepared to do (Brider, 1993; Meyers, 1994). Understaffing is qualitatively different in 1995 than in the previous data. Nurses complained about understaffing and worried about the quality of care in all periods. What is different in the 1990s is that, in addition, they are now afraid of losing their jobs through downsizing and layoffs.

Allocation of Funding and Treatment Resources

In the 1979 narratives, where this theme began, arguments against futile treatment usually asserted that treatment caused unnecessary suffering (see page 94). In the 1989 and 1995 data, arguments against futile treatments shifted from a concern with patient suffering to a concern over wasting scarce resources that could be better spent on preventive measures:

> (89.02403) . . . why can't our Medicare dollars be spent for Clinitron or similar beds in nsg. homes rather than wait for an impossible situation to develop and then use valuable resources for a less than 50% chance of recovery.

> (95.14) I know legally nurses should perform CPR on [a] patient when patient is a full code, but we knew in this case it was useless. Just think of money, technology involved to intubate . . . . Very few . . . patients survive in a case like this.

The literature confirms this shift in focus. For example, nurses in a 1996 study expressed anger at patients who waste healthcare resources. One said:

> Addicts, suicidal patients, I could not help but feel a certain amount of anger. You've charcoaled them out because they've overdosed for the third time in a row—OK, fine, do the job the next time. Don't call 911 . . . taking up tax dollars and nurse time, it's a waste of resources. (Smith et al., 1996, p. 27)

Patient Decisions

This theme, *patient decisions,* refers to the notion that patients and families should be involved in decisions about their healthcare, and that caregivers should act according to patient decisions insofar as possible. Both in the narratives and the literature, an increased championing of patient decision-making parallels an increased concern about scarcity of healthcare resources and the notion that it is acceptable to allow people to die rather than "doing everything" to prolong life at any cost.

This theme began to emerge in the 1989 narratives, where a few nurses reported that their institution was moving toward letting patients make decisions about whether to have heroic and life-prolonging treatments. However, this was certainly not the norm:

> (89.00462) . . . I am in agreement with the newer thinking about letting patients decide their own preferences in terminal or severe chronic long term illness. I felt different 24 years ago but after many years of working with only this kind of patient, quality of life is more important to me than quantity. Of course I feel this has to be the decision of the individual in question.

Prior to the 1980s, ethics literature frequently recounted instances in which patients' wishes were overridden by caregivers, especially physicians. A 1977 publication tells of an elderly woman with cancer, who "during the nursing admission interview mentioned several times her desire to die quickly." However, her family persuaded her to begin a regimen of chemotherapy, and a surgeon performed a venous cutdown. The story continues:

> Mrs. W. started crying softly and said, "Please do not let them do this to me." The surgeon neither acknowledged her plea nor stopped working . . . . (Tate, 1977, p. 43)

In contrast, a 1991 survey found that "there was a low frequency for treatment despite objection" (Berger et al., 1991, p. 518).

Many of the 1995 narratives, such as the following, contained references to the idea that patients and families should be a part of the decision-making process.

> (95.42) . . . there's usually no dilemma because most decisions are left to the family. They are the ones who will have to live with the decision!

However, there were still instances in the narratives and in the literature when caregivers ignored the wishes of patients and families (e.g., Meyers, 1994; Wheeler, 1994).

Heroic Measures and Letting Die

For the purposes of discussion, I combined the *heroic measures* theme from Phase 1 with the *letting die* theme that emerged in Phase 2. *Heroic measures* stories were those that contained detailed descriptions of unnecessary and/or futile treatments of dying patients. They focused on the patient's suffering or on describing the details of the life-prolonging measures. Stories coded *letting die* were subtly different. In those, the nurse expressed that it was acceptable, even preferable, to discontinue or not initiate life-prolonging measures, saying things like "We should have let him die peacefully."

In the 1970s, many hospitals were actively generating do-not-resuscitate (DNR) policies. However, the literature indicated that the issue of prolonging life had not been resolved in all institutions nor to the satisfaction of many nurses. When Curtin (1979b) wrote an editorial saying that cardiopulmonary resuscitation (CPR) is misused and puts the nurse in a difficult position, more nurses sent letters of response than to any editorial in the history of the journal. Even in the late 1980s, many hospitals still did not have a DNR policy, and in those that did, physicians often disregarded it (Yarling & McElmurry, 1986b). The narratives are different from the literature in this regard. None of the 1934, and only two of the 1979, narratives even mentioned heroic and life-prolonging treatments as being problematic. Most of those nurses were upset if resuscitation was *not* done or if they had to obey a DNR order.

Nursing studies of the 1980s and 1990s identified prolonging life with heroic measures as one of nurses' most frequent and most disturbing ethical problems (Berger et al., 1991; Davis, 1981; Meyers, 1994; Wheeler, 1994). Congruent with this, the idea that "allowing" people to die was a "good" thing began to emerge as a

theme in the 1989 narratives, which contained many, many stories of life-prolonging, unnecessary, or futile treatments (not necessarily involving DNR). In some institutions in 1989, the use of life-prolonging or futile treatments had already peaked and was being done a little less often. One of the nurses in Meyers' study of moral suffering said:

> I think that overall the practice where I work is relatively humane. They try not to . . . get people too strung out on life support or anything. (1994, p. 56)

The 1995 narratives agree with the literature. Although they include some reports of inappropriate life-prolonging measures, nurses' stories also indicate that this is becoming less of a problem in many institutions.Nurses worried, though, that this was because of institutions' cost-cutting efforts rather than consideration for patients' rights:

> (89.00734) . . . resuscitation and/or excessive measures i.e. surgery, excessive treatment, dialysis, chemotherapy, of elderly or terminally ill patients . . . . This . . . problem has improved in recent years. What saddens me is that it's been $$$ not ethics that have changed the situation.

Ethics Committees

I included this theme merely to mark the time it appeared. It was not a strong theme in any of the time periods. The first mention of hospital ethics committees occurred in the 1989 data, and only two or three nurses mentioned them in the 1995 data. One of those was a nurse who started a nursing ethics group which she called a moral distress group—a group in which nurses could not only discuss ethical problems, but in which they could provide support for each other. The other nurse described a typical multidisciplinary ethics committee that functioned in an advisory role. These findings support Meyers' (1994) study, in which nurses did, albeit infrequently, mention using their ethics committees.

In a recent survey, 79% of the 220 nurse managers and executives responding indicated that they had recourse to an ethics committee (Blancett & Sullivan, 1993). Similarly, in an ethics and human rights survey done at the ANA convention in 1994, 55% of the respondents said there was a multidisciplinary ethics committee in their organization. However, only 42% listed the ethics committee as one of the resources available to them for ethical problems (Scanlon, 1995). The fact that my data

mentioned ethics committees infrequently probably indicates that nurses are not using ethics committees, not that institutions do not have them.

Quality Assurance Committees

I included this theme merely to mark the time it appeared. It was not a strong theme in any of the time periods. The first mention of quality assurance (QA) committees occurred in the 1989 data; and the 1995 data also included 2 references. QA committees, along with ethics committees, provide one avenue for nurses to use in their efforts to be patient advocates. For example, it might be a way to address nurses' concerns about safe staffing and to effect satisfactory patient outcomes.

Nursing Culture

Nursing is a subculture of the organizations in which nurses work and, in some cases, receive their education. The narratives provided some insight into the nature of nursing education and work during each time period. Findings in this section include information about nurses' relationships with patients, physicians, and other nurses, as well as comments about professionalism and cultural diversity.

Nursing Education

Although the narratives did not comment often about nursing education, a few details could be inferred. For example, some stories included comments such as, "I was working at the hospital and taking night classes." Because professional socialization so strongly influences role conceptions, I thought it necessary to use the literature to characterize nursing education in the different periods, even though it did not constitute a theme in the narratives.

From the beginning of the century, physicians attempted to control nurses and nursing education. In 1906 a physician, in a nursing graduation speech, said: "Every attempt at initiative on the part of nurses . . . should be reproved . . . . The professional instruction of . . . nurses should be entrusted exclusively to the physician, who only can judge what is necessary for them to know" (Dorland, cited in Ashley, 1976, p. 78). The fact that a physician was invited to speak at a nursing graduation is evidence that this reflected a cultural norm. The apprenticeship system of education, existing well past 1934, socialized nurses to be obedient and subservient (Ashley, 1976, p. 75).

Prior to 1927, 73% of the hospitals with schools of nursing used only students and had no graduate nurses as staff ("The American Journal of Nursing

1900-1940," 1940). In the 1920s, nursing education underwent intense scrutiny by several official groups. As a result, educators created new schools, reorganized old ones, raised entrance requirements and began university-based programs; and hospitals stopped relying entirely on students and began hiring some graduate nurses for patient care.

In the 1930s, as a result of both the adoption of higher standards and the Great Depression, weak nursing schools began closing. By 1940 there were only 1,303 state-accredited nursing schools, compared to 2,205 in 1927. Nevertheless, they graduated about the same number of nurses ("The American Journal of Nursing 1900-1940," 1940).

By 1979, university education of nurses had become common and diploma schools were closing. Nursing was struggling to become a profession in its own right, but medical organizations still felt the need to evaluate, comment on and control nursing. A report by the Institute of Medicine noted that by 1980, only 15% of nurses were still diploma trained (1981), and speculated that the variety of educational programs reflected and contributed to the ambiguity of nursing roles.

Nursing leaders complained that in both nursing education and practice the prevailing milieu continued to be authoritarian, male-dominated and militaristic. Even in universities, schools of nursing were often under control of the school of medicine. Women administrators of schools of nursing were usually merely token members of male-dominated committees, and further that for many nursing students:

> The "critical" issues seem to be matters like residence regulations and dress codes . . . . While other students . . . were marching for peace . . . . few, if any, of the nursing students were involved . . . . (Group & Roberts, 1974, p. 372)

Despite the trend to higher education for more nurses, nursing education is not always a liberating experience. In a 1996 study, two graduate students stated that conditions in nursing education were sometimes as oppressive as those in practice:

> "Faculty sometimes can see a student that has a lot of potential and will cut a student down just to put them in their place. . . you should have freedom of expression of your ideas without being stifled or hurt in some way." (Smith et al., 1996, p. 25)

The Nature of the Work

This theme includes nurses' comments about specific tasks they performed, the kinds of illnesses the patients had, the way the work was structured and

scheduled, the workload and staffing patterns, and nurses' reactions to the work. The theme *staffing and workplace redesign* also includes nurses' comments about workload and staffing, but it was a theme only in the 1995 data and refers specifically to the downsizing of hospitals and resulting layoffs of registered nurses that began in the late 1980s.

1934 Nursing Work

To provide perspective, the life expectancy for a white male baby born in the 1930s was 59.06 years; for a female white baby, 62.65 years ("The American Journal of Nursing 1900-1940," 1940, p. 1091). Antibiotics had not yet been discovered, and nurses in 1934 were less likely to be caring for octogenarians with chronic diseases than they now are. The work differed in other ways as well; and yet some aspects of the work remained constant through the years. For example, as most bedside nurses would testify, the cultural expectation that nurses should work hard exists today much as it did in 1934.

The 1934 narratives described the nature of some of the hands-on patient care. For example, nurses mentioned feeding patients, washing linens, answering lights, administering rectal feeding, doing lab work such as urinalysis, sterilizing utensils and instruments, making infant formula and washing rubber sheets. There was no reference to intravenous therapy; in fact, in one story the nurse called an intern to administer clysis. The only machines mentioned were thermometers, surgical instruments, and rectal tubes. As previously discussed, students provided care to hospitalized patients. Graduate nurses worked in homes and in public health, and did private (or special) duty with the sickest hospital patients.

In the early 1930s nurses focused on finding work and staying alive. Only later could they think about improving working conditions. According to Reverby, "60 percent of all nurses were unemployed by 1932-1933" (1987, p. 177). As a way to cope with the devastating unemployment during the Great Depression, the American Nurses' Association encouraged "sharing"—that is, shortening the work day of the nurses in order to be able to employ more workers and "cure that ancient evil, the long hours of nurses" ("The American Journal of Nursing 1900-1940," 1940, p. 1090). As the number of hospitals grew, the need for labor gradually increased and hospitals had to begin hiring graduates. However, most nurses preferred private duty. The number of nurses who chose private duty or public health nursing over hospital work (when they could get it) indicates that some nurses found

conditions in the hospitals repressive (Melosh, 1982). Nahm's (1940) findings do not appear to support that notion, however. Of the nurses in that study, 98% said they were very satisfied with their work, even though the sample in that study consisted of 100 institutional, 100 private duty, and 75 public health nurses.

1979 Nursing Work

For the most part, the 1979 narratives described the work of nurses in hospitals; but nurses also mentioned working in public health departments, community mental health agencies, and family planning clinics. By 1979, intensive care units (ICUs) were commonplace and many of the narrators were ICU nurses. Nurses gave high-tech, medical-model care in addition to the physical and emotional support they had provided in previous years. As use of respirators increased, ethical problems began to include considerations of prolonging life and excessive treatment:

> (79.47) . . . not exchanging gases well enough . . . reflexes were fairly good but his pupils were fixed . . . . The physician had to make a choice as to how long to keep the patient on the respirator like a vegetable, or pull the plug . . . This physician wrote the order to disconnect the respirator!

Note the use of an exclamation point in the last sentence of #79.47, suggesting that writing such an order was unusual for that time.

In the 1970s, at the same time nurses were developing specialized knowledge, nursing organizations were participating more in political activity. In 1970, the ANA established a political arm, Nurses Coalition for Action in Politics (Bowman & Culpepper, 1974). Nurses began to claim the authority to participate in institutional and public decision making (Murphy, 1986).

1989 Nursing Work

The 1989 narratives do not indicate that the work changed much compared to 1979. Nurses continued to work in public health departments, community mental health agencies, and family planning clinics in addition to working in hospitals. Hospice work was new in these narratives. As in 1979, nurses did high-tech work, and it was the source of many of their ethical problems:

> (89.1183) The infant was four months premature. . . . The infant was on a ventilator, given TPN's [total parenteral nutrition] and interlipids, a heart catheterization was done and serial blood studies. She was on a high level of oxygen.

Before 1980, hospitals coped with nursing shortages by recruiting more students or using auxiliary workers. During the 1980s, though, women were drawn to many other more attractive career options, and nursing school enrollments fell. In addition, nurses were beginning to leave nursing because of lack of administrative support for improving working conditions ("Three new studies," 1981). For the first time, there was interest in the effects of the work on the nurses themselves (Wandelt, Pierce & Widdowson, 1981). In an effort to keep nurses from leaving nursing, studies were done and recommendations were made for new management approaches that would foster more nursing participation and collaborative practice (e.g., McClure, Poulin, Sovie & Wandelt, 1983). As it turned out, this was short lived (see *Nurse-Physician Relationships* on page 103).

1995 Nursing Work

The 1995 data indicate that nurses worked in a variety of settings. The narratives conform to the now axiomatic statement that patients are increasingly older, sicker and discharged quicker. The following characterizes the patients in the narratives:

> (95.63) An elderly male . . . with a bad septicemia. He had been living in a nursing home for over one year post CVA [cerebrovascular accident]. He had been bed bound and aphasic all this time, with contractures and bed sores. He was . . . intubated and after one and one-half weeks of antibiotics . . . his condition worsened. He was in both liver and renal failure. DNR . . . a dying, vulnerable human being.

As would be expected, such patients require the nurse to be adept at using technology, for example: dialysis, ventilators, in vitro fertilization, and a computerized documentation system.

The 1995 narratives mentioned a variety of specialized and advanced or expanded nursing roles, for example: AIDS researcher, nurse in an AIDS clinic, chemotherapy nurse, surgical circulating nurse, psychiatric team nurse and nurse manager. On the other hand, bedside nurses were apparently still expected to be generalists. At least two nurses mentioned that they "floated" to other floors—sometimes without regard for their lack of familiarity with the specialty:

> (95.5) I have covered the day care center before. It is very stressful. First, we aren't familiar with Peds and their meds.

Similar to the 1934 narratives, physicians in 1995 decided the level of nursing care to which a patient was entitled, at least to some extent. For example, when a patient is discharged from the hospital (by the physician), it is also the physician who decides whether the patient is to be followed by a home health nurse. Third-party payers, including Medicare, require a physician's order for home health nursing care.

The Nursing Hierarchy

This theme refers to relationships and communication of nurses with their nurse peers, supervisors and managers. Such relationships were influenced by the hierarchical structure of the hospitals.

From the beginning, American nursing contained two distinct subcultures: the elite educators and leaders of the professional organizations, and the worker nurses (Melosh, 1982; Reverby, 1987). There was a rigid, strictly enforced and essentially unquestioned hierarchy in which nurses supervised and deferred to other nurses. A study conducted during 1938 and 1939, indicated that "about 1/4 of the nurses are afraid of head nurses and supervisors" (Nahm, 1940, p. 1391).

The 1934 narratives in the present study support Nahm's findings that supervisors and head nurses of that time were powerful and often harsh and unkind. Nurses took orders from other nurses, as well as from the doctors:

> (34.72) This evening the supervisor reprimanded me most severely for an act which she claimed was proof of thoughtlessness and incapability to do my work . . .

> (34.31) When a doctor orders a treatment, even though it is almost impossible for you to carry it out and the head nurse tells you not to, what should you do?

Although peers did not inspire the same fear as superiors, they were frequently just as critical. There was competition and jealousy among those of "equal rank," for example:

> (34.85) I came in training with the idea of being the best in my class, if possible. Although I have received some encouragement, I can't seem to bear to see this girl get anything that I don't receive.

Many of the narratives expressed the value of cooperation and team spirit. To the 1934 nurses, this meant that everyone would do a fair share of the work, no one would get special privileges, and everyone would follow the rules:

> (34.38) If a Catholic nurse is relieved early for Mass, is it not only fair that she report early so that a Protestant Church service may be attended by the other nurse?

By 1989, some hospitals had moved toward decentralization of the hierarchy, and many had autonomous nursing units. Most hospitals decentralized in order to save money by deleting some middle management positions. Others did so in an effort to create a supportive practice environment (e.g., Milner, 1993). Even with the more flexible hierarchy, the literature of the 1970s and '80s (see *Constraints and Supports* in chapter 2) suggests that staff nurses viewed head nurses and nurse administrators as sources of punishment rather than support. They felt that even if nurse administrators wanted to support them, they had limited power to do so.

The 1979 and 1989 narratives reflect the literature. They suggest a slight loosening of the hierarchical relationships among nurses within an institution—the hierarchy remained, but there seemed to be fewer layers of it. Actually, the 1979 and 1989 narratives refer to peer relationships infrequently. A few of the 1979, and several of the 1989, nurses mentioned nursing supervisors and administrators as sources of support when advocating for patients:

> (89.00784) I was ordered over the phone to disconnect a young man from life support . . . . The man had massive head injuries. His parents were en route by airplane from another state. I refused to do so. *My supervisor supported my decision* . . . . the neurosurgeon . . . . was furious at me. [Italics added.]

As in the literature and in the 1934 data, though, the 1979 and 1989 narratives described many more incidents of non-support than of support by head nurses and supervisors:

> (89.00593) After *I submitted numerous proposals to my Director of Nursing and with little feedback and staff and patient abuse continued*, I quit my job and went to work at another hospital in the emergency room . . . . I'm weary of trying to make a difference. [Italics added.]

Current studies indicate that nurses are still very conscious of a hierarchy in nursing. All the nurses in the 1996 Smith, Droppelman and Thomas study used the word hierarchy. They "also identified a sub-hierarchy within nursing itself, in which critical care nursing is viewed as a higher-status specialty than psychiatric or maternal-child nursing" (1996, p. 25). As in the 1934 narratives, nurses in that 1996 study reported that peers were sometimes as disrespectful to them as physicians and

administrators. On the other hand, nurses in Rodney's (1996) study reported consulting, supporting and engaging in dialogue with each other. In chapter 5 of her dissertation she quoted a nurse as saying:

> Well, what we also do . . . is ask for feedback among ourselves like 'What do you think, do you see you know what?', or you know, 'How do you see this?' . . . we have conferences too sometimes . . . . we leave notes for one another. . . (in progress, page numbers not available)

In the 1995 narratives, nurses worked and communicated within the structure of the formal nursing hierarchy in their institutions, communicating first with the nurse next above them in the chain of command. As in the literature, the results of such communication varied. Several nurses told of receiving support from peers and supervisors in ethical situations. Others related the opposite. Examples of peer and supervisor nonsupport follow:

> (95.87) I want to have some stronger backing because one of the nurses I feel totally comfortable with saying . . . . "I don't want to care for this patient any more," and she said "That's fine." But I'm afraid I might get resistance from another nurse . . .

> (95.91) I reported it to my supervisor—which was a big mistake because she was a very rigid person . . . . she just went ballistic—and she often did . . . . I should be able to go to people—other nurses—that could help me problem solve . . . . I should have known that it wouldn't happen.

The following is an example of peer and supervisor support:

> (95.5) A nurse came to me to discuss her concern . . . . she was very upset . . . . The nurse and I went to our supervisor. We explained the situation . . .

Advanced practice nurses working in clinics were the ones most likely to mention management and administrative support.

Nurse-Physician Relationships

Characteristics of nurse-physician relationships are deeply ingrained in the nursing culture. From the late 1800s, loyalty, unquestioning obedience and deference to physicians were stressed for nurses in the United States. In return, physicians and hospital administrators (mostly male) insisted that nursing was women's work and should be subordinate to medicine. They fought nurses' efforts to professionalize and raise educational standards (Ashley, 1976; Reverby, 1987).

The 1930s

None of this had changed much by 1934. Nurses were trying to establish that they were professionals, so it must have seemed logical to affiliate with a dominant professional group (Melosh, 1982), even when that group was hostile and trying to prevent nursing advances. Loyalty to the physician took priority even over loyalty to the patient. In the 1934 narratives, for example, the nurses believed it acceptable to lie to patients in order to protect physicians, even in cases where harm was done to the patient:

> (34.30) A condition arises regarding a patient which is probably caused through oversight on the part of the physician. The nurse is aware of this but keeps this in strict confidence. Is she not duty bound to do so?

Nurses were expected to not bother busy physicians with petty matters such as patient comfort. Despite their strong devotion to the rules of the institution (another role theme), they would sometimes even break the rules (e.g., give a medication without an order) rather than disturb a doctor:

> (34.46) The doctors were busy in the operating room. A very sick patient was restless and every attempt to make her comfortable failed. Would a nurse have done her duty if she gave the patient a sedative without an order?

The 1934 data indicate a cultural assumption that physicians held power over both patients and nurses. Apparently physicians' power was on the same level as institutional power. They seemed exempt from institutional rules:

> (34.64) If a doctor offered a nurse who is in training and he knows it is forbidden to smoke, a cigarette, should she accept?

Physicians' power over nurses extended even to sending them on personal errands which the nurse believed to be immoral.

> (34.43) The Doctor in charge of our office asked me to take a sealed envelope to the druggist across the street. I returned to the office with a package that I am sure contained two pint bottles of whiskey for our guests. I did not appreciate being asked to go on such an errand, but I realized that . . . . the Doctor would have become indignant. I owe my job to him so I executed the errand . . . without giving the slightest hint that I suspicioned anything wrong.

One source of the physician's power was that nurses depended on him for work. The doctor determined whether patients needed a graduate nurse, student

nurse, or private duty nurse, and he recommended nurses for cases. This power imbalance was apparently a cultural norm, because the narrator of the following example is actually *asking* whether the nurse should be fired, rather than saying "I think this is unfair." Apparently she accepts that the physician should hire and fire; her question is only whether this particular infraction *merits* firing.

> (34.33) A senior nurse tells a [patient] the work performed on him during an operation. The doctor is angered and demands that the nurse be dismissed. Should she?

In deference to physicians' power, nurses did not use direct communication with them. Even if a physician was endangering a patient's life, the nurse had to keep silent or be very tactful. Nurses "suggested" or "hinted" to physicians, as in the following example from the data:

> (34.29) The nurse suggests to the doctor that no company be allowed at night, stating the effect it produces on the patient. Although she is doing this for the welfare of the patient, is she assuming too much responsibility?

This makes sense considering nurses' socialization and the status of women in the 1930s, which were discussed in previous sections of this chapter.

The 1970s and 1980s

As a result of changes in society and healthcare (e.g., the women's movement, better education for nurses and the increased use of technology by nurses), expectations of obedience and loyalty had diminished in the 1970s and 1980s. For example, the 1976 ANA *Code of Ethics* no longer specified loyalty to the physician. In fact, if a nurse believed a practice to be incompetent, the code required her to speak up (American Nurses Association, 1976).

Because of the nursing shortage in the late 1970s and early 1980s, hospitals were desperate to improve practice conditions. They sponsored studies about nurse burn-out and attrition (Wandelt et al., 1981), which resulted in several documents recommending collaborative practice, or collegial relationships, as a way of attracting and keeping nurses. Nevertheless, old power imbalances remained. As the nursing shortage gave way to layoffs and downsizing in the late 1980s, the concept of collaborative practice as nurse-physician collegiality all but disappeared. Research demonstrated that physicians viewed their authority in patient care decisions to be greater than that of nurses, failed to recognize and value nurses' contributions to

patient care decisions, and did not perceive nurses as colleagues (Baggs & Schmitt, 1988; Katzman, 1989). Collaborative practice (in the sense of collegial relationships) depended on agreement from the physicians. Note the lack of collaboration in the following narrative:

> (89.01513) . . . Although we nurses have come to a satisfactory relationship in this regard with our other doctors, this one remains firm in his wishes . . . . we have found *to successfully work with this doctor that we need to follow his wishes*, [italics added] so we do (until a float nurse comes along who doesn't know, then we all get "chewed out" when this doctor's pt. has been told something).

I found only two instances of collaborative practice in the 1989 narratives, and none in 1979. The following is an example:

> (89.00022) As a hospice staff nurse I was requested to insert an NG tube for feedings on a comatose AIDS pt. During discussion with the MD I was able to relay patient wishes requesting no tube feedings or extraordinary life support. The physician, who had cared for this pt. for several years, then remembered that the pt. had also told him the same thing. I was fortunate in fact that I was dealing with an MD who was willing to listen me . . . . I may have less of a problem since I work Hospice Unit where the MD's will work with us.

The narratives parallel the literature. Nurses in the 1979 data were less inclined to blind obedience and more inclined to criticize medical practices, although they did not necessarily confront the physician or report the practice. During this period, nursing students were socialized to see nursing as a profession with a unique body of knowledge, and indeed their knowledge base was expanding; so it seems logical that some nurses would have enough—or would believe they had enough—knowledge to judge the appropriateness of medical treatments and decisions.

As in 1934, many of the 1979 and 1989 nurses still feared physicians. Clearly they had the power to make trouble for nurses:

> (89.02552) I would always try to protect my pt. as much as possible without getting in his way but I have always felt very intimidated by him . . . . my supervisor . . . agreed that I should do what I feel is necessary to protect my pts. rights. She said she would speak to the doctor - but I never heard another thing about it. I did notice that I am assigned to work in his room as little as possible - which is fine with me.

The narratives demonstrate that physicians could be verbally abusive to nurses at will:

> (79.31) . . . with words I will not repeat he demanded to know . . . I explained that I had no choice . . . He did not accept my reasoning and continued yelling about the stupidity of some nurses . . .

Nurses in the 1979 and 1989 narratives communicated more assertively and directly than in the 1930s, but they were still suggesting and hinting. They had to "know how to handle" a physician because it was apparently the norm for physicians to disregard their communication. Nurses told many stories in which the physician disregarded their requests. For example, the physician would refuse to:

1. Come to the hospital after the nurse had telephoned to express her concerns about a patient and ask the doctor to come in.
2. Begin or discontinue a particular treatment, after the nurse asked, on behalf of the patient, for him to do so.
3. Change an order for a treatment with which the nurse or the patient did not agree.

Some nurses told of refusing to follow physicians' orders when they could not persuade the physician to act in the patient's best interests. However, open disobedience often did not prevent undesirable actions:

> (79.61) . . . . In the past, I had discussed this doctor's actions with the doctors on the medical Committee as did other personnel, but nothing was ever done. His peers knew the type of medicine he practiced, but nothing was ever done by those in authority or those who had the power to act.

In order to effect changes in physician decisions and behaviors, nurses frequently took covert actions or obtained backing from someone in power in the institution, for example a nursing supervisor or a hospital administrator. But physicians still maintained a great deal of influence with institution administrators:

> (89.00593) . . . due to administration's refusal to discipline or restrict incompetent physicians. Their rationale is that "physicians make money for the hospital and if we have rules for them to follow, they will just take their business elsewhere."

The 1990s

By 1995, loyalty and obedience to physicians was no longer a cultural assumption in nursing. One 1996 study depicted nurse-physician relationships in

general as adversarial and hostile (Smith et al., 1996), and one nurse described turf battles over "what part of patient is the doctor's and what part is the nurse's" (p. 24).

Collaborative practice had again become a buzzword in hospitals—but no longer from a desire to attract and retain nurses. The term had become a euphemism for (a) a type of workplace redesign that replaces nurses with unlicensed personnel and (b) delivery of standardized care on strict timelines via a multidisciplinary (read "medical model") care plan. Even now, true collaboration does not appear to be widespread, especially in hospitals. A nurse in a Canadian study said: "It definitely is very typical . . . . everybody in the hospital works together except for the doctors" (Rodney, 1996; in progress, page numbers not available).

It must seem intuitively obvious to most nurses that in 1996 they are still in a power-under situation. That notion is supported by Smith and colleagues' (1996) study of anger, which noted that "doctors held a superior rank" (p. 24), and that physicians rudely ignored or discounted nurses' communications to them. Nurses resorted to angry communication in efforts to make themselves heard:

> I have had real confrontations with physicians that were literally shouting, screaming, throwing matches. And I've even had some of the worst come back and apologize. (p. 29)

Nurses in Wheeler's (1994) study also described incidents of physicians "pulling rank." For example:

> A decision reached at a team meeting was rescinded by the physician, who neither informed nor discussed the matter with staff, but simply altered the treatment plan to conform to the newly-arrived-at and independently-made decision. (p. 67)

Similarly, Evans (1995) described a case in which a nursing supervisor confronted a physician about lying to a patient; but "Dr. X did not reply and walked off the unit" (p. 6). Meyers (1994) reported that nurses still needed to play the "doctor/nurse game" of "indirectly, carefully leading a physician to write desired orders for a patient" (pp. 58-59).

In the 1990s, nurses were contesting questionable medical treatments even more frequently than before—by talking to the physician, communicating through the organization's management hierarchy when that failed, and even publishing accounts of incompetent practice (e.g., Curtin, 1992). Like the literature, the 1995 narratives

contained many mentions of physician practices that nurses considered to be incompetent or unethical. For example:

> (95.64) What really bothered me was that we weren't appropriately treating this man . . . . they wouldn't give him enough Ativan to keep him from having symptoms of withdrawal. I just kept going to them and going to them and they finally said, "Give what you want."

In the 1995 narratives, nurses communicated more directly with physicians and with somewhat better outcomes. However, true communication was still too often dependent upon the physician's whim. In the following example, the nurse was able to obtain pain relief for her patient only after persisting for over 48 hours. However, she was at least not sanctioned by her institution for her assertiveness:

> (95.61) [The patient was having more than usual post-operative pain, but was being treated by physicians according to the routine medication protocol.] I . . . asked them to order a PCA pump . . . . Her physicians [stated], "Just give her what we ordered . . . she is four days post-op." Acute pain services team [recommended] a Fentanyl PCA and some Tegretol. I called C's physicians and asked them to read the recommendations and was told, "We'll be back later." They never came back that day.
>
> I thought to myself, "Enough is enough. I don't care whose feathers I ruffle" . . . . I was extremely assertive this time as I approached her physicians. I asked Dr. W., "Please look at the recommendations made . . . Look in the computer and see how much medication it took in the last 48 hours just to make the pain tolerable . . . . This is a human being with a need you have to acknowledge now!" Taken aback by my strong assertiveness, the physicians finally ordered a Fentanyl PCA . . . . I felt like I had wrestled an army to get my point across, and I had to be extremely assertive, almost nasty, to get them to listen to me!

In the following scenario the physician behaved in the traditional way. However, because the nurse was a unit director, she was not intimidated and she persisted:

> (95.8) I met with the physician. The hospice nurse was also present. We told the physician that Joe wanted to go home . . . . The physician did not appreciate our input and I heard later that I had gone out of my boundaries . . . . I discussed this case with administration and . . . mechanisms were being implemented to review the case.

The 1995 narratives contain the first descriptions of nurses and physicians communicating comfortably, and in one case a nurse actually approached a physician

for support in an ethical matter. In many of these stories, though, the physician was female or the nurse was a manager or an advanced practitioner:

> (95.91) [An AIDS patient committed suicide.] So I talked to the physician—and I don't remember his exact words, but . . . . he was very nonjudgmental . . . was very supportive of me, and understanding my conflict with it. But also, in a sense, solved the ethical issue because it wasn't an issue for him . . . . It seemed like a natural progression because I worked very closely with this doctor and spoke to him several times a week . . .

Nevertheless, the 1995 narratives contained several references to the power imbalance between physicians and nurses (see *Powerlessness*, in chapter 5). The stories were similar to the 1934 narratives; the difference is that there were fewer such references in the 1995 data:

> (95.59) I allowed the nursing staff to be upset because of the procedure and risk a legal suit by not having the physician conform to a standard of practice. If I stopped the physician I risked reprimand and job security.

The 1995 narratives contain the strongest theme of nurse-physician collaboration, but even in that data the theme was weak. Although the literature suggests that true collegiality is still not widespread, there is probably more multidisciplinary collaboration in practice than was indicated by the narratives in this study. Most of the participants in this study were responding to a request to describe an ethical problem. Nurses would be unlikely relate stories of collaboration in response to that type of request. Because true collaboration removes some of constraints to nurses' ethical practice, it is likely that more ethical problems would arise from a *lack* of collaboration.

In the present healthcare context, nurses function as case managers and quality assurance evaluators, and hospitals are beginning to require at least some degree of multidisciplinary/collaborative practice, in order to meet insurance companies' timelines and quality assurance standards and to help contain costs. Of course the use of "critical pathways" in an institution is not sufficient evidence that there is true collaboration. Critical pathways and standardized care may or may not reflect nursing input.

Nurse-Patient Relationships

In 1934, patients were about the only ones lower than nurses in the healthcare hierarchy. Nurses could actually refuse to give information to patients, tell them what to do and even scold them—except for male patients, who could apparently abuse nurses at will.

> (34.76) . . . a patient . . . insists on moaning and groaning although in a nine bed ward. I'm afraid that I give her rather severe scoldings.

In defying or refusing patients, the nurse invariably invoked hospital rules, not having much power of her own.

Although patients approached nurses freely, openness was not a hallmark of the nurse-patient communication in the earliest narratives, at least on the part of the nurses. Ethics texts of the period confirmed that a nurse could lie to a patient with a clear conscience "as long as she is acting for his good and not for her own profit" (Aikens, 1929, pp. 183-184).

In the culture of 1934, kindness may have been a more basic virtue than truth-telling, so from the cultural perspective of that time, telling the truth to a patient may have seemed unkind in some instances. Recently, Davis said:

> I come from a country where we think that someone who tells the truth is a virtuous person. This same behavior of telling the truth viewed from a different cultural perspective may seem unkind, and kindness in that culture may be a more basic virtue. (1990, p. 688)

By 1979, nursing literature was becoming inclined to advise nurses to tell the truth to patients except in "rare situations" (Mahon & Everson, 1979, p. 6).

Through the years, nurses began to give information of more substance to patients—information and advice about their physical condition. Compare the following narratives, for example:

> (34.36) If a student is asked by a patient's mother whether or not they should employ a special nurse, and she really feels there is no need for one would she be right in saying so.

> (79.40) We talked with the doctor and he seemed to understand and left the consoling of the family with us.

> (89.01981) I encouraged her to have an abortion and to have her tubes tied as I felt she may die if she carried this pregnancy - her children needed her alive and well.

> (95.68) In another case, a patient was offered a heart transplant, but refused, stating that she was old, a grandmother, and it was her time to die. The nurse argued with her that she was only 50 years old and did not have to give up and die. The nurse gave her information on heart transplantation and even called a previous heart transplant recipient to persuade the patient to accept the transplant.

However, in all four time periods, there was some "sacred" information that the nurse was expected not to give to patients. The following incidents illustrate that even in recent years, the extent of nurses' communication with patients was more or less at the whim of the physician:

> (89.01513) In my hospital we have one physician who is very strong in his desire that nurses do not give his patients any information (ex: their progress, results of diagnostic procedures, prognosis, even the names of the meds they are being given).

> (95.41) . . . the medical staff takes a long time telling the parents [the child's prognosis]. I feel that I am deceiving the family when they ask questions or want to talk about how well their child is doing and I am not in a position to reveal what is going on.

The 1995 narratives are different from the other periods in that they contain many more descriptions of patient teaching—usually for the purpose of facilitating self-care. In part, this is because the trend to early discharge has created a situation in which patients are discharged from hospital still needing treatments and care. This means that someone, usually the nurse, must teach patients and families what they need to know for self-care. The information-giving theme may also be exaggerated in the 1995 data because several of the narratives were replies to a request not only to describe an ethical situation, but to explain the thinking and actions that occurred. Some of the stories were very long and, therefore, mentioned information-giving even when it was not central to the issue.

Beginning with the 1979 narratives, nurses frequently spoke of forming covert alliances with patients in order to meet patients' needs or honor their wishes. In those data, many nurses told stories of physicians treating patients despite the patients' objections. When direct communication was inadvisable or ineffective in achieving patient advocacy, the nurse would join with the patient in disregarding physician's orders or ignoring institutional rules. For example:

> (79.151) . . . I returned to talk with Ms. H. and told her the doctor thought she should take the medication but *I added, "I guess it's one's own decision to decide what we put in our mouth."* She laughed.

> However, she did take the medication when she was severely depressed but not when she felt she could function without it. *She let the doctor think she was taking it as prescribed.* [Italics added.]

These findings are congruent with Jezewski's (1993) notion that nurses and patients are, in a sense, natural allies. Using the concept of *culture brokering*, which she defined as "the act of . . . mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change," she said that "nurses and patients make obvious and genuine allies since both have historically suffered the indignities of powerlessness in the modern health care system" (p. 80).

As in previous years, nurses in 1995 still resorted to subversion when the system was unresponsive. In an example from the literature, a nurse in a recent study described an instance of "taking the back door" as a route to patient advocacy:

> There were [orders to] hold sedation . . . to give minimal amounts of sedation. Nobody really ever followed that. They would just [acknowledge] there's no way that they're going to wean this patient off the ventilator and just go ahead and . . . sedate [him] anyway. (Meyers, 1994, p. 57)

Although some subversion was present in the 1995 data, only one nurse told of a situation in which she covertly involved the patient. Even then, she conveyed the patient's wishes directly to the physician.

> (95.83) Oncologist told me that I needed to convince the patient to have more chemo. When I asked patient she said no. Called husband, explained everything. He said whatever she decided was fine with him. Doctor was called, patient made DNR.

The 1995 participants included slightly more advanced practice and master's degreed nurses, who may be more assertive and direct with physicians, and who therefore have less need for covert actions. Additionally, there were more female physicians than in previous years, which at least tends to diminish gender based power differences.

It may also be that the present healthcare environment decreases the need for subversive activity in order to effect patients' wishes. With the present reimbursement systems, some power has shifted from hospitals to insurance providers and regulatory agencies, and from them to patients. There is currently more institutional concern for respecting patients' decisions about their care. Furthermore, an increased interest in

cost containment is occurring in a system that capitates all care or pays by the diagnosis rather than by the procedure; therefore institutions are more inclined to agree with patients' decisions to refuse treatment. Add to that the litigious nature of U. S. society, and the emerging phenomenon is that physicians and administrators will tolerate nurses' open expression of the *patient's* wishes, even though nurses' own opinions carry little weight.

Professionalism

In this study, professionalism indicates nurses' need to be separate, superior to, or different from patients. It includes the idea that nurses are somehow special and set apart—by their knowledge, for example—and perhaps should be recognizable by their demeanor. This resembles O'Neill's (1992) description of classism. O'Neill said that although nurses come from all classes, they were expected to be and act middle-class (e.g., with regard to their deportment, dress and language).

Professionalism was especially important in the early 1930s because of the low status of nursing and nursing education. Because nurses were trying to establish that they were professionals, it seemed important for them to be recognized as being set apart from patients and their families. A group of graduate nurses wrote to the *AJN* a letter that reflects the concern with professional appearances:

> A small group of student nurses have caused a great deal of community gossip . . . . They think nothing of having social relations with the porters, orderlies, and ambulance drivers.
>
> . . . . What can be done to stop the above practice? ("Questions," 1930, p. 1070)

Melosh (1982) speculated that professional demeanor "helped nurses to defend their emotions against the shocks of hospital life, and . . . threatening situations . . . [including] the physical intimacy of nursing and its psychological associations with sex and death" (pp. 53-54).

Partly because of the way in which it was defined for this study, professionalism was a weak theme, appearing only in the 1934 data. It was apparently a cultural norm during that time. The nurses in the narratives were concerned with public opinion of nurses, carefully addressed each other as "Miss," and tried to keep patients and families from being too familiar with them, as in these examples:

(34.45) How to explain to visitors that the telephone is for nurses only.

> (34.45) . . . keeps the chart in the room. Relatives persist in reading the chart. The physician in charge has shown them the graphic chart. They seem to feel they have a perfect right to read all the notes.

By 1979, what was culturally regarded as professionalism had shifted from the appearance and deportment of the nurse to assertions that autonomy and advocacy were appropriate to the nursing role. In the 1979, 1989 and 1995 narratives there was no theme of nurses trying to set themselves apart from patients. Following the emphasis on professionalism and higher education for nurses that ensued in the 1960s and 1970s, it may be that nurses had begun to take for granted that they were "set apart" from patients. Certainly they were in possession of a body of knowledge that most patients did not have. A specialized body of knowledge is one of the defining characteristics of a profession, and the role theme, *knowledge*, in chapter 5, reflects nurses' perceptions that knowledge was a norm of the nursing subculture.

Summary of Culture Findings

Examination of the narratives and the literature establishes that there were indeed differences in the cultural contexts of the four time periods. In terms of the United States culture, it has gradually become more acceptable, and even expected, that women will work—not just during family financial crises, but as a career. With each era, more and more policies and regulations have affected nursing, and lawsuits have become common. The lay public has gradually come to view nurses as having special knowledge, but still as the physician's helper more than as professionals in their own right.

Healthcare has changed dramatically in structure, but nurses are still considered expendable workers whose salaries count against the bottom line. Nurses in all four time periods voiced concerns that there was insufficient staff to care safely for patients—but the reasons for short-staffing were different in each period. New concerns have arisen with new technologies and the burgeoning costs of healthcare—for example: allocation of treatment resources, whether to perform heroic measures to prolong a patient's life and allowing patients to make decisions about treatments and even refusal of treatments. Two institutional structures that have been put into place recently are quality assurance committees and ethics committees.

In the nursing culture, the work has come to require more knowledge and use of technology. At the same time, nursing work has in the 1990s begun moving out of hospitals into homes and communities—similar to the settings of 1934. Nursing

education has changed since 1934, moving from hospitals into colleges and universities. Nurses gradually became socialized to expect that they should be autonomous professionals who serve as advocates for their patients. Nevertheless, hierarchies still exist in nursing and power imbalances still exist among the different health professions. Nurses today are less concerned with convincing patients that they are professionals than with convincing organizational administrators and other professions of that fact.

The cultural changes that occurred in the four study periods both affected and were affected by nurses' perceptions of their roles. In addition, the different contexts offered different constraints and supports for nurses to actualize their role perceptions—especially in relation to autonomy and advocacy. Role themes are presented in chapter 5.

CHAPTER 5

ROLE THEMES: PRESENTATION AND INTERPRETATION

Research Question 2 asked: What are the similarities and differences in themes of nurses' role conceptions that are reflected in ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)? In answer to that question, this chapter concurrently presents and interprets study data along with the relevant literature, in the hope of preserving a dialectic between the living narratives and the abstracted theory.

Theme Development

Role themes represent nurses' perceptions of what the nursing role is or what it ought to be. *Role conception* (also referred to as *perceived role* and *ideal role*) is the nurse's belief that certain functions are appropriate to the nursing role, regardless of whether the nurse was actually able to perform those functions. *Role enactment* (or *actual role*) is the extent to which the nurse can, or perceives he can, enact his role conception in the practice environment.

Relationship Between Role and Culture

Nurses' perceptions of what is appropriate to the nursing role are primarily a product of their socialization in school, at work and in the wider society. Role socialization involves internalizing the values and attitudes of the professional or occupational group (Hinshaw, 1978). A role is "a set of shared expectations" that includes beliefs about goals, values, and norms governing a person's behavior—much like culture (Scott, 1970, p. 58). Pinch (1985) demonstrated significant changes over time in nursing students' attitudes toward autonomy and promotion of patients' rights. This suggests that the role perceptions students had obtained from family and society were further developed by professional socialization.

To the extent that a particular role conception occurs frequently enough, it is a shared perception—making it a cultural norm. Role conception, however, is also influenced by individual differences, for instance in personality, cognition and knowledge (Hardy & Conway, 1978). The role themes identified in this study represent collections of individual perceptions (role) that may, but do not necessarily, represent collections of shared perceptions (culture).

Major Role Themes

In this study a major theme is one that appears with moderate consistency in all four time periods, or one that is very strong in at least one time period. In answer to the second research question, the following seven major themes of role were identified: advocacy, autonomy, powerlessness, obedience/rule-following, enforcement, knowledge, and teaching for empowerment and self-care.

I struggled with the wish to not deviate too much from the qualitative paradigm that guided this study, and yet I realized that it is easier to follow changes in multiple themes of role conception over time by looking at graphs and tables than by relying exclusively on narrative description. Qualitative content analysis does not preclude quantification (Ball & Smith, 1992); and explicit counting can even improve on implicit quantifications such as "few" or "many" (Morgan, 1993). Therefore, given the number and complexity of concepts and details presented in this study, I have chosen to illustrate it with tables and graphs. To facilitate visual illustration, I counted the frequency of occurrence of the five major role themes that seemed theoretically most relevant to moral problem construction (see Table 5.1).

All percentages used in this study merely indicate the proportion of narratives that contained a particular theme. For example, 3% of the 1934 narratives contained a sentence or phrase that could be coded for autonomy. That percent does not indicate some underlying amount of autonomy thought to be present in the narratives or in the population, nor does it imply that 3% of the nurses in 1934 had autonomy as a part of their role conception.

Advocacy

Advocacy is the articulation and defense of the rights and interests of another (Jezewski, 1993; Rushton, 1994). This analysis was limited to consideration of nurses' advocating for patients, and was concerned with nurses' conception of advocacy as an appropriate part of the nursing role (ideal advocacy) as well as their ability to actually function as advocates in practice (actual advocacy). Advocacy was identified in the narratives both by statements of valuing and descriptions of advocacy behaviors, after Linton (cited in Hinshaw, 1978, p. 275), who said in 1945, "A role consists of three components: values, attitudes and behaviors."

Table 5.1. Percent of Selected Role Themes, by Time Period

	1934	1979	1989	1995
Advocacy	3%	40%	34%	55%
All Autonomy (Actual + Ideal)	3%	48%	17%	26%
Autonomy (Actual)	2%	46%	12%	18%
Autonomy (Ideal)	1%	2%	5%	8%
Knowledge	0	24%	14%	25%
Obedience/Rule-Following	13%	13%	13%	14%
Powerlessness	3%	18%	30%	28%

Advocacy in the Narratives

In answer to Research Question 2, the advocacy theme was much weaker in the 1934 data than in the other periods (see Figure 5.1 on page 120). In the data, advocacy sometimes took the form of responsibility or duty statements (e.g., "I felt I owed it to the patient"). Advocacy included intervening between the patient and the system or more powerful others. The following are examples from the data of advocacy behaviors or beliefs:

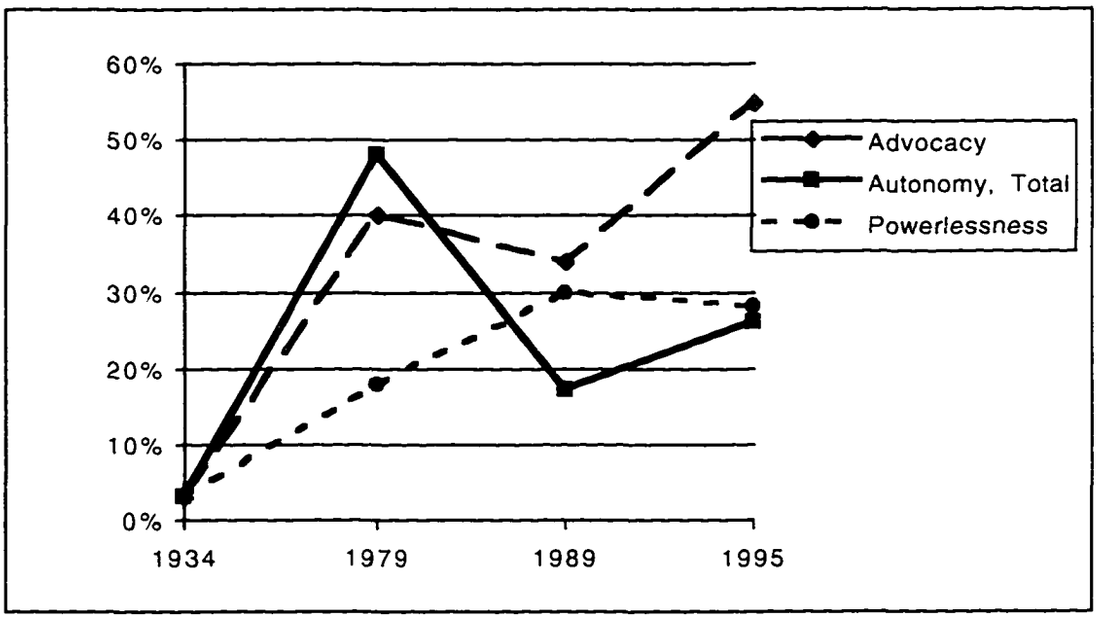
> (34.46) Would a nurse have done her duty if she gave the patient a sedative without an order? (Desire to be advocate)
>
> (79.54) . . . I reported what I felt was lack of medical care to the hospital supervisor and director of nurses. (Behavior)

For some of the 1934 nurses, the value of duty to the patient was an embryonic notion of patient advocacy. However they did not have advocacy clearly as a role conception. They were still questioning, still asking permission to fulfill their duty to the patient. For example:

(34.46) The doctors were busy in the operating room. A very sick patient was restless and every attempt to make her comfortable failed. Would a nurse have done her duty if she gave the patient a sedative without an order?

In the 1934 and 1979 data, advocacy stories often involved a caregiver who was endangering the patient by not following procedures or rules. In 1989 and 1995, advocacy shifted subtly to an emphasis on incompetent or unethical care. In all data sets, much of the advocacy was accomplished by reporting the incident to the nurse's supervisor or by documenting a series of incidents to turn in to nursing management.

Figure 5.1. Advocacy, Total Autonomy and Powerlessness (Percents)



Advocacy Literature

Findings are consistent with the literature. There were no references for advocacy in the nursing indexes searched for 1920-1950. During the first half of the century the literature stressed duty to the patient, but that duty was always superseded

by the duty to obey and loyalty to the physician. In the 1920s and 1930s, nursing education socialized nurses for subservience rather than patient advocacy. Aikens' 1929 ethics text said:

> An important duty for the nurse . . . is to meekly accept, as right and necessary, much that she cannot understand. A second duty is to try to see every situation from the viewpoint of those in authority (p. 18).

A journal letter to the editor described a case in which the nurse telephoned a doctor and described a patient's symptoms of toxic levels of prescribed "strychnia and whiskey." The physician insisted she give it as ordered, she complied and the patient died. The letter stated there was little a nurse could do to intervene on the patient's behalf:

> More than one nurse had too much self-respect to remain, yet what action could a nurse take except to leave the case? ("The Editor's Letter-Box," 1922, p. 146)

Although some nurses have always criticized the need for unquestioning obedience and loyalty, the military metaphor of nursing, steeped in those traditions, remained dominant until the 1960s (Winslow, 1984). In this metaphor, physicians were the commanding officers and the foot-soldier nurses were to obey them without question. As an example of such loyalty to the physician, the code of ethics proposed at the 1940 ANA convention referred to the patient as "the physician's" and said:

> In the broad field of health, the area in which results are depending upon nursing service, alone, is relatively small. ("A tentative code," 1940)

In the 1960s, schools began socializing nurses to include patient advocacy in their role conceptions. However, a study by Hofling et al. (1966) illustrated that they usually did not implement that aspect of their role. The researchers presented a case in which a physician gave a telephone order for a grossly incorrect medication to a nurse. In response to their questionnaire, all of the 21 nursing student respondents and most of the graduate nurse respondents indicated that they would not have given the medication. However, when researchers observed them in actual practice, 21 of 22 subjects indicated their intent to carry out such an order. Hofling et al. said:

> . . . a considerable amount of self-deception goes on in the average staff nurse . . . when thinking about her performance, the average nurse tends to believe that considerations of her patient's welfare and of

> her own professional honor will outweigh considerations leading to an automatic obedience to the doctor's orders . . . (p. 178)

Legally during that time, nurses could be held accountable for failure to protect their patients, whether or not they had the authority/autonomy to do so. Nurses' protection under the doctrine of *respondeat superior* (in which the employer is held responsible for the legal consequences of the acts of employees) was limited (Hershey, 1966).

Beginning in the 1970s, the nursing literature emphatically promoted the role of the nurse as patient advocate (Hutchinson, 1990). From the mid-1970s to the mid-1980s, literally scores of nursing books and articles promoted advocacy (Winslow, 1984). Some examples include Bowman and Culpepper (1974), Chapman and Chapman (1975), and Curtin (1979a). In 1976, advocacy was explicitly included in nursing codes of ethics; for example:

> . . . in the role of client advocate, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice(s) by any member of the health care team or the health care system itself, or any action on the part of others that is prejudicial to the client's best interests. (American Nurses Association, 1976, 3.1)

Advocacy is still an important dimension of nurses' role conceptions. The American Nurses Association's 1991 revised *Standards of Clinical Nursing Practice* listed advocacy as one of the measurement criteria for Standard V, which describes nurses' ethical obligations. All of the participants in Case's (1991, p. 68) study "described issues of advocacy as they talked about the experience of moral conflict." In a stratified sample of critical care and non-critical care nurses in three hospitals, Wlody (1994) found that patient advocacy was one of their foremost role conceptions, and that an advocacy role conception increased with higher RN educational preparation. Other examples of advocacy literature from the 1990s include Albarran (1992), Cahill (1994), Millette (1993), Rushton (1994), and Wocial (1993).

Whatever their ideal roles, opinions in the 1980s and 1990s were divided as to whether nurses can actually enact the advocacy role in an unfavorable practice context. Through the years, public opinion, laws and states' nurse practice acts did not keep pace with nursing's adoption and conception of advocacy (Winslow, 1984). Yarling and McElmurry (1986a) claimed that nurses in the 1980s were not free to act as patient advocates because it pitted them against powerful physicians and hospitals. On the other hand, Becker (1986) believed that institutions generally would support

nurses as patient advocates as long as they were being accountable and responsible in meeting patient needs. And there is evidence that some are doing just that. For example, nurses in a recent study (Smith et al., 1996, p. 22) said they used anger as a "weapon" to "defend or advocate for patients." One nurse successfully confronted a physician who was refusing to give an epidural to a Medicaid patient. She said:

> Well, I lay it on the line for the patients . . . I've had physicians be angry with me for telling a patient more than the physician wanted them to know at a particular time. But I have to put myself in the patient's place. (p. 27)

Apparently even though advocacy is firmly planted in the role conception of most nurses, it has not yet achieved the status of a norm in the larger healthcare subculture. Although making an argument in favor of the nurse as advocate, Pence (1994) noted that some nurses were beginning to criticize the notion of advocacy. Some say it is too idealistic, that nurses do not have the necessary independence to fulfill that role conception. Others say that it is adversarial and destroys any opportunity for collaborative practice. It appears that by 1990, advocacy had reached its zenith; however, no alternative model of nursing has emerged to supplant it in nurses' role conceptions.

Autonomy

Autonomy as a nursing role conception implies that it is appropriate for nurses to make decisions, including ethical decisions. By definition, autonomy implies possession of a competency, the freedom to exercise the competency, and some degree of independence and accountability (Dwyer et al., 1992; Mundinger, 1980). Discussion of autonomy in this study was limited to the moral and professional autonomy of nurses individually and collectively, and did not include considerations of patient autonomy.

In this study, autonomy was defined as either *ideal* or *actual. Actual autonomy* exists when the practice context allows the nurse to exercise autonomy as defined above; it implies the presence of ideal autonomy. *Ideal autonomy* refers to a nurse's belief that autonomy is an appropriate part of the nursing role—and specific to this study, it is a role conception of autonomy that exists where there is no actual autonomy. Actual autonomy may include both beliefs and actions; ideal autonomy includes beliefs only. The following is an example of an autonomy narrative:

> (79.30) The decision made by the nurse to ignore the physician's order to remove the patient to her room was a correct decision, based on her nursing judgment. She recognized a decline in the patient's condition and called in another physician, thus saving the patient's life.

The narrator in the preceding story is reporting both actual autonomy (a behavior) and the belief that nurses ought to act autonomously. This story was coded as actual autonomy because it includes both belief and autonomous action. When discussing the overall extent to which autonomy existed in an era, I considered both actual and ideal autonomy and referred to it as either *autonomy* or *total autonomy*. However, the distinction between ideal and actual autonomy had to be made for the purposes of some discussions, and I have tried to be careful to indicate whether I am discussing total, ideal, or actual autonomy.

Autonomy in the Narratives

In answer to research Question 2, autonomy in the 1934 data was conspicuous by its absence. Only 3% of the narratives included statements that could be coded as either ideal or actual autonomy. In the following example, the nurse did act autonomously, albeit surreptitiously; but she is asking for approval for her autonomous action:

> (34.46) . . . we do have a time resuscitating Dr. B's babies. Dr. B orders Morphine gr. 1/4--I give Morphine gr. 1/8. It is a problem--but I feel justified in doing it--again am I right or wrong?

The autonomy theme was strongest in the 1979 data (see Table 5.1 on page 119, and Figure 5.1 on page 120). For example:

> (79.165) Working on the maternity floor many times the office personnel would tell the poor women patients that they could not take their babies home with them unless they paid a certain amount . . . towards their hospital bill. But I would tell them just to leave because the hospital could not keep them or their babies against their will. Because these ladies are human beings and have intrinsic value . . .

The 1934 and 1979 results seem clear and easily confirmed by the literature. However, the 1989 and 1995 results are more difficult to explain. Because of the extended and expanded roles and activities of nurses since 1979, it might be expected that the autonomy theme would be at least as strong in the 1989 and 1995 data as in 1979. However the percents were only 17% and 26%, respectively, compared to 51% in 1979. I did expect that autonomy might be weaker in the 1995 data than in 1989,

given the recent emphasis on collaborative practice and nurses' lack of job security in a climate of downsizing. It may be that by 1989 the idealism of the 1970s had been tempered by the realities of the workplace, and the nurses in the data were verbalizing concerns that were more pressing than establishing their autonomy. Most of the autonomous action in the 1989 and 1995 data was reported by nurse managers, administrators and nurses in advanced practice roles. Those groups were more heavily represented in the 1989 and 1995 data, so this is difficult to interpret. Several staff nurse narratives were coded for autonomy though, and some of it took the form of direct actions, which carried more risk than simply reporting through the "chain of command." For example:

> (89.00452) She refused ECT's - her psychiatrist insisted she have them. She refused to sign the consent. Her family asked me (actually insisted) that I sign the consent if she wouldn't because they would not take her home in the shape she was admitted to our unit. I refused. Her psychiatrist also inferred the same, I still refused.

Autonomy Literature

Most study findings regarding autonomy were expected, in light of the repressive military metaphor and emphasis on obedience, both in school and in practice, that existed prior to the 1960s. Although educators were trying to teach initiative, "when these same students exercise the developed powers they are told that they have been unethical and have overstepped their bounds" (Parsons, 1930, p. 55).

Reverby characterized the 1920s and 1930s as a period of collaboration with physicians, but not of increased autonomy (1987). Reverby did not mean *collaboration* in the sense it is used today to indicate multidisciplinary practice. Labor unions gained strength during the 1930s, and nursing leaders began to fear that nurses would organize and destroy their long-held hopes for the professionalization of nursing. The leaders chose to collaborate with physicians and hospitals against the labor unions; but that cooperation was not rewarded by any increase in autonomy. It was not the norm in the 1920s and 1930s to conceive of an autonomous worker nurse—not for the public, nurse leaders and educators, nor for worker nurses themselves—much less for hospital administrators and physicians.

For the period between 1920 and 1950, only one article was listed under autonomy in either Henderson's or the *AJN* cumulative indexes. That article referred to autonomy for nursing schools, not for worker nurses. Letters submitted to the "Ethical Problems" column in the *AJN* reflect some worker nurse questions about

autonomy, for example: "What should the nurse do if . . . called in on a case where she suspects abortion?" The advice given did not encourage autonomy:

> . . . they are not questions for her to decide alone . . . . it is a question of agency policy and agency relationship rather than the immediate responsibility of the individual nurse ("Ethical Problems," 1931b, p. 493)

Physicians continued their active efforts to control nursing in the 1920s and 1930s. The American Medical Association completely ignored nurses' professional organizations, set itself up as the nominal authority on nursing, and appointed numerous committees on nursing. True to their traditional stance, physicians abhorred the idea of nursing autonomy (Ashley, 1976, p. 87). A 1928 Michigan State Medical Society report on nursing stated that nurses are helpers and agents of physicians rather than co-workers or colleagues ("Medical News," 1928, p. 1296).

Nursing literature of the 1960s and 1970s reflected growing emphasis on autonomous decision making. Schools of that time socialized nurses to be autonomous "professionals." One study found that the more education a nurse had, the more she supported an autonomous role for nurses (Meissner, 1981, p. 70). Pankratz and Pankratz (1974, p. 212) also found that nurses' perceptions of how much autonomy they "have, are allowed or would be willing to take" was correlated with advanced education, leadership, and work setting. The 1976 ANA code of ethics associated competence with autonomy and responsibility (Carroll & Humphrey, 1979, p. 23); and the new New York State Practice Act clearly defined an independent role for nursing (Fagin, 1975).

Nursing leaders asserted that nurses *ought* to have autonomy, and the literature provides evidence that some worker nurses were beginning to conceive of autonomy as part of their ideal role (Andrews & Yankauer, 1971; Bandman & Bandman, 1978; Christman, 1978; Diers, 1978; Munn, 1976). The most extreme model of nursing autonomy at that time was Lucille Kinlein, who was probably the first nurse to set up an independent nursing practice (Peterson, 1972).

Autonomy literature proliferated in the 1980s. Nursing leaders were still maintaining that the ideal professional role was characterized by autonomy (Gadow, 1980; Kramer, 1981; Mitchell, 1982; Mundinger, 1980) and suggesting ways to increase autonomy, for example through shared governance or baccalaureate education (e.g., Dungan, 1989; Jones & Ortiz, 1989; Lewis & Batey, 1982; Nowicki,

1988; Singleton & Nail, 1984). Yarling and McElmurry (1986a) contended that a nursing ethic is one of social reform that requires a strong sense of professional autonomy.

Whether or not they actually *had* any autonomy, some studies indicate that many staff nurses clearly included autonomy in their role conceptions in the 1980s and 1990s (Blegen, 1993; McClure et al., 1983; Meissner, 1981; Wandelt et al., 1981). Two nurses who were in practice before 1950 reported in personal communication that they began to notice an increase in their own autonomy in the 1980s (C. Leshovsky, 1992; R. Schutte, 1992). Leshovsky stated, "Now you're *expected* to question the physician's orders; you might face a lawsuit if you don't." This does appear to be an example of autonomy in the sense of responsibility for patient safety and for protecting the institution against malpractice claims. However, it does not demonstrate that nurses actually have any more autonomy in the sense of control over their practice. Perhaps nurses' ideas about what autonomy means have changed since 1979.

Although the advent of primary nursing in the 1980s increased nurses' expectations (role conceptions) of autonomy, the literature indicates that nurses still experienced disillusionment when the autonomy they were socialized to expect did not materialize in practice (Booth, 1983; "Johns Hopkins nurses," 1987; Quinn & Smith, 1987; Weiss, 1983). Winslow (1984) noted that most attempts at patient advocacy failed because of lack of autonomy—"because the system overpowers the nurse. The patient suffers or dies. The nurse gets fired or resigns in outrage. The system goes on" (p. 37).

In the 1980s, the bureaucratic form of management (an aspect of organizational and nursing culture) had become as much of a hazard to autonomy as were physicians (Jameton, 1984). One physician asserted that nurses were burned out because their autonomy was limited by "a litigation-conscious nursing administration shackling its own professionals . . . . The nurse . . . finds herself handcuffed by a wild proliferation of procedure codes telling her what she can*not* do" (LeMaitre, 1981, p. 1487). This is echoed in the 1989 narratives, in which autonomy was frequently expressed by appealing to hospital policy or to nurse administrators for support of the nurse's "autonomous" action counter to the wishes of a physician.

There were some in the 1980s who dissented from the mainstream ideology of autonomy for nurses. Packard and Ferrara (1988) questioned whether having

autonomy was inherently good, and they argued that nurses seek autonomy because they confuse professionalism with moral certainty. They disagreed with the claim that nurses lack moral autonomy, and contended that "nurses are fully part of the current political processes" (p. 70). Bishop and Scudder (1987) agreed with Packer and Ferrara that autonomy was overrated. They believed that it created conflict and interfered with team decision making. They went so far as to say that "the in-between situation of nurses [termed powerlessness in this study] . . . [is] a privileged position for coming to concrete decisions within a team setting" (p. 43).

Nevertheless, recent nursing literature still tends to characterize the ideal nurse as professional, autonomous and accountable (e.g., Raines, 1994; Roberts, 1990), and urges the creation of work environments that support nursing autonomy (Kramer & Schmalenberg, 1993); and several researchers are still studying nursing autonomy (e.g., Blegen et al., 1993; Cassidy & Oddi, 1991; Dwyer et al., 1992). Yet the drive for nursing autonomy seems to have abated somewhat in the 1990s. As large healthcare conglomerates turn to managed care and hospitals implement workplace redesign, they have begun to promote cross-training and multidisciplinary practice. More and more work is being done by unlicensed personnel, so the demand for nurses is shrinking—even the most prestigious colleges reported that few new graduates were able to secure positions in 1995, and many new grads were grateful to find jobs as technicians (Joel, 1995). Some nurse educators, seeing their enrollments falling again, are bowing to pressure from their colleagues in the practice arena to socialize nurses to think collaboratively rather than autonomously. Others fear that further loss of autonomy will cause nursing to regress to a narrow, task-oriented and disease-focused model, if it survives at all (Gorman, 1996). As has been true historically, there is no consensus on the issue of nursing autonomy.

Powerlessness

Powerlessness is feeling, or actually being, ineffective, helpless, lacking in influence or control, or unable to achieve the results one is seeking (Erlen, 1993; Seeman, 1959). It is represented by narratives in which the nurse reports being upset over her inability to change the course of events even though she may have taken action to try to do so. However, taking action was not a necessary condition for identifying powerlessness in a particular story. Several nurses, for example, indicated that they knew they were powerless to act in a situation because they had tried unsuccessfully in the past to effect change in similar situations. This is congruent with

Muff's (1988) statement that "powerlessness is a perceptual distortion born of prior disappointments" and that it is "the *sense* of powerlessness that makes assertion impossible" (p. 203).

Unlike autonomy and advocacy, powerlessness reflects a belief that the nurse is *actually* without power, not that nurses *ought* to be powerless. Many of the narratives reflected nurses' lack of power even when the narrator did not refer to the feeling of powerlessness. The following is an example:

> (34.29) A doctor walked into a ward and asked me to drape a patient . . . . I went to get the gloves for him and he said to never mind them—they weren't necessary. The next day the same thing happened. I had the gloves ready to hand them and he refused them.

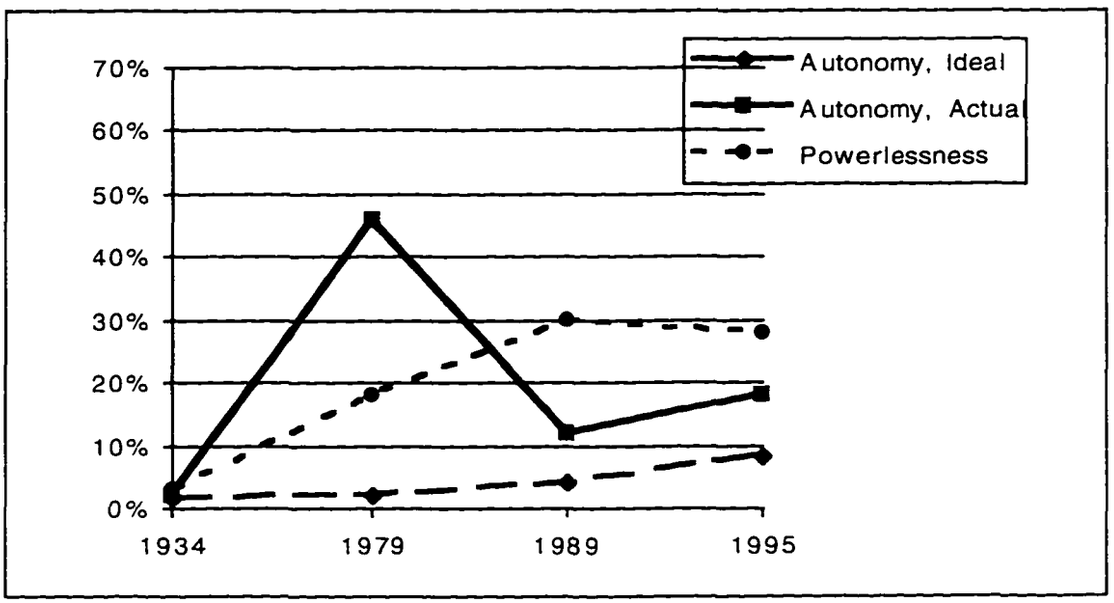
In this story, the nurse's powerlessness is demonstrated rather than verbalized.

Powerlessness in the Narratives

The powerlessness theme is strongest in the narratives in which nurses have an ideal role conception of autonomy, but little actual autonomy in the practice setting. This sets the stage for role ambiguity. For example, in Figure 5.2, on page 130, the theme of powerlessness is stronger in the 1989 and 1995 data, in which there is relatively less actual autonomy compared to ideal autonomy. Ignoring 1934, the theme of powerlessness is weakest in 1979, when the actual autonomy count was very high compared to ideal autonomy—that is, when more nurses were able to enact their ideal autonomy role. The theme of powerlessness was weakest in the 1934 data, when both the actual and ideal autonomy counts were the lowest. This suggests that it is, indeed, the difference between actual and ideal autonomy that sets the stage for powerlessness, and not the absolute absence of actual autonomy. That is, nurses whose ideal role conceptions do not include autonomy are probably comfortable in a practice context that precludes actual autonomy—they do not experience role ambiguity. This is not a perfect parallel, however, because there is only a moderate difference in the powerlessness percentages from 1979 to 1995, even though the percentages for actual autonomy are quite different. Undoubtedly there are other factors that contribute to powerlessness.

It may be that the 1979 narratives contained a stronger theme of actual autonomy than was actually present in the practice context of that time. But even if this is true, they nevertheless illustrate my hypothesized relationship between

Figure 5.2. Percentages of Actual and Ideal Autonomy and Powerlessness



autonomy and powerlessness. The nurses in the 1979 narratives frequently told of autonomous actions—and they reported relatively little powerlessness.

Powerlessness was a weak theme in 1934 (only 3% of the narratives included powerlessness statements), even though looking back from the perspective of the 1990s it would seem that nurses had less real power then than now. Logically, nurses who value obedience (as they did in 1934) would not be expected to perceive powerlessness in the sense that it was defined for this study. However, obedience was a theme in all 4 data sets. Therefore, it might be that the sense of powerlessness that existed in the three later data sets was related to the prevailing ideal role conceptions of advocacy and autonomy, which existed in a context that did not actually allow much of either. It may also have been related to the qualitative differences in the obedience theme in the later data sets, which is discussed on page 134. See also Figure 5.3 on page 132, and Table 5.1 on page 119.

Powerlessness Literature

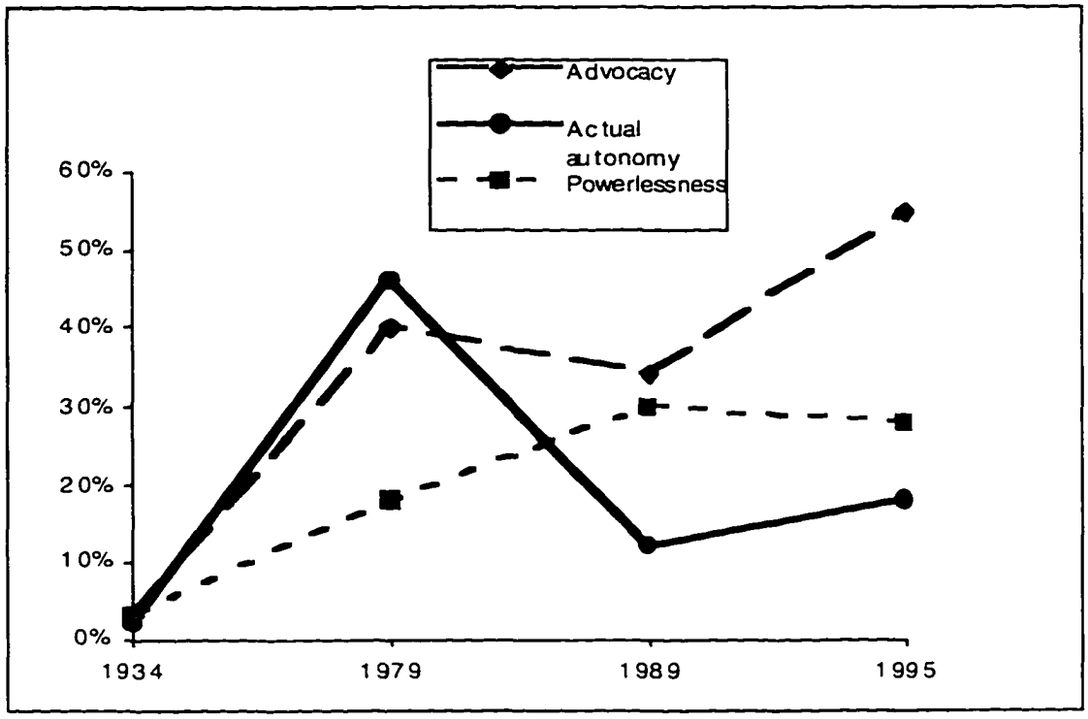
In the early literature, much of what would today be called powerlessness was discussed as a lack of autonomy. The 1930s literature did not specifically address the concepts of powerlessness or lack of autonomy. In the 1970s, the literature spoke often about nurses' lack of autonomy, but the term *powerlessness* was fully developed in the 1980s. The literature of the '70s was conflicting with regard to nurses' lack of autonomy (powerlessness), even though the 1979 narratives contained more reports of actual autonomy and fewer instances of powerlessness than the other data sets. Nursing schools in the '70s socialized nurses to hold autonomy as a role ideal, and most of the 1970s autonomy literature intended to promote nursing autonomy. However, some of it focused on the absence of nursing autonomy (Fagin, 1975; Melosh, 1982). For example, one ethical analysis of an actual case described a patient who had not been informed that she had cancer, and a physician who refused to tell her:

> [The physician] informed the nurse that he would consider any act of disclosure on her part to be inappropriate to her role as a nurse . . . . She was very uncomfortable lying to a patient who had come to trust her. However . . . she was hesitant to act contrary to the . . . family, the physician, and the head nurse . . . . So she acquiesced uneasily. (Yarling, 1978, p. 40)

Other literature of the 1970s lamented that nurses saw themselves as "objects of the power of others," having "internalized the attitudes of subordination projected by those in positions of authority" (Bowman & Culpepper, 1974, p. 1054). If, as some maintained, nurses were their own worst enemies, their autonomy was also undermined by others—for example, physicians, third-party payers, and organizations (Pankratz & Pankratz, 1974, p. 211). Noting that neither nurses nor other women were represented on health advisory committees and hospital boards, Heide (1973) saw the plight of nursing as reflecting the general oppression of women in American society.

The slightly stronger presence of powerlessness in the 1989 and 1995 data is supported by the literature of those periods. In a study by Erlen and Frost (1991), 84% of the nurses interviewed included descriptions of powerlessness in ethical situations. Participants spoke of "feeling trapped," "caught in the middle," "helpless," "frustrated," and "not able to have any control" (p. 401). Erlen and Frost commented:

Figure 5.3. Advocacy, Actual Autonomy and Powerlessness



> This nurse described herself and other staff nurses as trying to be patient advocates. However, when they were unable to implement that role, she explained, "We . . . were on the short end. The physicians had more power than we did so their wishes were carried out." (1991, p. 401)

Booth (1983) also stated that nurses thought of themselves as lacking authority and control. Rodney (1988) found that nurses experienced feelings of powerlessness when they were unable to provide adequate analgesia for dying patients. Prescott and Dennis (1985) measured nurses' perceived involvement in making policy to control their practice or structure their work, and found that staff nurses in 15 general hospitals had little authority or influence.

Sands and Ismeurt (1986) showed a connection between nurses' felt powerlessness and their perceived lack of support from administrators and supervisors. In ethical situations, powerlessness might also be caused by nurses'

uncertainty about and inability to communicate clearly their perception of the ethical problem (Erlen & Frost, 1991). Nurses learned from the women's movement that they should be autonomous and assertive, but find themselves caught in situations in which they feel powerless to achieve those ideals and powerless to change their situations (Muff, 1988).

In the Erlen and Frost (1991) study, nurses reported that they tried unsuccessfully to intervene in situations where aggressive treatments were being done despite the wishes of the patient and family. Nurses in two other recent studies reported feeling ineffective in resolving ethical dilemmas and unable to enact their advocacy roles:

> [They] felt ignored when they tried to act in the best interests of the patient. As one nurse wrote: "When I go back to the patient, he asks me if I had spoken to the doctor. I answer 'yes,' but that's all I can say. Should I honestly tell him that nobody paid any attention?" (Holly, 1993, p. 114)

> Nurses' perceived lack of power is the most common recurring theme. Subject after subject reported feeling powerless to intervene in the preferred manner for the client's well-being. (Millette, 1994, p. 670)

The media have continued to portray nurses and physicians in stereotypical roles. The traditional image in the late '80s was still that the nurse merely carries out the physician's orders (Kalisch & Kalisch, 1987). Others, too, have noted that the public generally does not perceive nurses as having much power (Champion, Austin & Tzeng, 1987; Hughes, 1980; Morrow, 1988).

Nurses in Rodney's (1996) study expressed feelings of powerlessness when family members insisted on continuing treatment against the patient's wishes, or asked that information be withheld from the patient. Smith, et al. (1996) stated that the bulk of the data in their study of anger indicated nurses' lack of control and power. The nurses in that study spoke of powerlessness in many situations:

> Powerlessness in its purest essence was not even having a voice: "I had the experience as a nurse of being voiceless, of having no voice." (p. 29)

Obedience

As a theme, obedience is an expression that the narrator believes nurses ought to follow the rules and comply with the requests and orders of "superiors." Obedience includes a sense of duty or obligation to the patient, the physician, the profession and

the institution. It includes loyalty, the necessity to follow orders without questioning, and the idea of the nurse as the doctor's helper. For example:

> (79.42) . . . . student nurse was giving . . . bath in bed . . . . a doctor stuck his head into the room and demanded that she make rounds with him. Reluctantly the student covered the patient and told him that she would be back in a few minutes . . . . In her haste to leave, she had failed to leave the call bell accessible to the patient's reach.

Obedience in the Narratives

By 1979, the military metaphor had been replaced by the metaphor of nurse-as-advocate, so I expected that an obedience theme would not be as strong in that data as in 1934. That was not the case. The obedience theme was present in essentially the same proportion (13-14%) in all four sets of data (see Table 5.1 on page 119). The consistency of this theme across time may be an artifact of the procedure used for counting it. The count included all references to obedience, without differentiating between nurses who indicated they valued obedience and those who obeyed the rules because they felt they had no option. If only obedience-as-a-virtue had been counted, the proportions would have been much higher in 1934 than in subsequent data. In addition, there are undoubtedly some nurses in any era that are more comfortable with rule-following than with independent functioning and decision-making. For example, Gynther and Gertz (1962) showed that nurses in the 1960s, did not go into nursing looking for independent functioning; and Pankratz and Pankratz (1974) asserted that nurses tended to place a higher value on helping people than on developing professional autonomy and that, in general, they were subassertive and organizationally dependent.

There were qualitative differences between the 1934 and subsequent data. In 1979, obedience began to resemble powerlessness, in that nurses had to follow orders and policies that they believed were not in the patient's best interest (e.g., "Code everyone"). The 1934 data contain the perspective that there is a duty to obey the rules because they are the rules, even if such obedience causes unhappy consequences for the nurse or others. It was as though rule-following was a virtue in and of itself. In the following story, the nurse believes she should follow the rules (physician's order) even when they are futile and upsetting to the relatives:

> (34.54) Although a patient is fatally ill and unconscious, is it not the duty of the nurse to continue all treatments prescribed by the physician

> regardless whether there is any improvement or not? Relatives criticize this and complain that the patient is deriving no benefit and would be better left alone.

The 1934 data are subtly different from the other periods in another way. There were no instances in the later narratives of nurses reporting themselves to "the authorities" for breaking a rule; and they no longer obeyed because of a sense of duty or obligation to the rules per se or to the institution. The later nurses indicated that they followed the rules because they were afraid they would be punished for breaking the rule (or law, or policy). Many such stories were found in the 1979, 1989 and 1995 data sets. In the following example, the nurses are obeying an order because they are apparently afraid of the physician and perhaps of other unspecified constraints. A nurse in 1934 might have said, "Although the patient does not wish to be on the ventilator, is it not my duty to follow the physician's orders?" These nurses seem to be saying, "I hate obeying this order, but I have no choice."

> (89.00122) One of the cardiologists was very difficult to work with - he had no respect for nurses and had been reprimanded several times for being verbally abusive to them. He had an elderly patient with end-stage emphysema who was on a vent and had requested many times to be taken off and had extubated himself several times. The doctor refused to wean him from the vent or realistically speak to the family about the condition and wants. Unfortunately, it was solved by the man arresting and dying, but *the nurses felt trapped in caring for a patient who rejected and fought all the way.* [Italics added.]

Some of the 1995 narratives show another subtle shift in obedience and rule-following. In the 1934 narratives, the reason for rigid, unquestioning adherence to the rules was that one had to follow the rules in order to "be good." In the 1995 stories, nurses thought about the rules, policies, and so forth, and decided to go along with them because they agreed with them or because there was good rationale for them. In the following example the nurse follows the school system's rules because she believes in confidentiality and informed consent, not because she believes in unquestioning obedience or because she is afraid:

> (95.27) Confidentiality is another issue . . . . we are in a couple of elementary schools and students became very aware of how . . . acquiring permission to do things goes beyond what they are used to . . . . To even interact with a child they need permission from parents, and the whole mechanics of doing this within a school system . . . is really cumbersome. It is hard work to do ethical practice in a community

> setting, and the barriers out there, in order to have it done in a way that is sanctioned . . .

Obedience Literature

Obedience was a part of the military metaphor for nursing that existed during the first half of this century. The following is an example of a nursing leader using the military metaphor in her writing (Perry, 1906):

> Carrying out the military idea, there are ranks in authority. (p. 451)
>
> . . . . The military command is couched in no uncertain terms. Clear, explicit directions are given, and are received with unquestioning obedience. (p. 452)

During that time most nursing ethics courses taught behavior and etiquette. These courses dictated obedience to the rules and instructed nurses not to rely on their own judgment. Kennedy (1922) criticized such courses for being "little more than an elaborate presentation of the rules and regulations of the nurses' home, and the hospital" (p. 368), but that criticism was an exception to the culture of the period. Aikens' (1929) ethics text provides examples of the emphasis on military-like obedience to orders.

> To learn to do the thing ordered punctually . . . when her own judgment opposes it or when she feels it to be unnecessary; to refrain from arguing the case when she feels she has a strong side to present. (p. 66).
>
> In a hospital a system of semi-military discipline prevails. (p. 69)

The shift away from a nursing duty to obey can be seen in the historical development of the ANA *Code for Nurses*. The earliest versions of a nursing code of ethics described the nurse, in part, as obedient, trustworthy, and loyal ("A suggested code," 1926; Viens, 1989a). When a code was finally adopted, in 1940, it stated that "loyalty to the physician demands that the nurse conscientiously follow his instruction and that she build up the confidence of the patient in him" ("A tentative code," 1940). The 1950 revised code omitted the statement about loyalty to the physician, but continued to stress the nurse's dependence on the physician: "A nurse recommends or gives medical treatment only in emergencies and reports such action to the physician at the earliest possible moment" ("A code for nurses," 1950). Not until 1969 were references to the physician dropped from the code (Viens, 1989b). Finally, in 1976,

sexist language was removed from the code and the new "interpretive statements" began to emphasize the nurse's role as client advocate (American Nurses Association, 1976). It seems doubtful that the codes caused a shift in role conceptions from obedience to advocacy. What is more likely is that societal changes, especially in the roles of women, and professional socialization in schools of nursing created the change in role conceptions—and the nursing code of ethics changed gradually to reflect this.

Even in the 1980s, Hull (1982) maintained that women in the U. S. were socialized by a sexist society to have a conforming orientation. The development of professional autonomy may also be restrained by the environments in which nurses work and the rigidity of their educational experiences. Women see themselves as "excluded from decision-making in the world at large" and that "inexperience in decision-making may help to explain the passivity of some nurses" (Schutzenhofer, 1987, p. 279). Or perhaps some nurses who do not have autonomy as a part of their role conception may be those with a psychological tendency to obedience.

Enforcement

This theme indicates that part of the nurse's role is to help enforce rules and policies by documenting or reporting to someone in authority what other healthcare workers do—especially as it relates to incompetence, bad ethics, or patient care. Enforcement is similar to "snitching" or "tattling" except that it is not necessarily done surreptitiously as those terms imply. It is limited to the actions of reporting or documenting, and does not involve active interventions such as confronting or physically restraining another caregiver.

Enforcement in the Narratives

Enforcement was a pervasive theme that was present in other themes. Often the nurse enacted her advocacy role by being an enforcer, for example by reporting a policy infraction to the medical chief of staff. Advocacy is different, though, because rule-breaking and incompetence are not the only threats to patients, and nurses' advocacy actions can be something other than merely reporting someone. Furthermore, patient welfare is not necessarily an issue in enforcement. Strongly related to the obedience theme, enforcement embodies the idea that when someone breaks the rules or fails to follow policy (i.e., is not obedient), the nurse has a duty to report the incident. In the 1934 data, this included reporting one's own infractions.

> (34.37) A senior nurse prepared a medication and gave it to a young student to bring to a pt. She made a mistake in the name with the result that it was given to the wrong pt. No harm resulted but shouldn't that senior nurse have reported to her Supt. of Nurses her mistake?

In 1979 and 1989, the enforcement theme was exclusively about reporting others, not one's self. Usually this was done in an effort to be a patient advocate:

> (79.54) . . . I reported what I felt was lack of medical care to the hospital supervisor and director of nurses.

> (89.00102) . . . . He smelled of alcohol . . . . I wrote the Dr. up.

Despite the cultural emphasis on obedience and rule-following in 1934, the enforcement theme became even stronger in 1979 and 1989. One possible explanation is that in 1979, nurses who had little autonomy may have used enforcement as a way to effect the strong advocacy role requirements that had developed in the 1970s. Except for the 4 cases of whistleblowing, enforcement was not present as a theme in the 1995 data.

Enforcement Literature

In her study (from which the 1934 data were taken), Vaughan (1934, p. 47) said that "The majority of the situations stated are concerned with observing the rules of the school and the obligation of reporting to the authorities improper conduct on the part of others." The expectations when reporting someone were that the person would be sanctioned or that the activity would be stopped.

Citing Dietz's 1939 text, *Professional Problems of Nurses*, Winslow (1984) said that nurses during that time had only four available strategies for coping with a doctor's apparent ineptitude. One of these was to consult with (i.e., report to) some other authority figure, for instance the nursing supervisor. The proposed nursing code of ethics published in *The AJN* in 1926 implied that reporting (i.e., enforcement) was the proper activity for fulfilling the role of patient advocate:

> . . . loyalty to the motive which inspires nursing should make the nurse fearless to bring to light any serious violation of the ideals herein expressed. ("A suggested code," 1926, p. 600)

Knowledge

Knowledge in this study is a theme for narratives from which it could be inferred, either by belief statements or reported behaviors, that the narrator perceived scholarship, learning and possession of a specialized body of information (e.g.,

scientific knowledge) to be a major part of the nursing role. Frequently this took the form of reports that the nurse had evaluated the medical care and deemed it adequate or inadequate. Such an action assumes that the nurse has, or believes he has, enough knowledge to pass judgment on medical treatments and believes it appropriate to do so. For example:

> (34.65) For the patient's sake why can't a nurse tell parents that a 2% ammoniated mercury is better than zinc oxide which was physician's prescription?

Knowledge emerged as a theme in the 1979 data. It was moderately strong in the 1979, 1989 and 1995 data sets. There were only two or three narratives (fewer than 1%) in the 1934 data in which knowledge was represented (see Table 5.1 on page 119).

In the 1930s, national nursing reports showed that nearly 25% of all nurses had one year of high school or less (Reverby, 1987, p. 85). This fits with the U. S. Bureau of the Census data cited by Giele (1993), which states that in 1930 only 28.8% of 17-year-olds completed high school, and that in 1940, females completed a median number of 8.5 years of school. Nursing literature of that era did not emphasize scientific knowledge as an important part of the nursing role. Of course nurses had to have some kinds of knowledge, for example of procedures; but it was not often stressed as a characteristic of the nursing role. And many believed that nurses' actual roles did not demonstrate knowledge. For example, some elite nurses (administrators and educators) criticized schools for preparing nurses inadequately, implying that there was scant enactment of the knowledge role ("Professional ethics," 1922).

> Concessions . . . have permitted the acceptance of relatively large numbers of immature and, all too frequently, poorly prepared students. (p. 885)

In the early part of the century, there was little regulation of quality in either nursing education or work. The first mandatory licensing law was not passed until 1938. During the 1920s and 1930s, hospital schools of nursing were just beginning to attach importance to classroom work; it certainly was not yet the norm. In 1930, *The AJN* reported that some schools were developing more structured curriculums (cited in Melosh, 1982, p. 44). But in many hospitals in the 1920s and 1930s, patient care was so inadequate that physicians hesitated to send their patients to some

hospitals. Blame was usually placed on nurses for being materialistic and lazy and on nursing schools for educating them so poorly (Garling, 1985).

Teaching for Empowerment

Teaching for empowerment is patient teaching for the purpose of empowering patients to perform self-care or make decisions about their healthcare. Many other instances of patient teaching were mentioned in the 1979, 1989, and 1995 data, but not in the 1934 data. However, teaching specifically to empower patients emerged from, and was a strong theme in, the 1995 data. The following are examples:

> (95.22) So my role is to try to help the students empower the patients as much as they can.
>
> (95.91) She [the patient's mother] was giving him his IV medications, so she needed to know about universal precautions . . . . I think you need to educate the caregivers to their potential of contamination of many organisms . . .

This theme is not an important concept in the Wilkinson bifocal model. However, it does reflect the healthcare environment of the late 1980s and 1990s, in which DRGs and cost-cutting led to shorter hospital stays and the need for patients to assume more of their illness care. This, in turn, created the need for nurses to do more and more patient teaching.

Minor Themes

In addition to the major role themes, I identified 13 minor themes. Minor themes are those that were not evident in all four time periods, or which were moderately evident in one time period and weak or absent in the others. They were developed for possible utility in comparing role conceptions across time periods and in explaining the relationships between role conceptions and problem formulation within a single time period. Because they were not major themes, less confirmation was sought for them in the literature. The minor themes were: appearances, assertiveness, caring, competence, cooperation, gentleness, honesty, loyalty, morality, religiosity, subservience and summoning. I have chosen not to discuss these themes because (a) they are not central to the analysis, and (b) they would add considerably to the length of this report.

Summary of Role Themes

Seven major themes were identified and discussed. Thirteen minor themes were identified but not discussed. Three of the major themes (advocacy, autonomy and powerlessness) are especially important concepts in the Wilkinson bifocal model. The advocacy and autonomy themes were weak in 1934 and became progressively stronger in the newer data (except for 1989, when autonomy was weaker than in the 1979 and 1995 data). Powerlessness was strongest in the 1989 data and weakest in the 1934 data. Knowledge and obedience changed very little over the time periods, except for the complete absence of knowledge as a theme in the 1934 data.

The themes of advocacy, autonomy and powerlessness are interrelated. To a lesser degree, they are intertwined with knowledge, obedience and some minor themes as well. For example, nurses who focus on the obedience and subservience aspects of their role may not experience as much powerlessness when their advocacy role is thwarted in practice. Powerlessness peaked as a theme in the 1989 and 1995 data, when advocacy was strong and actual autonomy was relatively weak.

The role themes were presented separately in this chapter in order to compare them across the 4 periods being studied. Their relationships to cultural context and moral problem construction will be explored in chapter 7.

CHAPTER 6

PROBLEM CONSTRUCTIONS: PRESENTATION AND INTERPRETATION

This chapter answers the third research question: What are the similarities and differences in the fit of the Wilkinson bifocal model to ethics narratives of nurses from four different time periods? In it I concurrently present and discuss results along with the relevant empirical and theoretical literature, as in previous chapters. Addressing the question of whether the model is useful for classifying nursing ethics problems, the section on *Paradigm Cases,* beginning on page 144, restates definitions and analyzes a paradigm case for each problem type. The section on *The Bifocal Model: Historical Comparisons*, beginning on page 156, more specifically answers Research Question 3 as it traces historically the notable patterns of problem constructions found in the data.

The moral problems the nurses described were not necessarily the classic life-and-death questions of traditional bioethics literature. Even when asked to describe an ethical problem, nurses often told of the difficulties they encountered simply in providing good patient care or in giving patients the information they needed. This fits with Liaschenko's (1993a) findings that nurses' ethical concerns arise from their day-to-day practice. Traditional bioethical discourse has focused on dramatic cases and difficult dilemmas thereby excluding (McInerny, 1987; Mitchell, 1990), discounting, trivializing, or sentimentalizing the ethical concerns of nurses. The stories in this study help give voice to the true concerns of nursing ethics, which arise out of nurses' day-to-day work and relationships.

Wilkinson Bifocal Model

In the Wilkinson model (1993), shown in Figure 6.1 on page 143, moral problems in nursing sort into two broad categories: decision-focused and action-focused. Decision-focused problems are those situations in which the difficulty is in knowing the right action to take. The question is: "What is the right thing to do?" Decision-focused problems consist of two sub-types: moral uncertainty and moral dilemma. Action-focused problems are those in which the nurse feels secure in her/his judgment about what is right; but is prevented from carrying out that moral judgment. The central question is: "What risks am I willing to take in order to do what is right?" Prior to this Phase 1, the model included four action-focused problem sub-types (see

Figure 6.1. Wilkinson Bifocal Model of Nursing Ethics Used in Phase 2

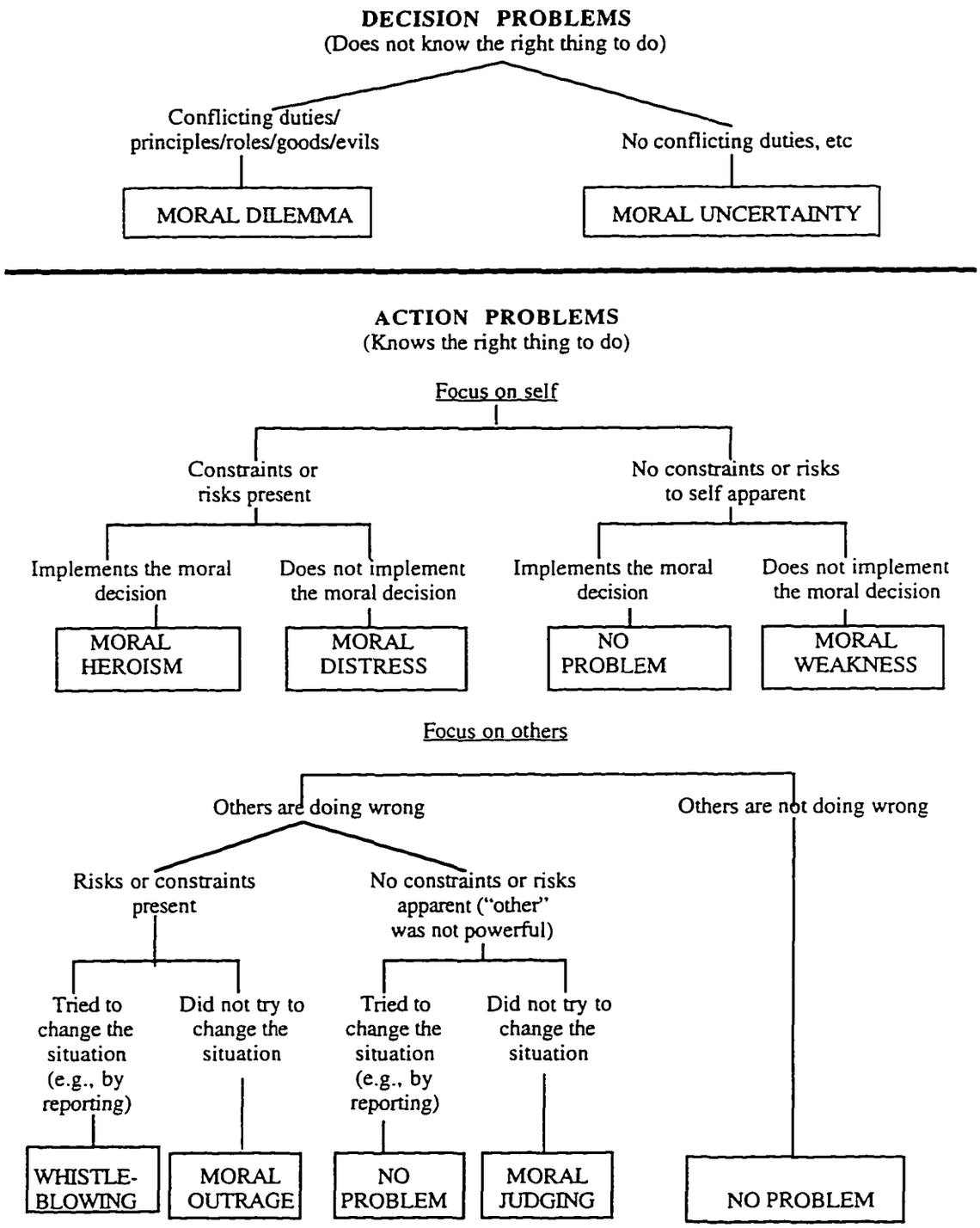


Figure 2.1 in chapter 2): moral distress, moral heroism, moral outrage and whistleblowing. Moral judging, moral weakness and no problem were added at the end of Phase 1 and used in the analysis in Phase 2. See Table 6.1 for a comparison of pre- and post-study model categories.

Table 6.1. Comparison of Phase 1 and Phase 2 Model Categories

Categories Used in Phase 1	Categories Used in Phase 2
•Decision problems	•Decision problems
Moral dilemma	Moral dilemma
Moral uncertainty	Moral uncertainty
•Action problems	•Action problems
Moral distress	Moral distress
Moral outrage	Moral outrage
Moral heroism	Moral heroism
Whistleblowing	Whistleblowing
	Moral judging
	Moral weakness
	No problem

Paradigm Cases

A *paradigm* is an outstandingly clear or typical example—in this study an example of particular types of moral problems. Complex concepts, such as moral problem type, are often better explicated by use of an example rather than a definition. Also, there is precedent for using paradigm cases to study ethics. Before principles-based ethics became the norm during this century, moral philosophy relied on the method of casuistry. Casuistry used cases and particular instances to analyze moral arguments and concepts (Jonsen, 1986). *Paradigm cases* in this study are those that contain the definitive dimensions of moral problems shown in Table 3.4 in chapter 3.

The bifocal model was found useful for classifying nursing ethics problems. Every problem type described in the model was found in each of the data sets, with

the exception of whistleblowing, which was not found in the 1934 data (see Table 6.2).

New Problem Types: Definitions and Paradigm Cases

The three problem types added to the model during Phase 1 were: moral judging, moral weakness, and no problem. Probably they were not apparent from previous work and from the literature because they do not create a high level of moral suffering. The bifocal model grew inductively out of my own experiences with moral distress, so for the 1985 research my starting point was with nurses who were suffering—those with moral distress. In that study, I focused on the effects of moral distress on nurses—on their moral suffering. In describing their moral suffering, several nurses related a story that caused moral suffering but did not quite fit my definition of moral distress. I called this moral outrage. In reviewing the literature during Phase 1, I discovered two other slightly different moral problem situations that caused moral suffering: moral heroism and whistleblowing. The process, in short, was that I started with the cue "nurses are suffering" and proceeded to explore the situations that were causing it, using a situation I knew about (moral distress) and Jameton's (1984) definitions of moral uncertainty, dilemma and distress. However, by keeping an open mind and using qualitative analysis, I began to detect other "almost-but-not-quite-the same" moral problem constructions, including those that did not create as much emotional upheaval in the storyteller.

Perhaps some of the problem types would have surfaced sooner had I begun theorizing by asking "What are all the possible problem constructions that nurses make?" Instead, I began with the particulars and explored moral distress and outrage in detail, noting their similarities and differences and comparing them to the moral heroism and whistleblowing work done by others. This approach enabled me to achieve a richness of detail about individual problem-types and their contexts that would not have been possible with a more deductive and direct approach.

Moral Weakness

Moral weakness is an action-focused problem in which nurses know the right thing to do, but do not do it—not because of constraints or risks, but out of their own perceived weaknesses (e.g., laziness and lack of self-control). Moral weakness is similar to moral distress except that in moral distress the nurse is aware of constraints to, or risks of, taking action (see Table 3.4 in chapter 3). Moral weakness is similar to

Table 6.2. Classification of Narratives According to Wilkinson Bifocal Model Categories

Problem Type	Proportion of Stories Containing Problem Type			
	1934	1979*	1989*	1995*
Decision Problems, Total	**54%**	**9%**	**8%**	**10%**
Moral dilemma	6%	8%	5%	8%
Moral uncertainty	47%	0.5%	1%	2%
Unable to subclassify	1%	0%	1%	0%
Action Problems, Total	**40%**	**87%**	**87%**	**78%**
Moral distress	2%	11%	23%	14%
Moral outrage	8%	16%	23%	17%
Moral heroism	1%	21%	11%	8%
Whistleblowing	0%	7%	10%	3%
Moral judging	13%	5%	2%	6%
Moral weakness	5%	2%	0.9%	0.8%
No problem	6%	25%	11%	27%
Unable to subclassify	6%	0%	6%	2%
Unable to classify at all	6%	5%	6%	11%

*Percents do not total to 100% because of rounding.

the lack of moral motivation, virtue or character discussed by philosophers. For example, Jos (1988) said, "There are times when people know what it is they should do but fail to act accordingly" (pp. 323-324) because they give in to their instincts, passions, or selfish desires. In telling a story of moral weakness, the nurse may relate that it was merely inconvenient to do the right thing, or expedient to do the wrong thing, as in the following example:

> Paradigm Case. (79.141) As student nurses, we were not allowed nor taught to administer intravenous fluids. I knew that as a graduate this skill would be required, so I decided to teach myself. When assigned to patients in the intensive care unit who were unconscious and with no hope of recovery, I practiced with a needle and syringe to learn to "hit the vein." I do not feel the decision was correct. Even though the patients were terminal, I was violating their rights as patients and individuals. I . . . should have waited until after graduation and attempted to obtain this training under proper circumstances.

Analysis of the case: This nurse, focusing on her own actions, knew it was wrong to practice on the unconscious patients, but she did it anyway. There were no contextual pressures for her to do it, except for her own desire to acquire a skill. She admits she was wrong, but apparently is not experiencing much moral suffering. A skeleton plot of the typical moral weakness story would read: I knew that I was wrong; there was no risk to me in doing the right thing; but I did wrong anyway because it was easier for me.

Moral Judging

In the Wilkinson bifocal model, moral judging is an action-focused problem in which the nurse believes that others with equal power, for example other nurses or the patient's family, are acting immorally. There is no risk to self and no other constraint, but it essentially does not occur to the nurse to intervene. She is more intent on pointing the finger at the "bad others" than on considering whether anything could be done to change the situation.

> Paradigm Case. (34.39) The night nurses have to sleep during the day and it is becoming a problem how to keep the day nurses quiet. They run through the corridors and whistle and sing without the least bit of consideration. This could and should be prevented as these nurses need rest in order to do their work at night.

Analysis of the case: The nurse is talking about others' actions, not asking "What should *I* do?" Her words, "This . . . should be prevented," imply that the others are doing wrong, so this nurse has made a decision about what is right. She says nothing about what she might do to make the situation better, but implies that someone else is responsible to stop those who are doing wrong. She is judging both the night nurses and the supervisors who do not chastise them. A skeleton plot of the typical judging story is this: Those other people are doing something bad; there would probably be no risks involved in my acting, but it doesn't even occur to me that I have any responsibility for stopping them.

Judging is similar to moral outrage except that a power imbalance exists in outrage (see Table 3.4 in chapter 3 and Appendix B). Because the discrimination between them is so fine, interpretation of the data was difficult. Judging did not emerge as a category until late in Phase 1, so a separate count was not included for it in that phase. However, in Phase 2, judging problems were counted for all the data from both phases.

No Problem

In the Wilkinson bifocal model, *no problem* is a problem construction in which the nurse knew the right thing to do and did it with no risk to self and with no contextual constraints. I added the no problem category in Phase 1 because many nurses told stories about ethical problems they had satisfactorily resolved. This, of course, did not fit with any of the predefined categories that had emerged from a previous focus on moral suffering and moral distress. No problem does not necessarily indicate that it was easy to determine the right thing to do; but once the nurse decided what was right, the decision was implemented without risk or constraint.

> Paradigm Case. (34.46) While getting ready to make formulas for the babies I realized that I had not sterilized the medicine glass. Thinking, "Oh, well what's the difference" I was about to use it unsterilized. My conscience began to trouble me. I boiled the glass.

Analysis of the case: This nurse, focusing on her own actions, knew that the right thing to do was to sterilize the medicine glass. Despite a moment of hesitation, she did the right thing. Because that was what her cultural context required of her anyway, she took no risk in doing the right thing. The skeleton plot of a typical no problem construction is: This was the right thing to do; there was no risk in doing it; I did it.

Nurses sometimes construct a moral situation as no problem simply because they have learned to manipulate the system to achieve what they believe to be right for their patient. There are some risks, but they know how to avoid them. This resembles Hutchinson's (1990) *responsible subversion*. As a nurse in Rodney's (1996) study said, "You always have to work a way around the system to make it work."

Original Problem Types: Definitions and Paradigm Cases

The original model problem types are presented in this section: moral uncertainty, moral dilemma, moral distress, moral outrage, moral heroism and

whistleblowing. These seem to be the problem constructions that engender the most moral suffering for nurses.

Moral Uncertainty

Moral uncertainty is a decision-focused problem in which the nurse is not sure what principles or values apply in the situation, or perhaps cannot even clearly identify the nature of the problem (Jameton, 1984).

> Paradigm Case. (34.36) If older nurses are making a break in technique, would it be a very serious offense for a younger nurse to correct the break?

Analysis of the case: This narrative represents moral uncertainty because the nurse does not clearly identify the nature of the problem. It is not definite that she even thinks of it as a moral issue, although probably she does since her instructions from Sister Vaughan (the researcher) were to keep a journal of her moral problems. She certainly has not made a decision about what is right, so it clearly is a decision problem. There are no conflicting principles or actions—no "rock-and-a-hard-place"—so it is not a dilemma (the other kind of decision problem in the model). But there seems to be some kind of moral issue lurking here. It is exactly this nebulous sort of situation that constitutes moral uncertainty. The alternative, as was true for many moral uncertainty problems, would be to code the problem as "unable to classify." The typical moral uncertainty story line is: "I'm not entirely comfortable with this, but I'm not sure why; oh well . . . ."

Moral Dilemma

A moral dilemma is a decision-focused problem in which two or more moral principles or duties clearly apply, and the principles call for mutually inconsistent or equally unsatisfactory actions. "Moral arguments can be made for and against each alternative; neither appears decisively right, although one alternative must ultimately be chosen" (Mitchell, 1990, p. 427-428); so no matter what the nurse does, an important value must be sacrificed. The nurse does not feel certain he knows the right thing to do (i.e., has not made a moral decision):

> Paradigm Case. (34.52) Yesterday one of the patients died. This morning one of the other patients asked me about her condition. If I told her it would aggravate her condition because she is a very nervous individual; if I didn't I would have to lie about it.

Analysis of the case: This nurse has not made a decision about what is right. She will eventually have to choose one of the two alternative actions, and neither seems acceptable to her. She knows it is wrong to lie to a patient, and she believes it would be harmful to tell the patient the truth. Ultimately she thinks, "This is what I'm going to do, but I don't know if it's right or not; I'm between a rock and a hard place."

Although a moral dilemma is a decision problem, it does not preclude the nurse's taking action. Nurses do not have the luxury of abstaining from action, because in many situations to *not* act is, in effect, an action. For example, if a patient asks a nurse for his prognosis, the nurse must either tell or not tell. Both choices constitute actions on the part of the nurse, and both have effects. Many nurses reported in their stories that they had taken some action, but even when telling about it much later, they were torn because they still did not know what was actually right. Their action did not resolve the issue for them nor change their problem construction (dilemma). The following is an example in which the nurse chose one of two less-than-perfect courses of action, but never became comfortable with her decision. As she saw it, she could counsel to (a) protect the fetus and harm the living children or (b) protect the living children and harm the fetus:

> (89.01981) I am against abortion as are my religious beliefs. I had a young mother of 19 years whose husband was unsupportive secondary to his severe alcoholism. The family was very poor, on public assistance. The mother's health was poor. She had 2 living children and had a miscarriage and hemorrhaging approximately 6 months prior to this latest pregnancy. I encouraged her to have an abortion and to have her tubes tied as I felt she may die if she carried this pregnancy—her children needed her alive and well. Although abortion was legal and her abortion at the time was carried out in a hospital, it caused me some upset to go against my religion's ethical beliefs.

For the purposes of the Wilkinson model it is irrelevant whether the nurse made the most ethically justifiable choice; and it is irrelevant that there may have been other possible courses of action for the nurse. The point is that, given the cultural context and the nurse's personal knowledge and perceptions, *she* constructed this problem as a dilemma. For another nurse taking the same action, the situation could easily have been constructed as no problem or moral distress.

Borderline Cases of Moral Dilemma

Action problems may sometimes resemble a dilemma. In some action problems the nurse first makes a moral judgment, but is troubled about carrying it out because it will have unhappy consequences for someone. For example, "I knew that for the good of her patients I should report that she was stealing drugs, but I was torn because it probably meant she would lose her job, and I felt sorry for her." Jameton would say that the second decision (whether to carry out one's judgment) is a "second-order" moral dilemma. He has said that the nurse first makes a moral judgment about the rightness or wrongness of a course of action and then "makes an *additional* decision . . . about following through on that judgment" (Jameton, 1993, p. 543). In the Wilkinson model, this type situation is not a dilemma, it is an action problem with a constraint—concern for a friend, or fear of losing a friend. The nurse knows she should report her friend (moral decision), but loss of the friendship is a constraint to her actions.

A no problem case may also resemble a dilemma. In telling her story, the nurse says "I knew clearly that it was the right thing to do. But I hated to do it because it would have a bad consequence for someone. I did carry out the action though, even though it was hard for me to do." This is not a dilemma because the nurse has made a judgment about what is right. At that point she encounters a "second-order dilemma" and must weigh the good effects of her chosen action against the good (or bad) of the consequences. In a true dilemma, she would be looking at the good/bad of one action vs. the good/bad of a different action. She would not say "I knew what was right to do, but the cost of doing it was so high." Still, both produce a great deal of conflict in the storyteller, so they are very much alike experientially. In such borderline cases the difference is probably artificial. When analyzing cases, we attempted to differentiate the borderline cases by asking first, "Did the nurse say, 'I knew this was right, but . . . ?'" We then looked carefully at her reasons for hesitating to act. If the nurse hesitated because the actions would cause harm to *the patient or a colleague* then it was classified as a dilemma. If the reasoning was focused more on self, such as "*I* didn't want to lose her friendship," then it was probably not a dilemma. Given that line of reasoning, if the nurse did not act it would be moral distress; if she did act it would be no problem (as long as there were no other constraints involved.) This is a fine discrimination, as the no problem definition requires that there be no

constraints—and in this case of no problem we are allowing some constraints, as long as they are minor and internal (rather than external).

The following story is a borderline moral dilemma case. It is difficult to know if the nurse was choosing between two moral principles (prevent harm to patients vs. prevent harm to co-worker), or if she believed the right thing to do was to report her co-worker but hesitated to do so because of the risk of losing his friendship. This problem is not clearly a dilemma because the nurse knows the welfare of the patients is the most important consideration and in the end does not "feel very guilty" about her actions (has made a moral judgment). It is not clearly no problem because the possible loss of the friendship functions as a mild constraint to the nurse's action. It is not clearly moral heroism because the constraint was internal, affective, and minor (as compared to an external constraint such as being sued or fired) and because the person involved in the constraint was an equal-power peer.

> (79.95) A fellow staff nurse and co-worker became involved with a drug problem . . . . it came to the point that he was unable to function in his expected and vital duties as the nurse in charge of the intensive care unit, and finally absence from work frequently . . . . he was suspended . . . When he was given a second chance, he again failed to succeed in conquering his problem. One day at work he became unable to function in any capacity and was sent home.
>
> *The decision I was faced with was whether or not to aid in convicting him or stay true to our friendship . . . I decided I would sign as a witness* to [a patient's] testimony . . . which, in the end, would result in this nurse being relieved of his duties and possibly his nursing license. I did this because *the welfare of the patients, who are already critically ill, is much more important* to me than this person's friendship.
>
> . . . I feel that this is the only [decision] that would totally benefit the people whom I am responsible for—the patients. *I gave my decision a lot of thought before acting*, and . . . *[I did] not feel very guilty* about my action. [Italics added.]

This case also illustrates that even after taking action the nurse may continue to experience the situation as a dilemma, not feeling entirely comfortable with her choice. In nursing, dilemmas tend to have that effect. The nature of a true dilemma is that there is no clearly good choice of action. The nature of nursing is that action must nevertheless be taken.

Moral Distress

Moral distress is an action-focused problem in which the nurse knows the right thing to do, but cannot pursue that action because of institutional or other constraints, either perceived or real. Additionally, the nurse focuses on her own actions in the case (in contrast with moral outrage, in which the focus is on the actions of others). The central question is: "What risks am I willing to take to do what is right?" Moral distress is similar to moral heroism except that in moral heroism the nurse implements her moral decision, whereas in moral distress she does not.

> Paradigm Case. (89.01301) . . . . One small woman who had been receiving an I.M. diuretic twice weekly had this increased to daily by our Chief-of-Staff. When the patient developed severe arm pains immediately following each injection, I requested that the dose be reduced. The doctors refused. I discussed the problem with the RNs on 3-11 and 11-7 and both felt that the daily IM's were detrimental. However, since bringing this reaction to the physician's attention several times and with the same refusal, I continued to administer the daily dosage. Attempts to have our nursing Director intervene also brought negative results. Consequently, only death resolved this patient problem. Seeing this little lady writhe in pain has haunted me for years. Had I to do [it] over, I would have charted but withheld the drug.

Analysis of the case. This nurse is focusing on her own actions in the case ("I continued to administer the daily dosage . . . . I would have . . . withheld the drug"). She believes the right thing to do would be to give less of the drug ("I requested that the dose be reduced"). She believes it was wrong for her to continue giving the prescribed dose ("Had I to do [it] over, I would have charted but withheld the drug"). From her narrative, one can infer that contextual constraints kept her from doing what was right. She did the things that were risk-free: (a) she brought the patient's "reaction to the physician's attention several times and with the same refusal," and (b) she tried to "have our nursing director intervene." Since those in power obviously did not agree with her assessment of the situation, one can infer that they would not have supported her had she taken matters in her own hands and withheld the drug. No doubt she felt she had no choice but to acquiesce. And finally, she experienced the moral suffering that typically accompanies a problem construction of moral distress: "Seeing this little lady writhe in pain has haunted me for years." This is a typical moral distress scenario: "I knew it was wrong but I knew I'd get in trouble if I didn't do it; I did it; I felt awful about it and I still do."

Moral Outrage

In the bifocal model, moral outrage is an action-focused problem in which the nurse believes that others are acting immorally, but feels powerless to stop them. The nurse does not participate in the act, and may not consider that intervening is even possible. Consequently he does not feel responsible for the situation. The resulting painful feelings (usually anger) are directed outwardly at the "immoral others." When the immoral others are peers, the problem construction is moral judging, not outrage, unless the failure to act is based on grave risk to self. Moral outrage usually focuses on caregivers who are more powerful than the nurse or on organizations and systems.

> Paradigm Case. (89.01551) The older person who does not wish extraordinary measures to be taken, has a living will - This person (87 y/o) has a cardiac arrest in church - he is anoxic for at least 15 minutes before reaching the hospital. To be kept alive by drugs and a ventilator for 1 week because the Drs. are afraid of being charged with murder. The wife wants it to be over - this is very wrong.

Analysis of the case: The nurse has obviously made a decision about what is right/wrong and has stated it clearly: "this is very wrong." She even gives justification for her decision: the patient "does not wish extraordinary measures . . . has a living will . . . . The wife wants it over." This nurse is focusing entirely on the actions of the doctors and the legal system. We cannot tell if she participated in the life-prolonging measures or care of the patient, but she apparently does not feel that she, herself, did anything wrong or that she had any responsibility in the situation. One must infer that the nurse feels powerless or believes there would be some risk in trying to change the situation. The physicians are more powerful than the nurse, but even they are afraid of the legal system. This is typical moral outrage thinking: "*They* are bad and I can't do anything about it; they are immoral and I am angry!"

Moral Heroism

Moral heroism is an action-focused problem in which the nurse is confident that she knows what is right, and carries out her decision despite the presence of contextual constraints and/or personal risk. The nurse is concerned with her own actions rather than the actions of others. The action the nurse takes is usually, but not always, something other than reporting someone to a nurse administrator. Typically the action involves refusal to follow an order. If the nurse "goes public" or reports a physician to a medical chief of staff or hospital administrator (outside the nursing

chain of command), the problem construction is then a special form of moral heroism called whistleblowing.

> (89.00452) I work in psychiatry. . . . an extremely depressed patient (not suicidal though) who was elderly. She refused ECT's - her psychiatrist insisted she have them. She refused to sign the consent. Her family asked me (actually insisted) that I sign the consent if she wouldn't, because they would not take her home in the shape she was admitted to our unit. I refused. Her psychiatrist also inferred [sic] the same; I still refused.

Analysis of the case: The nurse made a decision that signing the consent would be wrong, probably because it violated patient autonomy. Focusing on her own actions, she decided that she should *not* sign, and she followed through with that decision. There were constraints: (a) The family might have caused trouble (e.g., complained to administrators), and (b) someone in the nursing or medical hierarchy could have criticized or sanctioned the nurse for not following the physician's orders. A typical moral heroism storyline is: "This is what I thought was right to do; there were some risks to me in doing it; after weighing the risks and benefits, I decided it was worth the risk; I did it."

Whistleblowing

Whistleblowing is a special kind of moral heroism in which the nurse believes that other health care providers (either individuals or organizations) are doing wrong, believes she has a responsibility to disclose the wrongdoing, and implements that decision despite personal risk or threat. Whistleblowing frequently is done to expose negligence, abuses or dangers to a patient or to the public welfare; but it may also be done to expose personal victimization, as in the case of sexual harassment (Andersen, 1990; Theodore, 1986). This study considered both internal and external whistleblowing. Internal whistleblowing involves reporting misconduct to the immediate supervisor and progressing through the chain of command as needed. In such instances, "going public" does not necessarily require that the nurse notify the media or a policing body outside of the organization, for example:

> (89.01963) A physician on staff would only make rounds on his pts. every 4-5 days. Frequently we could not locate him when needed. Written reports were made with appropriate copies of medical documents. These were sent to hospital administration. I worked in close association with Nrsg. Admin. in collecting data. Administration met with the MD and the situation improved.

Analysis of the case: It can be inferred that the nurse believed the physician was doing wrong because she says she took actions to change what he was doing. Therefore this is an action problem. One must also infer that the risks to the nurse were that the physician might retaliate and that the hospital administrators might side with the physician. The skeleton storyline of whistleblowing is: "They are bad and I must stop them despite the severe risks I may incur."

External whistleblowing involves going outside the normal reporting hierarchy and publicly reporting misconduct, negligence and the like (Bosek, 1993), as in the following example:

> (95.78) . . . I had worked for a manufacturer of heart products. They had lots of problems and 2 recalls in 1994 on by-pass products . . . leaking blood from stopcocks- glue bonds breaks—they refused to tell customers . . . . They did not want the products off the market . . . and they did not want the cost of recall . . . . The topper of this was giving the customer wrong serial number on products to pull . . . . I finally had enough . . . and went to the FDA . . . . next day I got fired- The good news is that I can look at myself in the mirror and know that I did the right thing for the patient and personnel safety.

Typically, the whistleblower exhausts all sources for problem resolution before "going public" (Petersen & Farrell, 1986). However, in this study, that was not a necessary dimension of whistleblowing.

The Bifocal Model: Historical Comparisons

This section specifically answers the third research question, which addresses an assumption of the bifocal nursing ethics model that problem construction is, in part, a function of the context in which the situation occurs (see Figure 2.2 in chapter 2). This assumption was initially grounded in the work of Gilligan (1977), who determined that people conceive and/or define moral problems in different ways; and in the theoretical discourse of narrative ethics (e.g., Jameton, 1990); and hermeneutics (e.g., Ricoeur, 1979; Tappan, 1990), which stress the importance of context. Mishler said that "meaning . . . is always "contextually grounded—inherently and irremediably" (as cited in Brown et al., 1989, p. 143). Chapters 4 and 5 have presented the sociohistorical and cultural contexts within which nurses enact their roles and within which ethical problems are constructed. The focus in this chapter is on the question of whether the Wilkinson bifocal model is a useful theory for explaining ethical problems in all 4 time periods, given the differences in those sociohistorical contexts.

Patterns of Occurrence

The findings for Question 3 support the Wilkinson model assumption that context affects problem construction. Following the rationale used in chapters 4 and 5, I have used tables and charts to facilitate comparison of problem construction in different time periods. Because the four data sets contained unequal numbers of stories, I converted the counts to percentages for comparison. Percentages used in this chapter merely indicate the proportion of narratives that contained a particular problem construction. They do not indicate, for example, the frequency with which a problem construction was thought to occur in the population.

As shown in Table 6.2 on page 146 and in Figure 6.2 on page 158, the pattern of problems identified in the data were, indeed, different for the different time periods. A comparison of specific problem types in the four data sets revealed ten noteworthy patterns, which appear in bold, underscored type in this section. This section discusses each pattern individually in relation to the nursing literature and the Wilkinson bifocal ethics model.

Decision Problems

In the Wilkinson model (Figure 6.1, page 143), there are two decision problems: moral uncertainty and moral dilemma. Three distinct patterns emerged for these problem constructions.

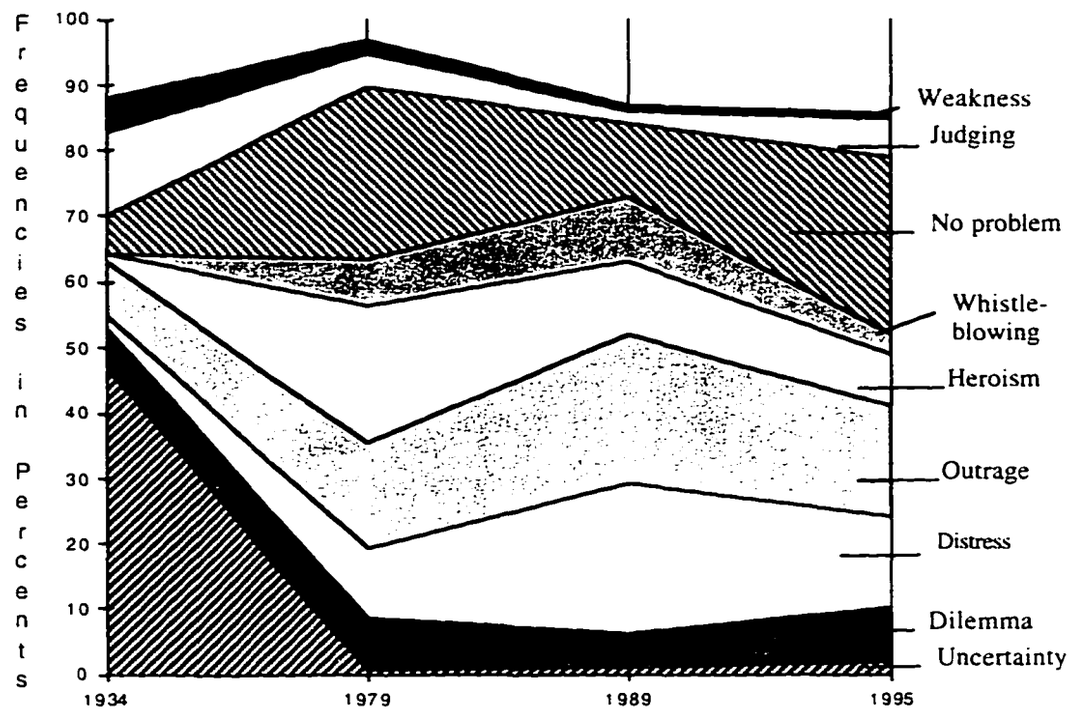
1. In the 1934 data moral uncertainty (a decision problem) was overwhelmingly the most frequent problem; it was nearly nonexistent in 1979 and 1989 and 1995.

Table 6.2, on page 146, and Figure 6.2, on page 158, indicate that 47% of the 1934 narratives were classified as moral uncertainty. The 1979, 1989 and 1995 data contained almost no uncertainty (0.5%, 1% and 2% respectively).

Literature supports a high level of moral uncertainty and confirms that the 1934 data are representative of moral problems of that period. In her study, from which the 1934 data were taken, Vaughan quoted a 1931 study by Beck that contained similar narratives. Beck's study examined ethics questions of students at a school of nursing. These narratives were all decision-focused problems, in which the nurses were either asking what to do or if they would be allowed to do it. For example:

> In supervising an operating room, could you question the doctor; if he intended to remove a healthy tube or ovary? (Cited in Vaughan, 1934, p. 80).

Figure 6.2. Bifocal Model Problem Types: 1934, 1979, 1989, and 1995



In addition, the 1934 data were much like the questions submitted by nurses to the "Ethical Problems" column that appeared intermittently in *The American Journal of Nursing* (*AJN*) between 1926 and 1932, as well as questions of ethics that appeared in another journal series, (e.g. "The Editor's Letter-Box," 1922, p. 229), which all asked "What is the right thing to do?" Even in situations where it seems the nurse surely must know right from wrong, her question was nearly always framed as one of duty, responsibility or rule, both in the data and in the literature. The nurse was asking, "Which rule should I follow?" rather than saying "I know what to do, but it is too risky to do it," as would be true of action problems. For example:

> A physician gave an incorrect medication from a poorly labeled bottle. Was the nurse at fault for failing to have the correct medicine ready for

> him and for labeling the bottle so poorly? ("Ethical Problems," 1931a, p. 92)
>
> [What should a nurse do when] called in on a case where she suspects abortion? ("Ethical Problems," 1931b, p. 493)

The answer given to the last writer was that "they are not questions for her to decide alone . . . . it is a question of agency policy . . . rather than the immediate responsibility of the individual nurse" (p. 493). Such literature demonstrates that nurses did not assume much responsibility for making ethical decisions. Vaughan (1934) commented in her study: "The majority of the situations stated are concerned with observing the rules of the school and the obligation of reporting to the authorities improper conduct on the part of others" (p. 47).

Ethics texts of the 1920s and 1930s (e.g., Aikens, 1930), and the few ethics articles in the nursing journals, concentrated on prescribing nurses' character and rules of right behavior (e.g., Crawford, 1926). They provided a rule for every situation, and authors never suggested that nurses should *decide* what was right to do. Unaccustomed to making decisions, a nurse who encountered conflicting rules solved her difficulty by asking someone in authority which rule to obey. She could then be a good nurse by doing as she was told.

The 1934 uncertainty count may have been somewhat inflated by the rules of inferencing used in analysis. Most of the 1934 narratives were very brief. Therefore, it was difficult to positively conclude whether the nurse knew what was right in every story—and it was essentially never directly stated by the nurse. It was even more difficult to determine whether she was or was not cognizant of conflicting principles and duties in the situation. Because nearly every narrative of that type was phrased as a question meaning "What is the right thing to do," we usually inferred that the nurse did *not* know what was morally right, and was *not* clearly aware of conflicting principles (ergo, the story was coded as moral uncertainty). The following is such a narrative:

> (34.29) If a nurse is positive that a patient has broken bones, after the other nurse on the case has hinted to the doctor, is it her duty to keep after him until an X-ray is taken?

Analyzing the narrative from a modern perspective, it seems obvious that the nurse would know that the right thing to do is to "keep after" the physician. However, from the perspective of a nurse in 1934, that is not so obvious. One can infer from the

context (see chapter 4) that this nurse did not have a firm opinion about what was right to do and was waiting for someone to tell her—so this is a decision problem. There are no conflicting principles and there exists no choice between two equally unsatisfactory answers—so this is not a dilemma. There are no other kinds of decision problems, so this is most likely moral uncertainty. Moral uncertainty is a decision-focused problem in which the nurse is not sure what principles or values apply in the situation, or perhaps cannot even clearly identify the nature of the problem.

2. The frequency of moral dilemmas was relatively low and relatively constant in all 4 time periods.

The frequency of moral dilemmas in the data ranged from 5% to 8% across the time periods (see Table 6.2, on page 146, and Figure 6.2, on page 158). Despite the fact that many writers use the term dilemma loosely, a similar low frequency of true dilemmas is found in the literature. Levine (1989, p. 125) believed that nurses confront a genuine dilemma only occasionally: "most of the day-by-day activities of nurses pose moral questions that can be answered in ways that are entirely satisfactory." Cunningham and Hutchinson (1990) agreed, stating that it is a myth that all situations with an ethical dimension are dilemmas.

An analysis of nurses' stories quoted in other studies confirms that true dilemmas do not commonly occur. Of the 14 moral problems described by nurses in Appendix E of Meyers' (1994) study, 2 (or 14%) can be classified as moral dilemmas using the Wilkinson bifocal model. None of the 22 classifiable stories in Fenton's (1987) thesis is a moral dilemma. When the Meyers and Fenton stories are added together for analysis, the incidence of moral dilemmas in those narratives is 6%.

A range of 3% in the data is minor in this study. In the 1995 data, for example, 3% represents fewer than 4 stories; and it represents only 32 stories of the entire 1,075-narrative data set. Given the number of inferences that had to be made in order to classify 1,075 stories, a 32-story variation in number suggests that the phenomenon was comparatively stable across time periods (contexts), even if a large margin for error were granted. Such constancy is probably inherent in the study definition of a moral dilemma as a decision-focused problem that occurs in a situation when two or more moral principles clearly apply, and the principles call for mutually inconsistent or equally unsatisfactory actions, which seem almost equally right or equally wrong.

Being decision-focused means that the problem is constructed around *deciding* what is moral rather than on the possibilities of, and constraints to, performing a moral action. In a moral dilemma, one's thoughts center internally on theoretical and philosophical considerations of what is right, rather than externally on applied and practical questions of what is possible to do. Because, by definition, the problem formulation cannot move beyond the theoretical, it remains internal to the nurse more than external and is, therefore, less context dependent. Of course, thinking is not context free; but neither is it totally context dependent. Furthermore, the context probably exerts more powerful control over what one does than over what one thinks. According to Frankl (1962), who wrote from his experiences in a World War II concentration camp, regardless of one's circumstances, there is a certain freedom to choose the thoughts and attitudes one holds. Logically, a problem formulation that is not strongly affected by context might occur with similar frequency in different contexts (i.e., over time).

3. The proportion of moral uncertainty in the 1934 data was dramatically different from the other 3 data sets.

As already noted, the proportion of moral dilemmas was almost the same in all 4 time periods. If the explanation regarding varying degrees of context dependence is correct, one would also expect moral uncertainty (the other decision problem) proportions to remain stable over time. That this did not occur is probably due to a peculiarity of moral uncertainty. Although uncertainty, like dilemmas, is a decision-focused problem in which the nurse does not know the right thing to do, the etiologies of the not knowing are quite different. In a moral dilemma, the nurse is aware of two unsatisfactory choices or equally compelling principles; but in moral uncertainty, the nurse is not sure what principles or values apply in the situation, cannot even clearly identify the nature of the problem, or may not be aware that it even involves ethics. This could be due to a lack of awareness and/or a lack of knowledge. Although moral uncertainty is a problem classification in the bifocal model, it actually represents the absence of a formulated problem. The remainder of this section will show how, in contrast to moral dilemma, this may indeed have been related to context.

The high moral uncertainty count in the 1934 narratives probably coincided with role conceptions that included obedience instead of decision-making and with a low awareness of ethical issues (see chapters 5 and 7 for further discussion). In the 1930s and 1940s, there was very little nursing ethics literature of any kind.

Henderson's *Nursing Studies Index (1930-1949)* listed 35 ethics titles, 19 of which were ethics texts (8 of which were written by physicians). Between 1931 and 1940, *The American Journal of Nursing Cumulative Index* listed 79 articles and texts under the headings "ethics problems" and "ethics." The subjects addressed most often were: relationships with physicians (12 entries); fees, working conditions, unions (12 entries); and ethical codes and standards (5 entries). Between 1946 and 1950, *The American Journal of Nursing Cumulative Index* listed only 7 ethics titles.

In the middle 1960s, there was a distinct increase in the number of ethics articles published in American medical journals (Stenberg, 1979), but the *Cumulative Index to Nursing Literature 1961-1963*, still listed only 15 titles under "ethics" (Grandbois, Crandall & Moore, 1967). For 1964-1966, it listed 26 titles (Grandbois et al., 1967). For the period 1965-1970, Pence (1986) found only 27 books and articles relating to nursing ethics. Bunzl (1975, p. 184) observed, "Despite the recent plethora of papers discussing medical ethics, little or no attention has been paid to ethical problems that are unique to the practice of nursing."

The publication of Davis and Aroskar's book *Ethical Dilemmas in Nursing Practice* (1978) ushered in what has been called the "new era of nursing ethics." Prior to that text, nursing ethics literature typically discussed legality and etiquette. Davis and Aroskar were the first to claim that nursing ethics was a unique field of inquiry, separate and distinct from traditional bioethics and medical ethics (Liaschenko, 1993b). This and other literature of the period made ethics a legitimate concern of nurses, no doubt increasing their awareness of moral problems and enabling them to make moral problem constructions.

In the 1970s, the volume of nursing ethics literature grew dramatically, quadrupling from 1970-1975 and again from 1975-1980 (Chafey, 1992). This is illustrated by Pence's (1983) 147-page annotated nursing ethics bibliography, in which all but one of the 75 articles listed under the heading "ethical decision making" were written between 1973 and 1982. The late 1970s saw "increasingly larger amounts of space in nursing journals given over to material on ethics"; [and a] "body of knowledge and literature uniquely nursing's and worthy of the name ethics" had developed (Stenberg, 1979, pp. 14-15). Sometimes entire issues or sections of nursing journals were devoted to ethics, for example:

- *American Journal of Nursing*, (1977, May). Contained a special 30-page feature on ethics.
- *Nursing Clinics of North America*, (1979, March). Half of the issue was a symposium on "Bioethical Issues in Nursing."
- *Topics in Clinical Nursing*, [(1982), 4(1)]. The entire issue was devoted to nursing ethics.

Between 1980 and 1985 the number of nursing ethics publications doubled, and then leveled off in the period 1986-1990 (Chafey, 1992). There is still a heightened awareness of ethical issues among nurses, though. For example, the ANA now has a committee working on revising the Code of Ethics, and frequently issues position statements on particular ethical subjects, for example withdrawing food and fluids (American Nurses Association, 1988). In an ethics and human rights survey administered at the 1994 ANA convention, 59% of the nurses said that ethics was not sufficiently addressed in their education, and 79% said that they were confronted either weekly or daily with ethical issues in their practice (Scanlon, 1995).

Because moral problem construction depends on awareness and knowledge, moral uncertainty is context dependent to the extent that the context enhances or diminishes awareness and knowledge of nursing ethics. Between 1934 and 1979, as more ethics articles began to appear in the nursing literature, both knowledge and awareness of ethical issues increased. For example, Carroll and Humphrey commented that the staff nurses who were attending their ethics class:

> . . . for the most part tend to think of themselves as colleagues of physicians. As a result nurses appear to be more autonomous and are apt to question more frequently physicians' and institutions' decisions. They are taking more responsibility as professionals and thus are now faced with many moral dilemmas. (1979, p. 5)

Although increased awareness would serve to diminish moral uncertainty, it would not, by itself, have that effect on moral dilemmas, in which the definition demands the presence of conflicting principles or duties. The existence of dilemmas, in any era, means that at least some nurses were aware of some situations in which duties or principles conflicted. An increased level of ethical awareness among nurses would increase the number of moral problem formulations, but not necessarily the number of moral dilemmas (they could, for example construct the problem as moral distress). The frequency of moral dilemmas does not increase unless the context

somehow produces more conflicting principles. The frequency of moral dilemmas would decrease if the context produced fewer such conflicts or if there existed, and nurses became aware of, a wider range of alternatives than the either/or construction present in the dilemma construction. The remainder of this report will establish that the context changes between 1934 and 1979 did not produce more situations of conflicting principles, but instead produced conflicts because of constraints to moral actions.

Action Problems

In all action problems, the nurse has made a moral decision. Except for no problem, moral judging and moral weakness, action problems also have in common the presence of contextual constraints to the moral action being contemplated. Constraints to nurses' moral actions have been well documented in the nursing literature from all periods.

> A review of health care literature from the past 30 years reveals a remarkable consistency in the identification of situational constraints in nursing practice. This consistency is apparent over time as well as across diverse bodies of literature—including literature on stress, burnout, ethics and moral reasoning" (Rodney & Starzomski, 1993, p. 23).

This section presents seven observations about the pattern of action problems in the four time periods studied.

1. In the contemporary (1979, 1989 and 1995) data, action problems—primarily moral distress and moral outrage—were overwhelmingly more prevalent than decision problems.

The 1934 data are strikingly different from the other three sets of data in this regard. The total number of action problems increased from 40% in the 1934 data to 87% in the 1979 and 1989 data (see Table 6.2, on page 146, and Figure 6.3, on page 166). This is reflected in the 1930s literature, in which the prevalence of decision problems has already been discussed.

Action problems began to appear in the literature of the 1970s. For example, the Canadian Nurses' Association special committee on nursing research published a request in *The Canadian Nurse* for detailed descriptions of nurses' ethical problems. Although they received only 22 responses, they were able to see three different kinds of problems in the responses. One of those problem types was called: "I know what

should be done, but what course of action should I take?" The following was given as an example, and in the Wilkinson model, it is a classic action problem:

> A sterilization procedure is frequently carried out for women who are said to be intolerant of the pill. However, the nurse discovered that they were not intolerant of the pill; this reason was given so that the procedure could be charged to hospital insurance. (Allen, p. 23)

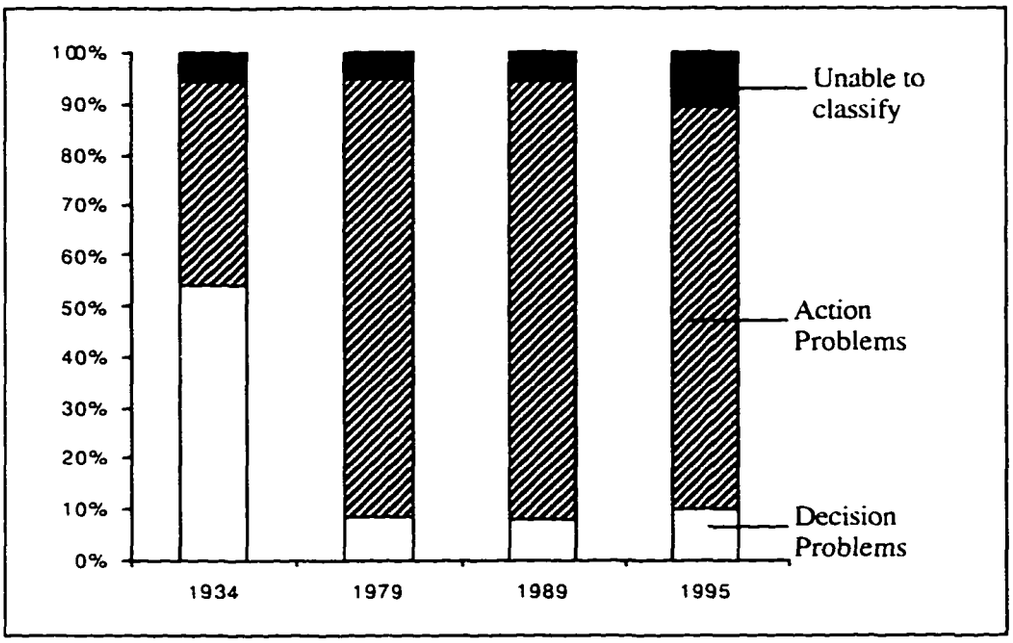
In her review of ethics research for the period 1987-1991, Chafey (1992) found the construct of moral distress in nine of what she called ethical practice studies. Even more recently, nurses in Meyers' (1994) study described experiences with moral distress (an action problem), although they were couched sometimes in advocacy language. For example, one nurse said:

> I think when I let myself down, and when I feel really bad, is whenever I don't think I have been a strong enough advocate, whenever there has been an opportunity for me to interact with the attending and say, "well, yes, okay, so you think he's got a two percent chance, but look at this, this, and this." Why didn't I say that? So in those situations, it's hard for me to feel good about what I did no matter what else . . . . if I can't argue convincingly . . . . I don't do it well, and I feel bad about not being as strong an advocate as I should be. (p. 43-44)

Meyers' (1994) study supports the conclusion that action problems are more prevalent than decision problems in the recent data. Of the 14 stories of nurses' moral problems presented in Appendix E of Meyers' study, 12 (86%) can be classified as action problems (2 moral heroism, 4 moral distress, 5 moral outrage, and 1 no problem) using the Wilkinson model. All of the 22 classifiable narratives in Fenton's (1987) study are action problems (8 moral outrage, 7 moral distress, 2 moral heroism, 2 moral judging and 3 no problem).

Action problems such as moral distress and moral outrage are differentiated from decision problems by the (a) existence of a decision about what is right/wrong, and (b) presence of constraints to moral action (see Table 3.4 in chapter 3). Therefore, a discussion of action problems must include a discussion of constraints. Although the cultural context in 1934 is similar to the other three periods in that constraints to moral action existed, chapter 4 has shown that in many other respects it was different. Therefore, this finding lends support to the influence of role and culture on the manner in which nurses construct and experience ethical problems. This discussion will be developed further in the next pattern, *Moral Distress*, and in chapter 7.

Figure 6.3. Decision Problems vs. Action Problems



2. <u>Moral distress, found in only 2% of the 1934 narratives, was most frequent in the 1989 data. Contrary to expectations, it was not the most frequently mentioned problem</u>.

Consistent with the narratives, the term moral distress was not found in the nursing literature prior to Jameton's 1984 definition of it (Wilkinson, 1992). It was alluded to but not named in *The Encyclopedia of Bioethics:* "The nurse is under an obligation to do what is in the best interest of the client, but can she or he always do so in a way that will not result in a loss of her or his job?" (Reich, 1978, p. 1142).

Some literature prior to 1934 did mention fear of physicians as a contextual constraint to moral actions (one antecedent to moral distress). For example, Aikens said:

> Not infrequently, a nurse is torn between her desire to be loyal to the patient's interests, and not be disloyal to the doctor, who has it in his power to turn calls in her direction . . . . nurses should understand how physicians look at the matter and proceed cautiously in doubtful situations. (1929, p. 184)

Yet, the other dimensions of moral distress (i.e., knowing what is right and feeling a responsibility for deciding and acting) were rarely present in the 1934 data and literature. I found only two cases resembling moral distress in the literature of that period. In one, an R.N.'s letter to an editor contained a story in which present-day nurses would probably experience moral distress, but in which that nurse did not. Obviously the nurse believed the doctor was about to do wrong; and her actions show that she felt some responsibility for intervening. However, when unable to do so, she apparently did not feel responsible for what happened. Furthermore, she focused on the physician's actions, and was undecided about what her own action should have been in the case. Therefore, the situation, for her, was not quite moral distress. The letter said:

> [At a home delivery, a doctor] dazed by liquor [failed to notice a nuchal cord.] I quietly tried to show the doctor the danger without exposing his mental state to the family . . . . strangulation resulted . . . . The doctor told them that the baby had probably died a day before the delivery . . . . What should I do? Will the doctor's conscience and the shock he had, prevent him from serving another patient in the same way? ("The Editor's Letter-Box," 1922, p. 229)

In the other case, a 1931 letter to the *AJN* "Ethical Problems" column, a nurse asked for advice in what, for her, was a decision-focused problem. The column editor's answer transformed the situation into an action-focused problem. The letter-writer described the case and asked: "What is the *ethical* responsibility of a nurse who knows that an overdose has been ordered and is unable to obtain a corrected order?" The reply was:

> If he refuses to admit his mistake, the nurse is justified in refusing to administer the dose [acting: doing what is right]. The nurse owes obedience to the physician, but no authority can take from her the responsibility for her own acts as an individual . . . . The nurse's responsibility is to the patient as a human being, which always comes before any obedience which one class owes to another. (1931c, p. 220)

It should be noted that the editor's reply reflects the thinking of the educated elite nurses of that time more than that of the bedside worker nurses.

In the 1970s, nursing literature began to discuss constraints to nurses' moral actions—a necessary dimension for action problems in general and moral distress in particular. For example Bunzl (1975, p. 188) stated that a nurse's first obligation is to prevent harm to the patient, but "a practical implication for most nurses seems to be

that they will lose their jobs if they fail to comply with the orders of physicians." In Pence's 1983 anthology, there is a heading for "Institutional Constraints to Ethical Practice," under which are 12 articles: 1 written in 1972, 4 in the late 1970s, and 7 in the early 1980s.

Consistent with study findings, a few cases of moral distress also began to appear in the 1970s literature, although they were not labeled as moral distress. These cases also contain examples of ways in which the cultural context had changed by then. For example:

> My *hospital has a policy of resuscitation of all patients who arrest in the absence of a written physician's order.* It is difficult to carry out a Dr. Blue when the patient has said he wishes no heroic measures undertaken." ("Nursing ethics: The admirable professional," 1974, p. 64) [Italics added]

Another case was described by Jacobson (1978):

> *A child was kept alive mechanically for weeks* . . . . I started avoiding him and felt guilty for it. I started questioning much of our unit's work: Is this what we are really here for? Doesn't quality of life mean something? I had to resuscitate him once, which was particularly stressful—I didn't want to succeed but I had to look like I was trying hard enough. (p. 146) [Italics added]

Recently, more cases of moral distress have been reported in the literature, although not all authors have labeled them in that way. Examples can be found in Miya (1989), Barr (1992), Haddad (1993) and Åström, Furåker and Norberg (1995,). Erlen and Frost (1991) found in their study that "nurses described being angry, frustrated and exhausted because of their inability to change the situation" (p. 403). They said:

> When nurses attempted to intervene in a patient situation, physician control again became evident. For example, nurses identified concerns about the aggressive treatment of patients by physicians despite wishes of the patient and family. (p. 401)

Another example is the following case, from Holly (1993):

> What am I supposed to do, it's my job to follow written orders. If there's no written DNR (Do Not Resuscitate), I have to legally call a code. I can't afford to lose my job. (p. 114)

Most recently, a nurse in a Canadian study told this story, which is a classic case of moral distress:

> We're always bringing him back, had we just left him there, we didn't check on him like every half an hour he could actually just have gone very easily and for a while there we were questioning . . . and I think it was being addressed now slowly, like why are we having to take blood cultures on him every time he has a fever . . . . I think enough is enough, either you've treated this . . . your treatment was not effective so so be it . . . . I saw him on the spinal cord unit . . . he has repeat admissions for pneumonia . . . . the mistake that was made is putting the trach in . . . (Rodney, 1996, in progress)

The number of narratives classified as moral distress increased steadily from the 1934 to the 1989 data; and as previously discussed, constraints to nurses' moral actions are evident throughout the literature from all time periods (Ashley, 1976; Augustine, 1991; Erlen & Frost, 1991; Fenton, 1987; Haddad, 1993; Ketefian, 1981; Kramer, 1974; McShea, 1978; Rodney, 1988; Rodney & Starzomski, 1993; Wilkinson, 1987/88). In one Canadian study, the 79 nurse respondents reported experiencing "a moderate degree of moral distress when carrying out their daily responsibilities," as measured by Corley's Moral Distress Scale (Wheeler, 1994, p. iii-iv).

Practice contexts are different in some ways in each of the four time periods, as demonstrated in chapter 4 of this study; yet many of the same constraints to moral action are present in all four data sets—for example, legal action and fear of physicians and administrators. Although constraints to moral action exist in each of the time periods, the incidence of moral distress (and, incidentally, moral outrage) was considerably less in the 1934 data, so it must be that the existence of constraints in and of itself is not enough to produce moral distress. Therefore, something else—for example role conceptions and other cultural influences—must account for the increase. The effects of role and culture on moral distress will be explored further in chapter 7.

Findings in this study (see Table 6.2, on page 146, and Figure 6.2, on page 158) lend only moderate support to previous speculations of Cahn (1987) and Wilkinson (1985; 1987/88) that moral distress is presently the most pressing of all moral problems for nurses. Excluding a construction of no problem (because it does not cause moral suffering):

- In the 1979 data, moral heroism and moral outrage occurred more frequently than moral distress.
- In the 1989 data, moral distress and moral outrage occurred with the same frequency.
- In the 1995 data, moral outrage was reported more frequently than moral distress.

Still, in all but the 1934 data, moral distress was very important (ranging from 11% to 23%). Moral distress and moral outrage tend to be the problems that cause the most moral suffering for nurses, and together they accounted for 27%-46% of the problems in the three most recent data sets. These study findings are supported by an analysis of the cases in two previously mentioned studies: (a) 4 (29%) of the Appendix E stories in Meyers' (1994) study were moral distress; and (b) 7 (32%) of the 22 narratives in Fenton's (1987) study were moral distress.

3. Moral outrage occurred frequently and consistently in the 1979, 1989, and 1995 data (ranging from 16% to 23%); and although it was less frequent in 1934 (8%), it was the third most frequent problem, even in that data.

As shown in Figure 6.2, on page 158, moral outrage was one of the most frequently described problems in 1979, 1989 and 1995. In 1979, moral heroism and no problem proportions were just slightly higher; in 1989, moral distress was reported with the same frequency; and in 1995, only no problem was higher. Although the incidence of moral outrage in the 1934 narratives was lower than in the other years, this can be attributed to the high percent of moral uncertainty (47%) and a lack of any kind of problem formulation by nurses. Even in the 1934 data though, moral outrage was the most frequently reported action problem except for moral judging (which is also other-focused).

Consistent with these results, examples of moral outrage can be found readily in the literature of the 1970s, 1980s and 1990s. The following is an example of moral outrage taken from a 1974 nursing journal:

> I phoned a doctor to question an order for normal saline on a 36-year-old female patient with mitral stenosis and repeated history of CHF. I was informed the order stood, and that if I wasn't so stupid I would have noticed that her sodium was low. (Her lab slip indicated an Na+ of 6 mEq/L, slightly below normal . . .) I assumed personal

> responsibility and slowed the I.V., charting both my conversation with the doctor and I.V. intake. I reported this to the morning charge nurse. The day shift returned the full I.V.; later that day the patient was transferred to ICU with pulmonary edema. She died the next day. I still feel extremely angry about this woman's death because I feel it was preventable. ("Nursing ethics: What are your," 1974, p. 37)

In more recent literature, of the 36 combined classifiable stories in the Meyers' (1994, Appendix E) and Fenton (1987) studies, 13 (36%) would be classified as moral outrage using the Wilkinson bifocal model—making it the most frequently mentioned problem in those studies.

If the study assumption is correct, that context affects problem construction, one must ask why, then, is moral outrage found with high frequency in data from seemingly dissimilar contexts. If the study assumption is justified, then (a) either the contexts must be similar in some important ways, or (b) something other than context must be involved. In fact, both are probably true. The contexts are similar in that nurses perceived constraints to their moral actions in all four periods; and in addition to constraints, individuals' role conceptions and sense of personal responsibility may weigh heavily in this problem construction (see chapter 7).

As previously mentioned in this chapter and in chapters 1 and 2, evidence of constraints to moral action were found in the data and literature from all four periods. Nurses perceived that they could not challenge powerful others without risk. Contextual constraints are necessary in order to define the presence of moral outrage, but the question of whether or not there are *actually* more or fewer constraints to nurses' moral actions in a particular time period is probably irrelevant to this and the preceding pattern. The data from all four time periods show that nurses *perceived* that there were such constraints, despite evidence that nurses presently are making decisions and functioning more independently than in 1934. With regard to the existence of constraints, nurses' *perceptions* of their practice context may not have changed appreciably in this century.

Like moral distress, the incidence of moral outrage increased slightly in the more recent narratives, even though perception of constraints remained relatively constant. So it must be that perception of constraints in and of itself is not enough to produce moral outrage. A comparison of moral outrage and moral judging may provide insight on this point. Both outrage and judging are other-focused problems in which the nurse does *not* act on her decision about what is right. The combined

frequencies of these two problems are about equal in all time periods (all contexts), as can be seen in Table 6.3, on page 173.

The presence of constraints is a characteristic of moral outrage but not of moral judging. These two problems have in common: (a) a focus on the actions of others and (b) failure to act on one's moral decision. This means that frequency of other-focused problems in which the nurse does not take action has remained the same across the four different cultural contexts. Therefore, a discriminating dimension other than constraints must account for any differences in their frequencies. One prerequisite to moral outrage is a focus on the actions of others rather than on the responsibility for one's own actions; so one might speculate that nurses who feel powerless to act or who do not see autonomy as appropriate to their role would focus on what others are doing—and perhaps experience moral outrage. The effects of culture and role, especially powerlessness, on the construction of moral outrage will be explored in chapter 7.

4. Both moral heroism and no problem are much more strongly represented in the contemporary (1979, 1989 and 1995) data than in the 1934 data (see Table 6.2, on page 146, and Figure 6.2, on page 158.

Moral heroism and no problem are alike in that the nurse both makes and implements a moral decision. The difference is that in moral heroism there are risks or constraints to the moral actions; in no problem there are not. Therefore, the commonality in their contexts probably does not have to do with the presence or absence of constraints, but with individual factors such as awareness and decision-making, although the contexts may have facilitated or inhibited those individual factors.

No problem.

The increased number of no problem classifications in the 1979, 1989 and 1995 data (25%, 11% and 27%, respectively) does not indicate that those nurses encountered moral problems less often. By definition, no problem means that the nurse was aware of a moral issue, knew what was right to do, and did it at no appreciable personal risk. Given the high level of moral uncertainty in 1934, and by implication the low level of awareness, it would be expected that nurses' no problem (and other problem) constructions would be low in that period and increase with the

Table 6.3. Incidence of Moral Outrage and Moral Judging (Percents)

Year	Moral Outrage	Moral Judging	Combined Frequencies
1934	8%	13%	21%
1979	16%	5%	21%
1989	23%	2%	25%
1995	17%	6%	23%

"new era" of nursing ethics. A decrease in the proportion of moral uncertainty necessarily means an increase in some other problem construction, including that of no problem. During the 1970s, several authors proposed models for nurses' ethical decision-making, implying or openly asserting that nurses should be involved in such decisions (e.g., Bergman, 1973; Murphy & Murphy, 1976). The following is a literature example of a no problem construction by a nurse participating in a study of nurses' skills in managing ethically difficult care situations:

> A young female patient wanted her doctor to be precise about her cancer diagnosis. But he was not on duty and therefore another physician on the ward gave her this information. I knew that he was the wrong one to inform her about her severe cancer diagnosis and prognosis. I let her know my opinion and tried to persuade her to wait, but she still wanted to be informed and so she was. (Åström et al., 1995, p. 1077)

Although this situation did not turn out as the nurse hoped, it nevertheless fits the no-problem category. The nurse believed that she ought to try to persuade the patient to wait; she did that; and there seems to have been no risk involved.

It should be noted, too, that in the 1979 data 22% of the nurses constructing no problem were either supervisors or directors of nursing; in the 1995 data, 47% were reported by advanced practice nurses and 17% by educators or managers. For the 1989 stories, Haddad (the researcher) reported that only 49% of her respondents identified their job position as staff nurse, and 9.9% held master's degrees. It may be that no problem coincides with cultural consonance, or a practice context that permits enactment of the nurse's ideal role. This will be discussed further in chapter 7.

Moral heroism.

Moral heroism is similar to no problem in that the nurse focuses on her own actions, knows the right thing to do, and does it. The only difference is that a moral hero acts despite an awareness of personal risk or sanctions. The presence of moral heroism and no problem are both indicators of nurses' engagement with moral issues; and moral heroism reflects the presence of action constraints in the context. Moral heroes are nurses who have overcome psychic distance and have chosen to be patient advocates (see *Two roads diverging* on page 176).

Study findings do coincide with the literature of the period. A prototypical case of moral heroism is the story of Jolene Tuma, a junior college nursing instructor who, in 1977, gave information about laetrile to a dying cancer patient—at the patient's direct and specific request (Stanley, 1979). Although the patient decided to continue with the chemotherapy, when the physician discovered that Tuma had given this information to the patient, he demanded that the college fire Mrs. Tuma—which they did. At his demand, the hospital also notified the State Board of Nurses, which suspended Tuma's license for six months (Benjamin & Curtis, 1986).

The literature reflects, overall, a more active engagement with ethical issues that began in the 1970s. Stenberg (1979, p. 10) said that nursing had been lagging behind (or not being actively engaged) in ethics because of "over 100 years of tacit compliance to obedience as the first law of practice." In addition, the 1970s literature actually urged nurses to be moral heroes. For example, Yarling (1978) said that the nurse has the legal and moral right to respond honestly to the patient, as well as a moral obligation to do so. Carroll and Humphrey told nurses that they were sometimes obligated to act as client advocates even if it meant jeopardizing their jobs:

> . . . to follow orders which the nurse believes are not in the patient's best interest is not to act responsibly toward the patient and is an abdication of the nurse's role as client advocate . . . . Nurses lack significant decision-making power. But in some instances, the client's welfare may require that they act on conscience rather than be subject to the decisions of others . . . . Whatever choice is made and acted upon, the nurse must take full responsibility for his or her action and accept the consequences of it. (1979, p. 29)

Given the evangelical zeal of those preaching advocacy in the 1970s, small wonder there were comparatively more moral hero cases in the 1979 data.

By the end of the 1970s, nurse researchers had begun to notice significant changes in the way nurses approached moral problems (Murphy, 1984). For example, Hutchinson (1990, p. 3) found that "given certain conditions—knowledge, ideology, experience—nurses engaged in responsible subversion" in order to function as patient advocates. That is, they violated hospital rules and policies for the sake of the patient, which is one of the ways moral heroes in the data implemented their decisions. Hutchinson said:

> A CCU nurse described how the physicians did not like nurses teaching patients about anything. The nurse cared for an elderly lady with a myocardial infarction who was sexually active and who wanted to know if she could engage in sex. The nurse chose to respond to her needs and teach her. (1990, p. 11)

However, in the 1990s, other nurses were beginning to give "second thoughts to the concept of the nurse as patient advocate" (Pence, 1994, p. 4). They began to question whether advocacy was desirable or even possible in the present practice environment—that is, whether nurses should or could continue to be moral heroes. At the same time, there were fewer instances of moral heroism in the 1989 and 1995 narratives than in 1979.

Although moral heroism is more common in the recent narratives than in 1934, compared to moral distress and moral outrage, relatively few (11%) narratives were categorized as moral heroism in the 1989 data—about half as many as moral distress and moral outrage. This is confirmed by current literature. Of the 14 stories in Appendix E of Meyers' (1994) study 1 (or 7%) can be classified as no problem, 4 (28%) as moral distress, 5 (36%) as moral outrage, and only 2 (14%) as moral heroism. One of the four stories quoted in the article by Åström, Furåker and Norberg (1995) represents moral heroism; the others are: 1 moral distress, 1 no problem, and 1 unclassifiable. The following is the moral heroism story:

> A dying cancer patient became worse and said good-bye to his wife and children. It was an emotional moment. In spite of the prescription which said that I could give diuretic and sedative medicaments I felt that the right thing to do was just to be present for the family. I read the situation and was able to manage it in a way I regarded as right. (p. 1077)

Griffiths (1993, p. 25) presented a real-life example of the advocacy exemplar (moral heroism), telling about a nurse who responded to a patient's request for information, even though she was aware "she could be treading on dangerous

ground." Curtin (1992, p. 21) told the story of a nurse who questioned an order for "nine times the normal dose of a corticosteroid to be given six times a day" and received no support when she appealed to her nurse manager. The young nurse "refused to give the medication without some explanation and made out an incident report," although nurses on other shifts administered the medication without questioning.

Two roads diverging.

Research demonstrates that it was, and still is, common for nurses to abdicate responsibility for ethical decisions (Berger et al., 1991; Berseth et al., 1984; Reckling, 1994; Wilkinson, 1985). Seventy percent of the 207 hospital nurses in Roach's survey (as cited in Tunna & Conner, 1993, p. 25), "stated that they had not been involved in any ethical problem for at least six months." Corley, Selig and Ferguson (1993, p. 124) found "wide variation . . . in nurses' participation in ethical decision making in a variety of situations." Many would say that there is little opportunity for participation (Davis, 1979; Holly, 1989).

The very existence of moral heroism gives rise to the question of why it is that some nurses experience moral suffering and are driven to take risks for their patients, while for others, moral issues tend to be constructed as no problem. The problem constructions of moral heroism and no problem can be partially explained by Case's (1991) two perspectives on moral conflict, which she called "two roads diverging" (p. 65). Case's two roads are:

1. The advocacy exemplar in which the nurse is willing to risk in order to achieve a desired outcome for the patient.
2. The "not my job" exemplar, in which the nurse externalizes responsibility for the desired outcomes by stating it is up to someone else to decide the outcome in question.

The advocacy exemplar fits the definition of moral heroism in the Wilkinson bifocal model. The "not my job" exemplar could be classified as no problem if the nurse believed the right thing to do was to let those who were "more qualified" decide ethical questions and simply fulfill their orders. The "not my job" nurses could not formulate problem constructions such as moral dilemma, distress and outrage because they would not be that engaged. If the nurse perceives though that, for her, there *is* no

ethical situation, then the problem could not be classified. There is no classification in the bifocal model for completely removing one's self from the ethical arena.

Gilligan also commented on the varying levels of involvement in moral decision making (1977), stating that women's lack of power makes them vulnerable and reluctant to take a stand on moral matters. She said, "To the extent that women perceive themselves as having no choice, they correspondingly excuse themselves from the responsibility that decision entails" (p. 487). The same could be said substituting *nurses* for *women*; and since most nurses are women, the effect may be even stronger.

Another possible reason that some nurses disengage from ethical decision making may be found in Parker's (1990, p. 37) speculation about moral apathy—that "an incongruence between beliefs and behavior can result in anxiety and frustration and over time can suppress and numb one's emotions. In the end, technically competent nurses may neither perceive nor care about the moral dimension of nursing." Fenton (1987) also said that some nurses pull themselves out of the ethical decision-making process after becoming disillusioned by their inability to implement their advocacy role and deal effectively with moral problems.

There is an even more insidious and pervasive phenomenon that helps to explain why some nurses abdicate their moral agency. John Lachs (1981, p. 11) says that *mediation* ("action on behalf of the other") results in *psychic distancing*, which is the price we pay for organized social living. Using the story of the shipwrecked Robinson Crusoe as an analogy, Lachs said:

> Without our Fridays each of us would have to perform by himself all the actions that support his life and express his self. Our companions relieve us of many of these tasks. They interpose themselves between each person and those actions that would otherwise be his . . . . The person who performs the action on one's behalf is "the intermediate man": he stands between me and my action, making it impossible for me to experience it directly. He obstructs my view of the action and of its consequences alike." (pp. 11-12)

Mediation has three major consequences, two of which are pertinent to this study:

1. We become infected with a growing sense of passivity and impotence—not that we are idle—we may be very busy performing mediated actions for others.

2. Mediated action introduces *psychic distance* between human beings and their actions; we forget the immediate qualities and long-range effects of our actions.

Think how Lach's consequences might apply to nurses, especially in hospitals. Although the responsibility for an act can be passed on, its experience cannot. The result is that there are many acts no one consciously appropriates. For example, if a physician orders a potentially fatal dose of morphine for a terminally ill patient, the *responsibility* for giving the medication passes on to the nurse. The *experience* of giving the medication, though, cannot be passed by the nurse back to the physician. The giving of the morphine exists only in the physician's imagination—he does not claim it as his own since he never lived through it. The nurse who has actually done the act, on the other hand, may always view it as someone else's (the physician's) and herself as but the blameless instrument of an alien will. In healthcare there are a myriad of such acts that no one consciously owns.[1]

As the chain of intermediate men[2] grows longer, we feel power over our own actions slip from our grasp. Mediation begins to blind us to the agency and the personality of the person. The person becomes a being who lives by the rules, assumes roles and begins to view agencies and institutions in his place—like giant organisms.

> In acting in a role within an institution, we act on behalf of the institution directly, and only indirectly on behalf of the individuals whom that institution serves . . . . Each [person] can declare that he is working for the good of the whole or at the command of superiors . . . . this . . . leads to the ultimate cop-out. The man cornered by his conscience can at some point no longer avoid knowing that what his role requires him to do is wrong. He then justifies his act by: "If I did not do it, they would simply get somebody else." (Lachs, 1981, pp. 68-69).

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[1] In addition to explaining disengagement from ethics, psychic distancing may also help to explain the problem construction of moral outrage, in which the nurse focuses on the immoral actions of others.

[2] "Intermediate men" is Lachs' terminology. He used masculine nouns and pronouns throughout.

5. Whistleblowing did not occur in the 1934 data and was, except for moral judging and moral weakness, the least frequently reported action problem in all periods (ranging from 0% in 1934 to 10% in the 1989 data).

Most of the whistleblowing reported in the narratives was of the internal type (as discussed on page 155). The 1985 nursing code of ethics required that nurses be whistleblowers (American Nurses Association, 1985). Nevertheless, there was little whistleblowing literature prior to the late 1980s. In one early article, a nurse reported a hospital for what she believed to be unethical and illegal termination of life support to a comatose patient. After being fired, she sued the hospital and was, in 1988, awarded $114,000 in damages for wrongful termination ("Court backs nurse," 1988; Veatch & Fry, 1987). Other pre-1989 whistleblowing references include Dozier and Miceli (1985), Feliu (1983), Price and Murphy (1983), Smith (1980), Witt (1983), and Zorn (1987).

More accounts of whistleblowing appeared in the literature of the '90s (e.g., Haddad & Dougherty, 1991; Silva & Snyder, 1992). Some of it indicated that nurses may be morally obligated to blow the whistle on employers (Bosek, 1993); but if that need arises, it means the system has failed (Fry, 1989; Napthine, 1993). Whistleblowing is dangerous for nurses (Barnett, 1993; Bosek, 1993; McDonald, 1994), and they usually do not engage in it except as a last resort (e.g., Andersen, 1990; Fry, 1989)–presumably when they have reached the point of resigning their jobs anyway and feel they have nothing to lose. Tadd (1994) argued that nursing codes of ethics place an unreasonable burden on nurses when they exhort them to report unprofessional conduct in the absence of an effective support network for whistleblowers. The following is a case of internal whistleblowing from the 1996 literature, in which the nurse said:

> . . . a diabetic patient who came for prenatal care . . . to a resident clinic, which is supposed to be overseen by staff physicians. And that just wasn't done in this case. And this patient was very brittle, eventually lost the baby. She kept getting different residents and nobody took that assertiveness to step in and manage her care, one person. And this patient needed that really bad. That was the most angry that I believe I've ever been. I went to the chairman of the department and laid it out. And he says, 'Well, we just can't give that kind of one-on-one care to all patients, you know. This is a patient in the clinic, it's not a patient who's a paying, private patient.' I was furious. (Smith et al., 1996, p. 27)

This story illustrates that whistleblowing does not always have the effect the whistleblower hopes for. Often, nothing changes. At worst, the organization punishes the whistleblower.

6. Moral judging occurred with the highest frequency in the 1934 narratives (13%) and was consistently one of the least frequent constructions in the other data sets. It had the second highest incidence of any problem construction in the 1934 data.

One of the dimensions of moral judging is that the nurse focuses on the action of others rather than on his own responsibilities in the situation. This is also true for moral outrage, which was the third most frequent problem in the 1934 data. Together moral judging and moral outrage accounted for 21% of the 1934 narratives. The culture and role conceptions of the time help to explain why this is so. The culture of that period required nurses to report others who broke the rules, and it did not encourage personal decision-making or responsibility. Obedience and rule-following also formed a part of nurses' ideal role conceptions in the 1934 data. I found no examples of moral judging in any nursing literature.

7. Moral weakness was slightly more prevalent in the 1934 data, but did not occur frequently in any period (ranging from 0.8% to 5%).

The reasons for this are probably similar to those given for moral judging. Role conceptions included obedience and rule-following, and cultural norms dictated that one report rule-breakers, even one's self. As noted in the discussion of *Moral Dilemma* (see page 149), a range of 0.8% to 5% in this study represents little variation. That is, the incidence of moral weakness in the data was actually fairly constant throughout all 4 time periods. Again, given that the contexts were different in important ways, how does one account for the same problem construction's occurring in different contexts?

According to Jos (1988) people often fail to act morally simply because they lack self-discipline and self-control—they give in to their impulses or selfish desires. He said, "There are times when people know what it is they should do but fail to act accordingly" (p. 324). If doing the right thing requires strength of character, and moral weakness is a lack of such strength, then one would expect about the same number of moral weakness cases in each time period—strength of character being

perhaps influenced more by internal factors, and ability to act being influenced more by external constraints.

The Dynamic Nature of Problem Construction

In analyzing the 1995 narratives it became clear that problem construction is dynamic rather than static. That is, in a particular situation, the nurse's problem construction changes over time, as the situation changes, as the nurse thinks about the situation and talks it over with others, or as the nurse takes action and sees that it does—or does not—have an effect on the situation. The 1995 narratives were especially revealing of this because they were very lengthy and were the product of interviews in which the interviewer asked many probing questions. Participants tended to tell their stories from beginning to end, and the stories often stretched out over days, weeks and months, during which the problem type could be observed to change.

The idea that a nurses' problem construction evolves over time fits with Andersen's description of the progression from moral distress to whistleblowing and then to moral outrage:

> When a nurse encounters patient abuse or neglect . . . patient advocates choose . . . to take action. However, in nonresponsive or defensive organizations, institutional constraints are applied that obstruct the nurse's ability to act on her decision . . . . In order to protect the patient and subsequently relieve the moral distress, the nurse seeks assistance through the administrative hierarchy, progressing methodically through the channels of command from head nurse to chief executive officer. (1990, p. 8)

Andersen explained that as the nurse progresses up the administrative hierarchy, she experiences moral outrage as the various levels fail to respond favorably and, in fact, begin to attack her.

The nurse in the following narrative progressed from moral outrage to moral distress and then to whistleblowing as she felt her own need to do something to change the physicians' behavior. When her actions produced no change, she again experienced the situation as moral distress and finally coped with it by leaving her job:

> (95.77) The American Cancer Society recommends that . . . a repeat exam is done at 1, 3 and 5 years and then every 5 years if no new [polyps] are found . . . . These physicians—not the specialists—have repeat exams much more frequently, sometimes every 6 months . . . . [This] is expensive. It is frightening to patients . . . . You can't tell a patient he is having unnecessary tests . . . . I also would document each

> procedure I felt was unnecessary and send it up the chain of command . . . . I didn't really get a good reason . . . . Eventually I quit. I just found it too hard to keep doing unnecessary procedures . . . . Too difficult for me. I gave up. . . . It is still happening this way.
>
> . . . . these doctors are self taught and the patient often has a much more difficult exam with wrong pain control; often not getting the job done and needing follow-up x-rays. It is a physician QA issue which will never be addressed. I sent letters up the ladder on this too. There is no hope.

In the following case, the nurse first experienced moral distress and then resolved it by taking action as a moral hero. She tried repeatedly to persuade physicians to prescribe effective pain relief (in the form of a patient-controlled analgesia, or PCA, pump) for a patient with bone cancer. During that period of time she experienced moral distress because she could not help the patient. Finally she took action by strongly insisting the physician do as she asked. At that time she became a moral hero:

> (95.61) I thought to myself, enough is enough! I don't care whose feathers I ruffle; but something has to be done . . . . Taken aback by my strong assertiveness, the physicians finally ordered a Fentanyl PCA. What else could they say, I had "laid the cards on the table," so to speak. I felt like I had wrestled an army to get my point across, and I had to be extremely assertive, almost nasty, to get them to listen to me!

These cases all seem to indicate that moral distress and moral outrage can be resolved by taking action. They then become either moral heroism or whistleblowing, depending on the nature of the action chosen. If the nurse does not take any action, she may continue to alternate between moral outrage and moral distress and never resolve the problem satisfactorily. Her problem construction will shift back and forth from moral distress to moral outrage, depending on her focus at the moment. Her moral suffering will alternate between anger at those who are doing wrong and guilt and anger at herself for not stopping them. The preceding cases reinforce that nurses can relieve moral suffering by taking action, either as moral hero or whistleblower.

Summary of Moral Problems Findings

The original problem constructions in the Wilkinson (1985) model were: moral uncertainty, moral dilemma, moral distress, moral outrage, moral heroism and whistleblowing. Three new problem types emerged from the data and were added to the model during Phase 1: moral judging, moral weakness, and no problem. In

comparing the 4 sets of stories, the following patterns of problem construction were found:

1. In the 1934 data, moral uncertainty was overwhelmingly the most frequent problem; it was nearly nonexistent in the other time periods.

2. The frequency of moral dilemmas was relatively low and relatively constant in all 4 time periods.

3. The two decision problems (moral dilemma and moral uncertainty) differ in the stability of their frequencies over time.

4. In the contemporary (1979, 1989 and 1995) data, action problems, primarily moral distress and moral outrage, were overwhelmingly more prevalent than decision problems.

5. Moral distress, found in only 2% of the 1934 narratives, was at its highest in 1989 (23%). Contrary to expectations, however, it was not the most frequently mentioned problem.

6. Moral outrage occurred frequently and consistently in the 1979, 1989, and 1995 data (ranging from 16 to 23%), and only slightly less frequently in 1934 (8%).

7. Both moral heroism and no problem were much more strongly represented in the 1979, 1989 and 1995 data than in the 1934 data.

8. Whistleblowing did not occur in the 1934 data and was, except for moral judging and moral weakness, the least frequently reported action problem in all periods (ranging from 0% in 1934 to 10% in the 1989 data).

9. Moral judging occurred most often in the 1934 narratives (13%) and was consistently one of the least frequent constructions in the other data sets. It had the second highest incidence (after moral uncertainty) of any problem constructions in the 1934 data.

10. Moral weakness was slightly more prevalent in the 1934 data, but was not very frequent in any period (ranging from 0.8% to 5%).

In addition, three other observations were made about problem constructions in general:

1. Moral dilemma and moral uncertainty, even though constructed as decision problems, do not preclude action. Nurses usually must act, even when they are not sure of the right thing to do.

2. Problem construction is dynamic and changes with time and thought—sometimes alternating back and forth between the same two problem types without resolution.

3. Moral outrage and moral distress can be resolved by taking action—which transforms them into either moral heroism or whistleblowing, depending on the nature of the action the nurse takes.

Patterns of problem construction in the different time periods were discussed in light of relevant ethics literature of each period. In answer to research Question 3, the Wilkinson bifocal model typology was found useful for classifying nursing ethics problems, and the patterns of problem construction were different in the data sets of the 4 time periods. The interaction between role conception and cultural context and their effects on problem construction will be discussed in chapter 7, following.

CHAPTER 7

SYNTHESIS OF FINDINGS: RELATIONSHIPS AMONG CULTURE, ROLE AND MORAL PROBLEM CONSTRUCTION

This chapter answers research Question 4 by discussing the pattern of moral problem constructions found in relation to the respective culture and role themes in each of the four time periods. Synthesis proceeded in two ways. First, I compared the interaction of culture, role, and problem types in each of the four periods—that is, I compared problem constructions and role conceptions in four different contexts. This was akin to comparing group means if this had been a statistical procedure. Second, I combined the four data sets, in a sense controlling for time but not other aspects of context. From this combined data, I examined just the individual narratives that had particular problem constructions (e.g., all moral distress problems) or specific combinations of role conception (e.g., all cases having advocacy but no autonomy) to see if the problems and role relationships were similar to the results obtained by comparing time periods. In a quantitative procedure, this would have been like using individual scores instead of group data.

For example, when I began comparing role themes in the various periods and attempting to relate differences in role conceptions to the differences in problem construction, I expected that in a period in which there was little autonomy in nurses' role conceptions, they would formulate fewer action problems. But I found that a comparison of total autonomy (both ideal and real) among the periods was not adequate to explain the difference in the proportion of action problems in each period. It was actually more useful in some instances to compare ideal autonomy (role conception) to actual autonomy (role enactment) without regard to period.

Effect of Context on Problem Formulation

The structure of a moral problem, or the way in which an individual formulates it, is determined by the interaction of the individual and the culture. Role conceptions are unique to the individual, but they are developed in and influenced by the culture in which the individual is situated. The sociohistorical/cultural context also affects the extent to which the person can enact a role conception. The fact that a nurse makes a moral decision does not necessarily mean that she can implement it. The

context provides a variety of constraints and supports that either facilitate or inhibit both the decision and the subsequent action.

The status of women, professional socialization, the employee status of nurses, role conceptions of autonomy and advocacy, and moral problems are concepts that form a web of intricate relationships. Although no one concept can be understood without the others, it is possible to change focus, first to one and then the other, examining a concept in detail and then in relationship to the other concepts. The individual concepts were examined in the presentation of findings on culture, role and problem construction in chapters 4, 5 and 6. As demonstrated in those chapters, there were some differences in nurses' role conceptions and in the nursing, organizational and United States cultures in 1934, 1979, 1989 and 1995. The pattern of ethical problems was also different in the four periods, providing support for the pre-study assumption that context does indeed influence nurses' constructions of moral problems (see Figure 6.2 in chapter 6).

Three important dimensions of context were used to interpret the effect of context on moral problem formulation: (a) cultural dissonance, (b) ideal versus actual role conception, and (c) the concepts of advocacy and autonomy as a part of nurses' role conceptions. These were discussed fully in preceding chapters, and will only be summarized here.

Cultural Dissonance

Some of the differences in problem construction can be explained by the notion of consonant and dissonant cultures. *Cultural consonance* in an organization exists when a subculture (e.g., nursing) operates in harmony with "other occupational cultures and with the overall organizational culture . . . . Members of all occupational groups are caring and supportive of one another and believe they are working toward the same goal" (Fleeger, 1993, p. 40). When cultures are *dissonant*, the opposite occurs. Nurses in Fleeger's study reported that "physicians interfered with their professional goals sometimes by obstructing delivery of patient care and sometimes by demonstrating unprofessional behavior toward nurses" (p. 40). Similarly, in all four time periods of this study, the nursing-physician and nursing-institution cultures were dissonant in various ways.

Ideal vs. Actual Role

"*Role expectations* (ideal roles) are position-specific norms that identify the attitudes, behaviors, and cognitions that are required and anticipated for a role occupant. *Role enactment* (actual role) is differentiated behavior or action relevant to a specific position" (Hardy & Conway, 1978, p. 76). When participants in social systems do not agree on which norms are relevant for a role (as would be true in cultural dissonance), then role enactment is idiosyncratic and role stress occurs, accompanied by a subjective state of distress called *role strain.* Role strain as a result of ethical issues would be similar to moral suffering in the Wilkinson bifocal model.

In this study, an *ideal role conception* (role expectation) is what the nurse thinks his role ought to be. *Actual role* (role enactment) is what the nurse actually does in the performance of the role. Ketefian (1985, p. 250) used the term *role discrepancy* to refer to the extent to which the ideal role conception differs from the actual role in practice. Individual and culture interact in the expression of actual role. This interaction forms the context in which the nurse experiences and constructs ethical problems. In this study, many of the differences in problem construction seem to result from cultural constraints on nurses' ability to enact their ideal roles (role discrepancy). I retained the notion of role-within-culture (especially role perceptions) in order to help account for some intrapersonal differences (e.g., cognitive, psychological, spiritual) that may not be entirely determined by culture and socialization.

Autonomy and Advocacy—Interaction of Role and Culture

The concepts of advocacy and autonomy are especially pertinent to this synthesis. The culture must allow nursing autonomy if the nurse is to enact an advocacy role. Different combinations of advocacy and culturally allowable (or actual) autonomy form contexts of cultural consonance or dissonance in which different kind of moral problems prevail. See Table 7.1, for example.

In Combination #1 of Table 7.1, the role expectation of no advocacy occurs in a culture where nursing autonomy is not valued or allowed. This is likely to be a context in which the nursing and institutional cultures are consonant, but repressive to the individual nurse. Lack of autonomy might not create cultural dissonance because, without the need to be an advocate, the nurse would not need any autonomy in order to fulfill that function. Cultural dissonance would occur in Combination #1 if, with the no advocacy role conception, the nurse also held a strong autonomy role

Table 7.1. Role Conceptions and Cultural Dissonance

Role Expectation (Individual Perception)	Autonomy Allowed (Cultural Norm)	Role Discrepancy & Cultural Dissonance
1. No advocacy	No	No?
2. No advocacy	Yes	No
3. Advocacy	Yes	No
4. Advocacy	No	Yes
5. Autonomy	No	Yes
6. Autonomy	Yes	No
7. Advocacy and autonomy	No	Yes
8. Advocacy and autonomy	Yes	No

conception (ideal autonomy) in relation to functions other than patient advocacy. By itself though, a culture that suppresses autonomy will not necessarily create cultural dissonance or role discrepancy.

Ketefian's (1985) findings support the conclusion that cultural dissonance and/or role discrepancy influenced nurses' problem constructions. She found that a *professional categorical (actual)* role conception was correlated positively ($r = .30$) with moral behavior as measured by her instrument, "Judgments About Nursing Decisions." A *professional normative (ideal)* role conception was correlated negatively ($r = -.13$). with moral behavior, as was a discrepancy between actual and ideal roles.

Because supporting literature has been given for role and culture themes in preceding sections of this report, presentation of literature to support those themes is limited in this chapter. In addition to the tables and figures in this section, refer to Table 6.1 in chapter 6.

Decision Problems: No Advocacy + No Autonomy

In the bifocal model, decision problems are those in which the nurse is unable to make a moral decision. The focus of the problem is on deciding the right thing to do. There are two decision problems: moral uncertainty and moral dilemma. Chapter 6 presented three patterns of decision problems:

1. In the 1934 data, moral uncertainty (a decision problem) was overwhelmingly the most frequent problem; it was practically nonexistent in the other time periods.

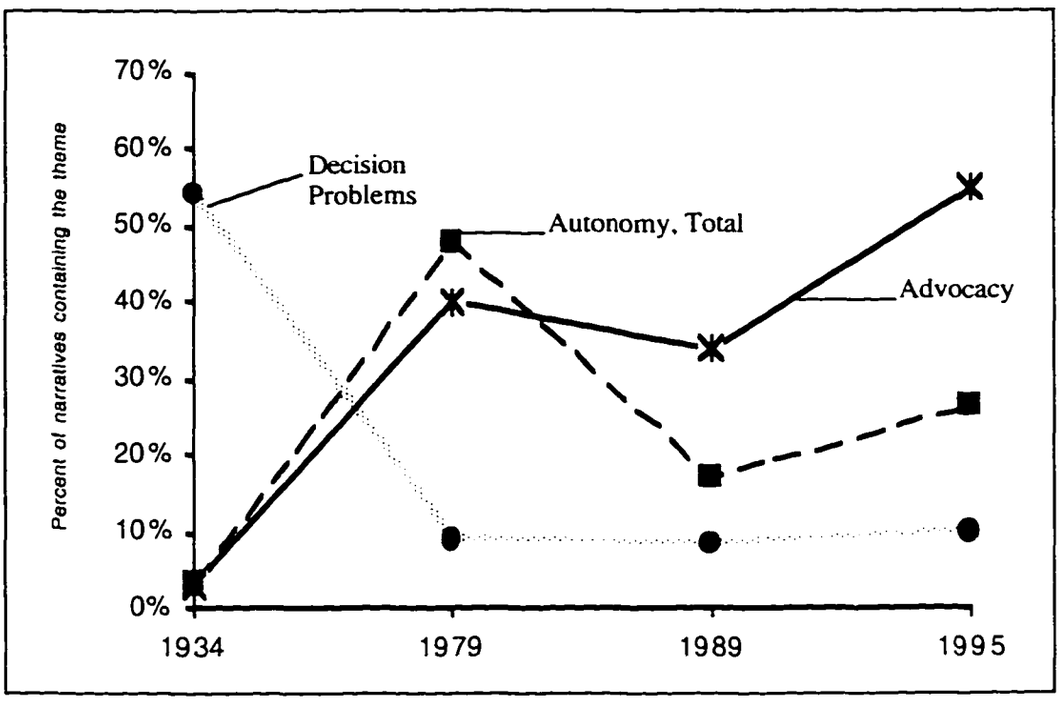
2. The frequency of moral dilemmas was relatively low and relatively constant in all 4 time periods.

3. Although both moral uncertainty and moral dilemma are decision problems, the frequency of moral uncertainty changed dramatically from 1934 to the present, whereas the frequency of moral dilemmas remained essentially unchanged.

In a context where neither advocacy nor autonomy were a part of nurses' role expectations and when, in addition, that combination fit with the expectations of the relevant cultures and subcultures, decision problems were most frequent in the data. In other words, nurses were asking mainly, "What is right?" rather than, "Can I *do* what I know to be right?" As shown in Figure 7.1 on page 190, this combination existed in 1934 but not in the other years; and 54% of the moral problems in the 1934 data were classified as decision problems. By comparison, in the 1979, 1989 and 1995 data, when the advocacy and autonomy themes were stronger, only 8-10% of the problems were classified as decision problems. This makes sense in view of the culture of the 1930s (see chapter 4).

One antecedent to an action problem is that the nurse has made a moral decision. In a moral dilemma situation, the nurse does make a decision in the sense that she decides what she will do; however, she is not able to decide what is *right* to do—so the problem remains a decision problem even though the nurse may take some action. Because decision-making was generally not a part of nurses' ideal or actual role in 1934, they would logically experience mostly decision problems rather than action problems. Furthermore, autonomy and advocacy were absent from nurses' role expectations at the same time that the nursing, institutional and wider cultures were socializing nurses and women in general to be self-sacrificing and obedient; therefore, there would be no role discrepancy. Role expectations in the data included obedience, appearances, competence, cooperation, gentleness, loyalty and subservience—none of which would have been likely to prompt active involvement and decision-making in ethical situations. In addition, this was before the "new era" of nursing ethics and before the proliferation of nursing ethics literature promoting ethical decision-making

Figure 7.1. Comparison of Problem Type and Role Conception in Four Time Periods: Advocacy, Autonomy and Decision Problems



for nurses. As all of these factors changed, action problems became more prevalent. Such changes will be discussed in the section on *Action Problems*.

Moral Uncertainty

As shown in chapter 6, moral uncertainty occurred most frequently in the 1934 data, being present in 47% of those stories. The 1979, 1989 and 1995 data sets contained only 0.5%, 1% and 2% moral uncertainty, respectively. Moral uncertainty represents the absence of a constructed problem. Like decision problems in general, it was probably produced in the absence of role discrepancy, and by cultural consonance rather than dissonance. The general American culture socialized women to be gentle and unassertive. The nursing, medical and institutional cultures socialized nurses to be subservient; and for any who might think of resisting, there was a strict hierarchy and a set of strictly enforced rules and penalties to keep them in line.

In the 1934 narratives, most nurses' role expectations and role expressions were congruent. Their culture and subcultures allowed and encouraged them to enact

their role conceptions: to be obedient, to follow and enforce the rules, and to not ask questions. Most nurses held and acted on these values. Other role themes that were strongest in the 1934 data were appearances, cooperation, professionalism and subservience. Themes that were least frequent in the 1934 data were advocacy, autonomy, assertiveness and knowledge (see Table 7.2).

The theme of obedience was moderately strong in all four time periods because of the way I defined it. Coding instructions required use of this code any time rules or obedience were mentioned, regardless of whether the nurse valued obedience or was chafing against it. Therefore, as defined, the theme does not cleanly separate role conception from role enactment or cultural requirements. However, I did note clear and strong qualitative differences when comparing obedience in 1934 to subsequent data. Nurses in the 1934 data indicated a strong duty to obey unquestioningly; whereas most nurses in later data did not feel a duty to obey—and frequently wished to disobey—but felt coerced to obey by their organizational culture. Because of the ambiguity in that role definition, I could not determine whether obedience was an important factor in the construction of moral uncertainty problems, although intuitively it seems that it ought to be. Analysis of all the moral uncertainty problems from the combined data sets revealed no particular pattern of role themes associated with that problem construction.

Table 7.2. Role Themes: Comparison of 1934 and Subsequent Data

Stronger in 1934 than in subsequent data	Weaker in 1934 than in subsequent data
Appearances	Advocacy
Cooperation	Assertiveness
Professionalism	Autonomy
Obedience (Unquestioning)	Obedience (Forced)
Subservience	Knowledge

Moral Dilemmas

The proportion of moral dilemmas was relatively constant and relatively small in all four time periods (ranging from 5% to 8%), despite some rather marked differences in role perceptions and sociohistorical contexts among the different periods. This suggests that role perceptions (especially of autonomy and advocacy) and sociohistorical context may not have as strong an influence on the construction moral dilemmas as they do on action problems and moral uncertainty. As discussed in chapter 6, compared to other problems, construction of a dilemma probably depends more on internal factors than on external constraints. It does require knowledge of ethical principles and duties, as well as ability to recognize conflicting principles and duties. Unlike action problems though, a dilemma can occur (or not) regardless of whether there are contextual constraints to nurses' actions, and regardless of at least some role expectations. For example, whether or not a nurse has a role expectation of advocacy, he would still experience a dilemma in a situation where there were clearly two equally right or wrong alternatives. That would be a question of "What is right?" not "What can I actually do?" so it does not matter (at that point anyway) whether the context will allow the nurse to express his ideal role. Only after the internal moral judgment is made does the cultural permission about what one is allowed to do become relevant.

To confirm this speculation, I examined various combinations of role conceptions to see if any particular ones tended to be associated with moral dilemmas. For example, combining the data sets from the 4 periods, I examined all 196 stories that contained a role conception of either ideal or actual autonomy. Of those stories, 7% were moral dilemmas. In the same manner, I examined all stories containing a role conception of advocacy, those containing various combinations of advocacy and ideal or actual autonomy, those containing obedience, and those containing powerlessness. Overall, the various combinations of role conception produced a range of 1% to 7% moral dilemmas, with one exception: of the 56 stories where there was actual autonomy with no evidence of a role conception of advocacy, 8 (14%) were moral dilemmas. Nevertheless, even with this one deviation, the patterns (or lack thereof) suggest that there is not a strong association between the role conceptions identified in this study and the construction of problems as moral dilemmas.

After analyzing narratives containing particular role themes, I then analyzed all 69 moral dilemmas in the combined data sets. In those 69 dilemmas, I was unable to

find any pattern of role conception except for a very weak role conception of knowledge. This, too, suggests that dilemma construction is not associated strongly with the role conceptions identified in this study.

Action Problems

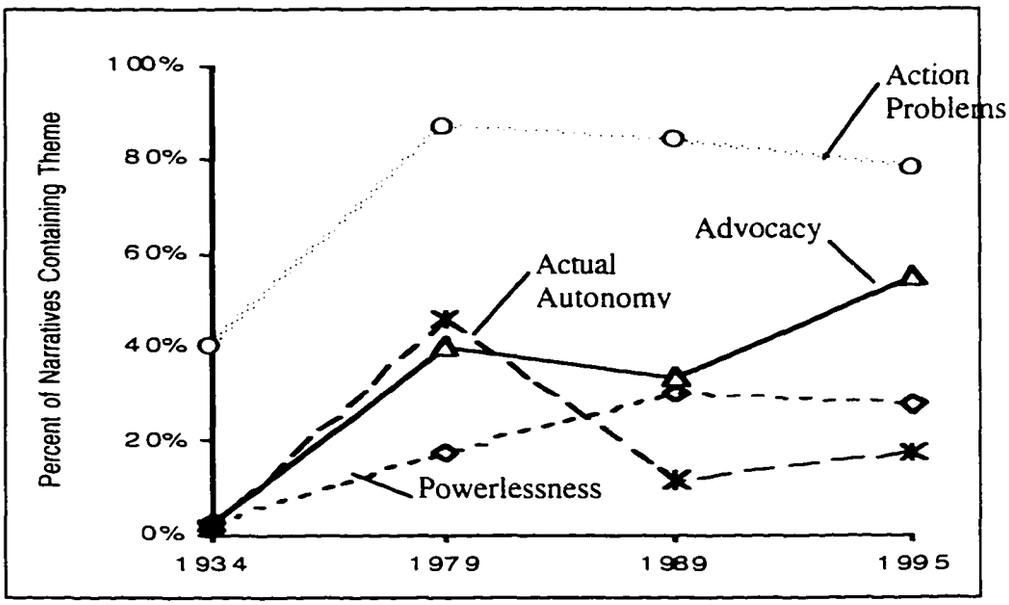
Action problems are those in which the nurse has made a moral judgment about what is right, but cannot carry out the moral action because of contextual constraints. Action problems were much more prevalent than decision problems in the 1979, 1989 and 1995 data, and seem to be associated with the role themes of autonomy, advocacy and powerlessness (see Figure 7.2 on page 194). Action problems were much more prevalent in the contemporary data sets than in 1934. Their significance is that they tend to produce the most moral suffering for nurses, and therefore hold the most potential for the negative impact on nurses' wholeness and patient care. Action problems are differentiated from decision problems by (a) existence of a decision about what is right/wrong, and (b) presence of constraints to moral action. As discussed previously, constraints to moral action were present in all four time periods. But despite that similarity, the 1934 context and role perceptions were different in other ways. After discussion of the no problem construction, this section will explore the effects of various aspects of role and culture on the construction of different types of action problems.

No Problem

No problem means that the nurse knew the right thing to do and implemented her decision either with no appreciable personal risk or with no indication that she recognized constraints to her action. Theoretically, a no problem construction is desirable because it would not produce moral suffering. It would therefore promote nurses' wholeness, facilitate effective patient care, and decrease nurse turnover in an institution. Logically, a context of cultural consonance should facilitate no problem constructions, and the data do lend support to this argument.

The no problem construction was most frequent in the 1979 and 1995 data, but all periods had higher percentages than 1934. It seemed to be influenced by role conceptions of advocacy, autonomy and powerlessness, as can be seen in Figure 7.3 on page 195. The category of no problem occurred more frequently when the theme of actual autonomy was also more frequent .

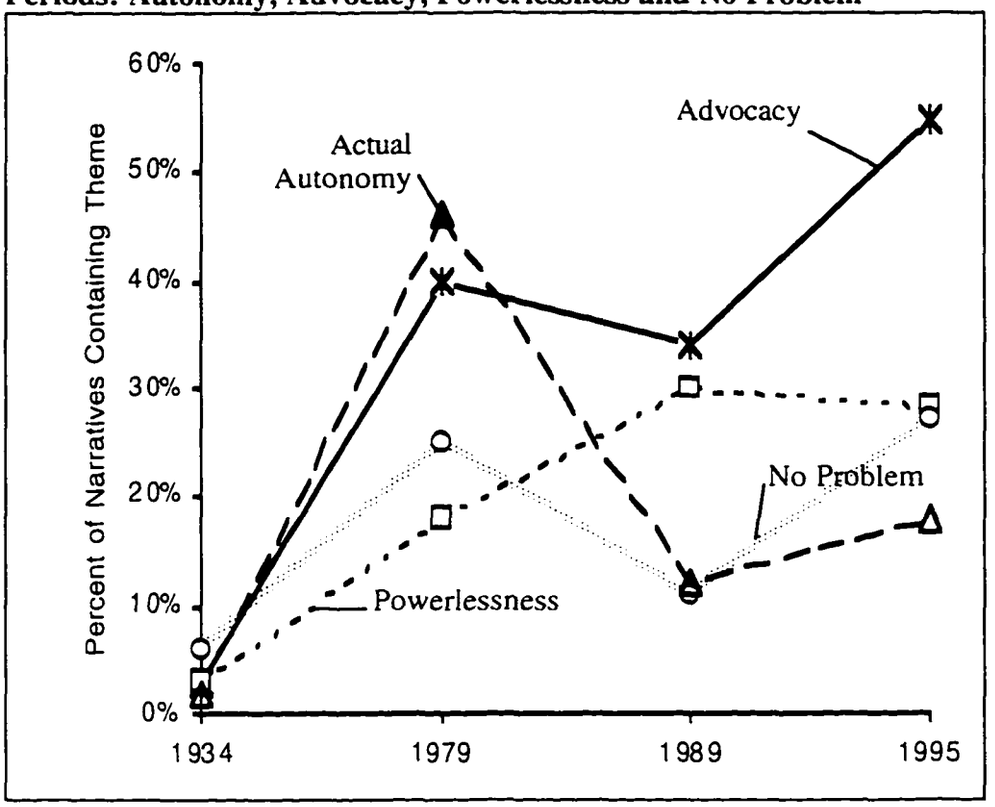
Figure 7.2. Powerlessness and Action Problems



The greater proportion of no problem in the 1979 data may reflect an increased awareness of nursing ethics that resulted from socialization via nursing schools and the literature. The first element of a no problem construction is that the nurse has made a moral judgment about what is right. Nurses were not doing that in the 1934 narratives. As ethics literature proliferated in the 1970s, nurses likely began to notice such issues in their practice and, ultimately, to make moral judgments. No problem was the most frequent construction (25%) in the 1979 data, followed by moral heroism (21%) and moral outrage (16%). That greater frequency may also reflect that it had become more acceptable in the nursing subculture, and to a degree in the institutional subculture, for nurses to be concerned with the ethical dimensions of their practice and to engage in decision-making of all kinds

Because so many of the 1934 problems were moral uncertainty, the other problem types (including no problem) would tend to occur more often as that construction was made less often. That is, nurses were beginning to construct problems, whatever the type. This may have resulted in part from the introduction of and emphasis on the nursing process that began in the late 1960s in nursing

Figure 7.3. Comparison of Problem Type and Role Conception in 4 Time Periods: Autonomy, Advocacy, Powerlessness and No Problem



education. The nursing process views patient problems as the phenomena of concern for nurses,and requires them to identify problems and formulate problem statements about patients' health status. It made problem construction a role expectation for nurses.

The other requisite for a no problem construction is that there are no significant risks or constraints to implementing the moral action. It has already been established that nurses perceived such constraints in all time periods, but in at least some cases they apparently felt free to implement their moral judgments. Such freedom may be reflected by the actual role conceptions of autonomy in the narratives. The no problem construction appears to be associated with a role conception of autonomy in an environment where the role can be enacted (i.e., actual autonomy). The actual autonomy theme was strongest in the 1979 narratives, when no problem occurred most frequently, and weakest in 1934, when no problem occurred least

frequently. It is also slightly stronger in the 1995 than in the 1989 data. The change in proportion of no problem stories from the 1989 to the 1995 data seems excessive compared to the small increase in the proportion of actual autonomy. However, I believe the higher 1995 frequency can be partly explained by the fact that the 1989 no problem frequency may be artificially low. All nurses providing the 1989 data were asked to "share a short written description . . . of a problematic ethical dilemma that impressed you the most during your professional career . . ." (Haddad, 1993). It is unlikely that they would have responded with a story that was *not* problematic (i.e., a no problem construction). The 1995 data, in comparison, came from a variety of sources, and the nurses were responding to a variety of instructions when they provided it. Some, for example, were asked to tell how they had resolved an ethical dilemma. For a few, the moral problem arose peripherally as they were discussing another subject (e.g., teaching and learning in the clinical area). This way of eliciting the data would allow for more stories about situations that were resolved satisfactorily (i.e., no problem).

Even if they had the same frequency of actual autonomy, the 1995 narratives might also have yielded more no problem constructions because of the demographics of the participants. Although more of the nurses in the 1989 data appear to have been managers, a larger proportion of the 1995 nurses held advanced degrees (M.S. or Ph.D.). Many of those nurses were working (some part-time) as staff nurses. Nevertheless, examining these differences among the four time periods did not provide a completely satisfactory explanation of the no problem construction.

Therefore, I examined the role conceptions in the no problem narratives within each time period. In the 1934 data, the only pattern was a moderate role theme of obedience in the no problem narratives: 25% of the 1934 no problem stories included a role theme of obedience. In comparison, for all problem types in the 1934 data, the overall obedience theme was weaker (only 13%).

I also examined all no problem narratives, regardless of time period, for ideal and actual role conception. Of the total 143 no problem cases in that combined data set, I obtained the percentages for role expectation and/or role enactment shown in Table 7.3 on page 197. None of the no problem narratives contained a role conception of ideal autonomy by itself, and none contained powerlessness. Most contained either

Table 7.3. No Problem and Role Conceptions. Combined Data Sets

Role Conception	% of No problem Stories (N=143) with this Role Conception
Autonomy, Actual (with no Advocacy)	41%
Autonomy, Ideal Only (with no Advocacy)	0
Advocacy + Actual Autonomy	50%
Advocacy + Ideal Autonomy	1%
Advocacy with no Autonomy	20%
Advocacy + Powerlessness	0
Powerlessness (with or without Advocacy)	0

actual autonomy or advocacy, and the overwhelming majority contained actual autonomy, either with or without advocacy.

A role conception of advocacy, because of the coding instructions, would sometimes have the same effect as a role conception of actual autonomy. Advocacy was coded when a nurse either indicated a belief that advocacy should be a part of the nurse's role or related advocacy behaviors—usually the latter. Unlike advocacy beliefs, advocacy behaviors imply actual autonomy, since an advocate cannot function without a reasonable amount of autonomy. This is illustrated by the stories that contained both advocacy and *ideal* autonomy (with no real autonomy)—indicating a lack of ability to enact the advocacy role. Only 1% of the no problem stories contained that combination of role conceptions. None of the powerlessness narratives were constructed as no problem.

It seems reasonable to think that nurses would also tend to make a no problem construction if they held role conceptions of obedience and cooperation, congruent with a cultural context where autonomy and independent functioning were neither

expected nor rewarded (i.e., in the 1934 data). In this scenario, nurses would accept the decisions of others without questioning. Either they would not make any problem construction at all ("not my job") or they would make a moral judgment that, "The right thing for me to do is to obey the directions of those who are qualified to decide." However, the relationship between obedience and no problem remains unclear. Obedience occurred in the same proportion in all four data sets, while the no problem proportion was actually lowest in the 1934 data, when it should be highest using a cultural congruence line of reasoning. However, when I examined *only* the no problem constructions, 25% of the 1934 no problem narratives contained an obedience theme, whereas only 13% of *all* 1934 problem constructions contained obedience (i.e., a role theme of obedience was probably more culturally congruent in 1934 than in the other periods). This suggests that cultural congruence is associated with a no problem construction.

Nevertheless, that is scant support for the connection between a role conception of obedience and a construction of no problem. It does illustrate that even within the same sociohistorical context, individual role conceptions influence different nurses to make different problem constructions. For example, even though obedience was a cultural role expectation for nurses in the 1930s, some nurses nevertheless had role expectations of advocacy and autonomy; and those nurses undoubtedly constructed problems differently than the nurses who had role expectations of obedience. In support of that assertion, in the 1934 data, all 6 moral heroism problems contained some combination of advocacy and/or autonomy in the role conception, whereas none contained obedience. As another example, in the 1934 context, 25% of the no problem stories contained a role conception of obedience; whereas only 3% had a role conception of advocacy or autonomy.

Powerlessness and Action Problems

Powerlessness is a subjective feeling of being unable to control events. As seen in Figure 7.2 on page 194, changes in the frequency of powerlessness in the data almost parallel changes in role expectations of advocacy and the construction of action problems. As the advocacy metaphor for nursing became culturally widespread in the 1970s, nurses felt more responsible to intervene on patients' behalf. During that same time, they were being socialized in nursing schools to aspire to be "autonomous professionals." When, in their practice, contextual constraints prevented them from advocating effectively for their patients, their actual lack of autonomy must have

become painfully evident. This supports my qualitative findings that powerlessness is one of the effects that moral distress and moral outrage have on nurses (Wilkinson, 1985).

Findings reported in Figure 7.2, on page 194, suggest that powerlessness is produced by the interaction of various ideal and actual advocacy/autonomy role conceptions within a context of cultural dissonance. Powerlessness occurred most frequently in the 1989 and 1995 data, when the advocacy theme was stronger than the actual autonomy theme. This confirms the obvious, that nurses with a strong desire to function as patient advocates experience powerlessness when they do not have the actual autonomy to do so. The literature confirms that powerlessness was and is a strong role conception among nurses in the 1980s and 1990s (e.g., Erlen & Frost, 1991; Sands & Ismeurt, 1986).

Since action problems tend to occur with a role conception of powerlessness, one would expect that there would be fewer action problems in organizations where there is true collaborative practice (assuming that collaborative practice actually empowers nurses). However action problems do not occur as a result of powerlessness alone, but from a variety of different constraints. So although collaborative practice may help to decrease the frequency of action problems by decreasing nurses' sense of powerlessness, it does not preclude the existence of other kinds of constraints or powerlessness from other sources. This helps explain the relatively high proportion of powerlessness and action problems in the 1995 data, during a period when so-called collaborative practice has become widespread in the healthcare context.

Autonomy and Action Problems

Autonomy consisted of both role expectation (ideal) and role enactment (actual) in this study. *Ideal autonomy* refers to narratives in which the nurse held a role expectation of autonomy, but in which there was no evidence that the role could be enacted. If evidence of enactment was present, then the narrative represents *actual autonomy*. There were relatively few narratives containing ideal autonomy. Sometimes the ability to act autonomously was related to cultural permission to do so, and sometimes it was related to other strong role expectations, specifically advocacy, which will be discussed later in this chapter.

Historically, although they claimed autonomy for the profession, nursing leaders in the United States did nothing to promote autonomy for "the nurse in the

trenches." On the contrary, Nutting (1918) referred to the need for discipline, viewing hospitals as "in a real sense battlefields where [patients] are fighting for their lives" (p. 162). Leaders' seeming lack of support for working nurses was undoubtedly multicausal. First, they had more in common socially and educationally with administrators and physicians than with the worker nurses. Also, their views reflected values of the times, which included the subservience of women. Finally, the military metaphor of discipline and training was needed to overcome the public's eighteenth-century image of nurses as low-class, uneducated, dirty, and possibly dangerous.

There was an obvious relationship in the data between the cultural inability to act autonomously and the formulation of action-focused problems. Figure 7.2 on page 194 shows that action problems were less frequent when autonomy was lowest, in the 1934 data. By 1979, autonomy had peaked in the data (more than doubled) and action problems constituted 87% of the total problems. At the same time, the frequency of decision problems dropped dramatically. This is not congruent with the preceding discussion of action problems and powerlessness because one would expect an increase in autonomy to reduce powerlessness and also action problems. This did not happen. Therefore, I concluded that a role conception of autonomy is not, by itself, sufficient to decrease the formation of action problems. The same is true for cultural congruence with regard to autonomy. It may be necessary, but it is not sufficient to decrease the number of action problems. There must be something else about the cultural context or another dimension of role conception that contributes to the construction of action problems. I argue that the missing link is a role expectation of advocacy.

Action Problems: Combinations of Advocacy and Autonomy

Figure 7.2 on page 194 shows that action problems were less frequent when role expectation of advocacy was lowest, in 1934. In the 1979 narratives, advocacy was much more frequent, and action problems constituted 87% of the total problems. The proportion of decision problems fell to 9% and no problem rose to 25% (see Figure 7.3, on page 195), indicating that nurses were both deciding and implementing some of their decisions.

This parallels the paradigm shift that occurred in the 1970s, when the literature indicates that nurses began to transfer their loyalties to the patient rather than to the physician or employing institution. The 1976 American Nurses Association *Code of Ethics* (1976) stated overtly that the nurse's primary responsibility was to protect the

client. Pence (1994) said: "Nursing's real moral problems began with the emergence of the model of patient advocacy that placed the nurse's primary allegiance to the person in need of nursing care. As long as nurses were socialized to be handmaidens . . . the primary moral responsibility was obedience" (p. 4).

Both cultural dissonance and role stress were operating in the 1979 narratives. Even though nursing cultural norms included autonomy and advocacy, the institutional and medical cultures did not share those norms for nurses, and nurses discovered that they did not have the actual autonomy they needed to enact their ideal role as patient advocates. Melosh (1982) said:

> Yet by 1970 . . . . The new collegiate nursing schools touted the nurse's authority and encouraged her to be an active advocate for her patients. But once on the ward, she slammed up against the limits of hospital bureaucracy, medical authority . . . (p. 205)

Having determined that action problems occurred most in a context of advocacy without autonomy, I examined each of the narratives, regardless of time period, that had a role expectation of advocacy with no indication of actual autonomy. There were three combinations of interest:

1. Advocacy with ideal autonomy (but with no actual autonomy)
2. Advocacy alone (in which no inference could be made regarding autonomy, either ideal or actual)
3. Advocacy with powerlessness (because powerlessness would be similar to advocacy Aith no actual autonomy).[1]

As evident from Table 7.4, on page 202, all three of these role combinations are associated with a high proportion of action problems.

Moral Distress: Advocacy Without Autonomy

Moral distress is an action problem that occurs when nurses have role expectations of both advocacy and autonomy, but find themselves in a situation where the nursing culture promotes autonomy and advocacy while the institutional culture

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[1] The distinction between powerlessness and advocacy-without-autonomy is subtle and seems to reside in the different levels of generality of powerlessness and the other two role themes. Qualitative analyses are ongoing, so it was only after much reflection that I became aware of the similarity between the two situations. A thorough discussion would be a digression at this point, but the distinction is one that, intuitively, I wish to keep.

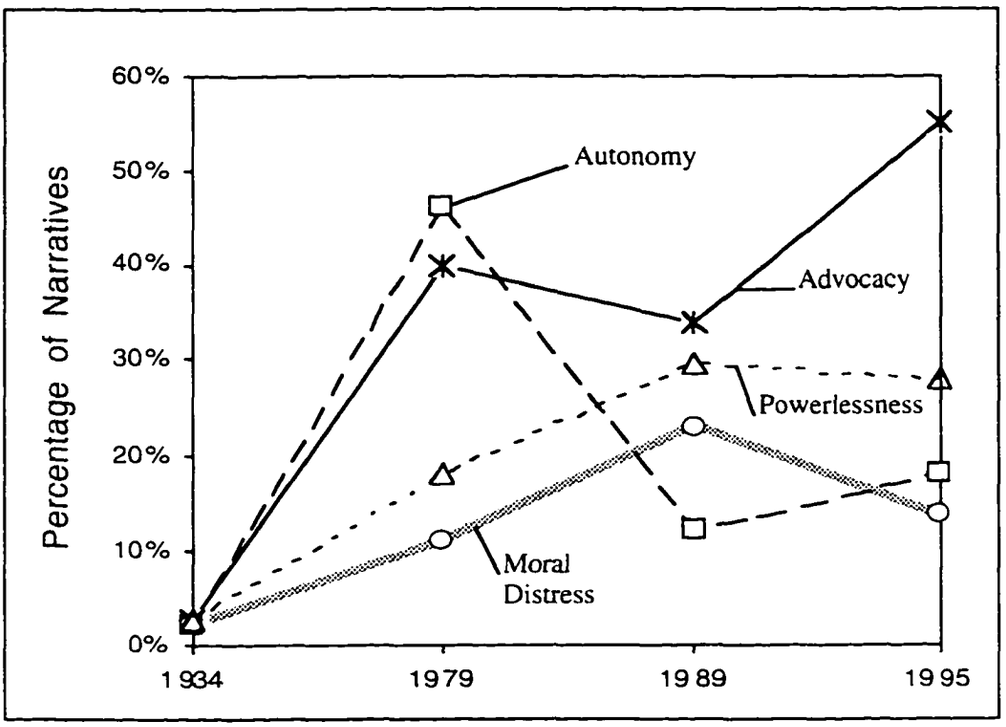
Table 7.4. Role Combinations of Advocacy-without-Actual-Autonomy and Action Problems (Combined Data Sets 1934-1995)

Role Combination	Total # of stories	Action Problems (%)	Moral Distress (%)	Moral Outrage (%)	Whistle-blowing (%)
Advocacy + Ideal Autonomy (No actual autonomy)	21	77%	29%	14%	10%
Advocacy Alone (Autonomy status unknown)	65	81%	18%	22%	18%
Advocacy + Powerlessness	36	93%	42%	31%	14%
Combined cases from preceding 3 rows	122	84%	27%	23%	16%

denies autonomy. They experience role discrepancy and cultural dissonance. Table 7.4 illustrates that moral distress is linked to an advocacy role conception in the presence of powerlessness and/or lack of autonomy. In addition, moral distress was present in only 2% of the 1934 narratives (see Figure 6.2 in chapter 6). It was most prevalent in the 1989 and 1995 narratives, when the autonomy theme was weaker than the advocacy theme (see Figure 7.4, on page 203).

Figure 7.4 also illustrates the parallel between moral distress and powerlessness. Both were more frequent in the data when the role conception of advocacy occurred more frequently than that of autonomy. By definition, moral distress occurs when the nurse has made but cannot implement a moral decision because of contextual constraints (e.g., in a context of cultural dissonance). Contextual constraints (e.g., physicians, administrators) were present in all four periods, leading one to conclude, incorrectly, that moral distress might occur with the same frequency. However, moral distress actually increased in frequency through the years despite the fact that nurses perceived some practice constraints in all four periods. The increased incidence of moral distress can be explained by the interplay of autonomy and advocacy. The recent narratives indicate that nurses' desire to be patient advocates increased, which could result in various action problems. At the same time,

Figure 7.4. Role Conceptions and Moral Distress



though, their desire for autonomy also increased; and even though there is probably more actual autonomy in the present practice context than there was in 1934, nurses still frequently lack the autonomy needed to enact their ideal advocacy role; and in addition, their expectations of autonomy may be higher. This results in powerlessness, which is strongly associated with moral distress. Additionally, the belief that one is an autonomous professional carries with it the idea that one is responsible for and has a right to make and implement decisions about events in one's practice. From that comes an emphasis on self, on deciding what one's own actions should be. That perspective is the difference between moral distress and outrage.

Figure 7.5 on page 206 indicates that moral distress occurs least frequently when there is actual autonomy, regardless of the role conception of advocacy; and moral distress was most frequent when there was either powerlessness or a role conception of autonomy or advocacy in the presence of no actual autonomy.

Table 7.5. Role Conceptions Associated with Moral Distress, Combined 1934, 1979, 1989 and 1995 Data

Role Conception	Total # of stories with that role	Proportion of this Role Conception Constructed as Moral Distress
Advocacy Alone (Autonomy status unknown)	65	18%
Advocacy + Ideal Autonomy (No actual autonomy)	21	29%
Advocacy + Actual Autonomy	111	3%
Ideal Autonomy alone (no advocacy, no actual autonomy)	10	40%
Powerlessness	133	35%

Table 7.5 shows the proportion of moral distress found in narratives with various combinations of autonomy, advocacy and powerlessness.

I also combined the four data sets and examined all 100 moral distress narratives, regardless of time period, to see what role conceptions they contained (see Table 7.6 on page 205). Only 3 of the 100 moral distress narratives contained a role conception of actual autonomy; 6 contained advocacy with no indication of autonomy, and the overwhelming majority contained some form of powerlessness—either with or without advocacy, or an advocacy role conception in the presence of only ideal autonomy.

Moral Heroism: Advocacy with Autonomy

Moral heroism narratives tended to include both advocacy and autonomy in their role conception, regardless of time period. Moral heroism is identical to moral distress except that a moral hero implements his moral decision despite the presence of contextual constraints or personal risk, whereas in moral distress he does not. Based on the patterns in the data, the context for moral heroism may be one in which there are role expectations of advocacy or autonomy and a culture that allows for nursing autonomy in some situations but makes it risky for the nurse in others. As seen in

Figure 7.5, on page 206, the context of advocacy *with* autonomy is associated with fewer of narratives classified as moral distress and moral outrage and more classified as moral heroism and no problem. By examining narratives with a role conception of ideal or actual autonomy, but without advocacy, it became apparent that advocacy is important in producing a moral heroism construction.

Table 7.6. Role Conceptions Contained in the 100 Total Moral Distress Narratives (Combined Data Sets)

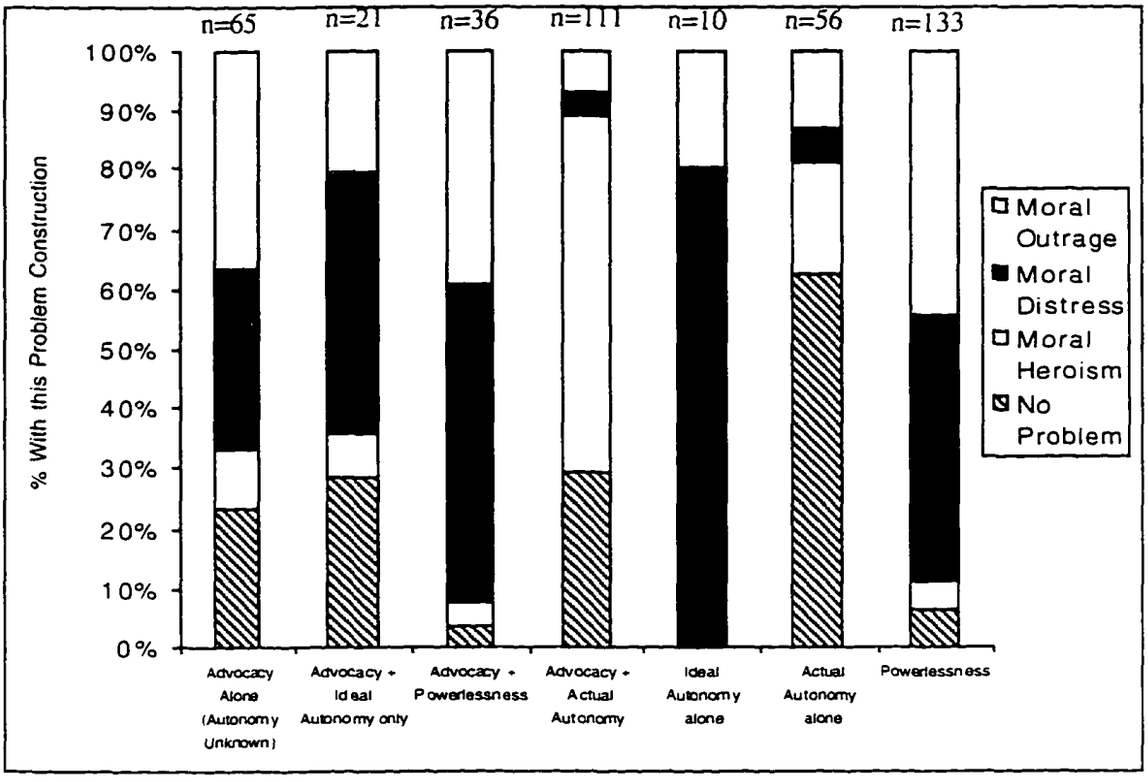
Role Conception	Proportion of the 100 Moral Distress Narratives with this Role Conception
Autonomy, Ideal (alone)	5%
Advocacy (alone)	6%
Advocacy + Ideal Autonomy	9%
Powerlessness	41%
Advocacy + Actual Autonomy	2%
Autonomy, Actual (alone)	1%

I also combined the 4 data sets and examined all of the 88 moral hero stories, finding that:

- 66% included both advocacy and autonomy
- 6% included advocacy without autonomy
- 1% included ideal autonomy but not advocacy or actual autonomy
- 8% included actual autonomy but not advocacy

This argument is confirmed by the fact that moral heroism was more strongly represented in the later data sets, which included more advocacy and autonomy codes than in 1934 (see Table 6.1 in chapter 6). This may indicate that a role expectation of autonomy, which includes the right to make and implement decisions, can give some

Figure 7.5. Effect of Advocacy and Autonomy on Moral Heroism, Distress, Outrage and No Problem (Combined Data Sets)



nurses the motivation/ability to enact their advocacy role even when there are cultural constraints to such action. That notion is supported by Pinch (1985), who said that "the foundation of the ideal professional role is the characteristic of autonomy which enables the nurse to promote patient rights as she relates to the patient in a patient advocate mode" (p. 373).

Moral heroism was most frequent in the 1979 data, occurring in 21% of the narratives (see Figure 7.6, on page 208). Although there were probably as many cultural constraints to nurses' actions in 1979 as in later periods, nurses may have been a little bolder about taking risks then because the risks seemed less serious or less likely to occur. The nursing shortage of the late 1970s meant that nurses had fewer fears about being fired for their actions, at least. Hospitals were so desperate for nurses during that time that salaries increased by 9% to 14% a year (Brider, 1993,

p. 32). However, except for 1979, relatively few narratives were categorized as moral heroism (1% in 1934, 11% in 1989, and 8% in the 1995 data).

Moral Outrage and Powerlessness

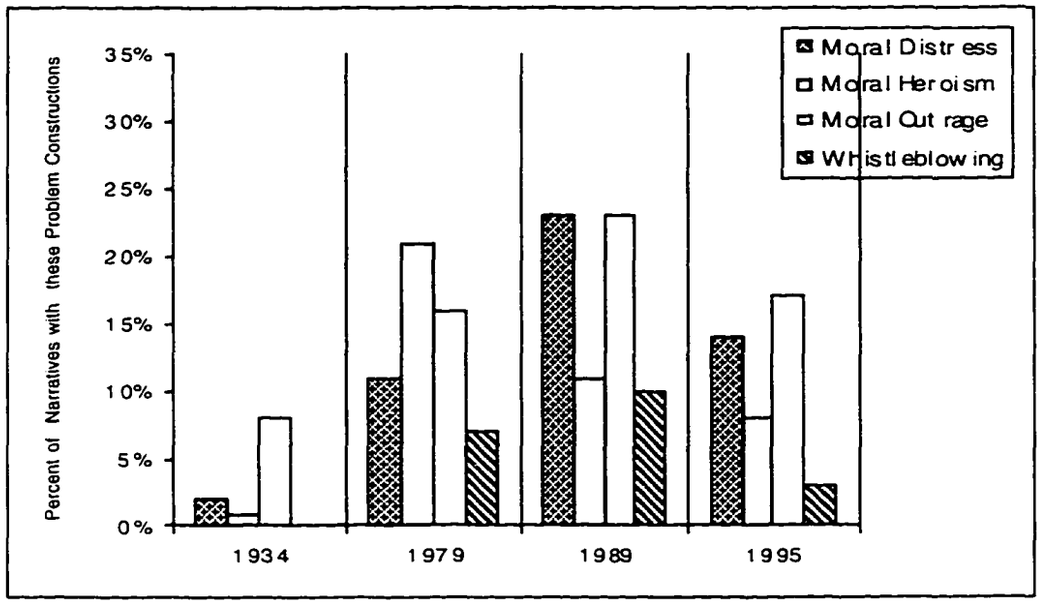
Moral outrage was the most frequently mentioned problem in the 1989 data. It ranked second in frequency in 1995 and third in the 1934 and 1979 data (see Table 6.2 in chapter 6, and Figure 7.6 on page 208). Moral outrage includes a focus on the bad things others are doing, rather than a focus on one's own actions. It does not seem to be associated with advocacy-with-no-autonomy in the same way as moral distress. Note in Figure 7.5, on page 206, that in narratives with a role conception of advocacy, moral outrage is least frequent when there is also actual autonomy. However, in the narratives with ideal or actual autonomy, but *without* advocacy, the proportion of moral outrage is still very low. Moral outrage is most frequent in narratives where there is powerlessness—either with or without advocacy as a role conception.

Examination of all 144 cases of moral outrage in the 4 combined data sets revealed that 31% of the moral outrage cases included a role conception of powerlessness. I did not find any clear pattern of advocacy/autonomy, except that approximately 74% of the cases included neither advocacy nor autonomy as either role expectation or enactment. Many of the moral outrage narratives included powerlessness, obedience, or subservience, either alone or in combination. This could mean that if a nurse's role expectations include these themes, and if they are the cultural norms, the nurse perceives that decisions and actions appropriately belong to others. Therefore, when bad things happen in moral situations, the nurse focuses on those who are "responsible" rather than on her own actions. This line of reasoning is supported by Pike (1991), although she did include focus on self in her definition of moral outrage as "an emotional response to the inability to carry out moral choices or decisions" (p. 351). Pike described a patient care unit where there was "true collaboration between clinical nurses and physicians," (p. 351) and found that incidents of moral outrage declined on that unit.

Whistleblowing

Whistleblowing was slightly more frequent in the 1979 and 1989 data, occurring in 10% of the 1989 narratives (see Figure 7.6, on page 208). Whistleblowing is the same as moral outrage except that the nurse acts on her moral

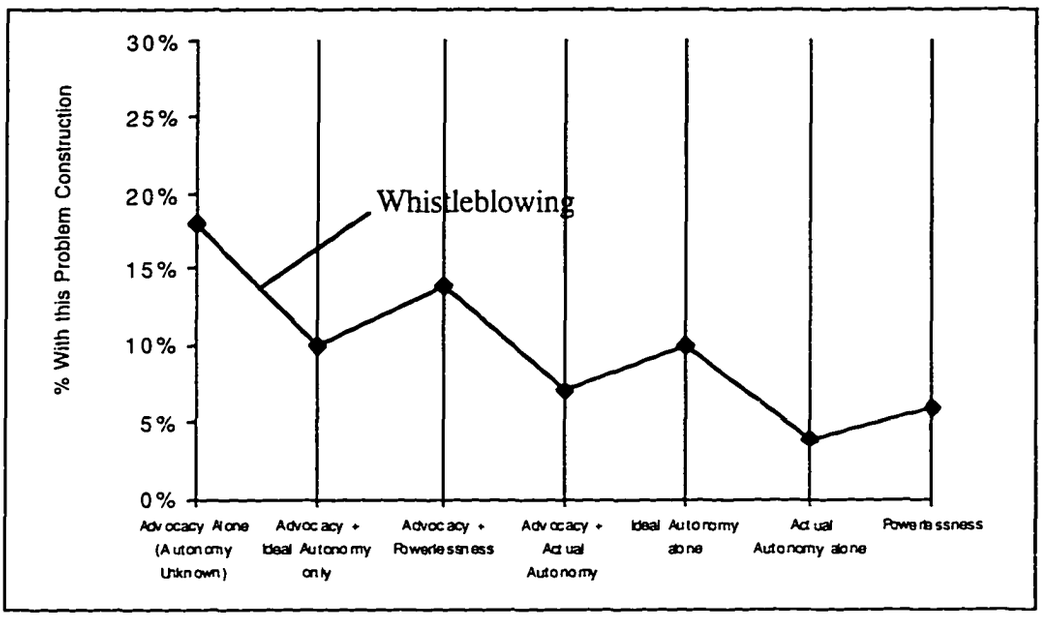
Figure 7.6. Action Problems in 1934, 1979, 1989 and 1995 Data



decision (that someone else is doing wrong). If constraints to action did not change over the years (as inferred by the presence of moral outrage), then what empowered nurses in 1979 and 1989 to "blow the whistle" may have been their role expectation of advocacy as compared to the 1934 role conceptions. However, this does not hold true when comparing 1995 data to 1989. There was less whistleblowing in the 1995 narratives, even though the advocacy frequency was much higher (see Figure 7.4, on page 203). Autonomy is associated with whistleblowing, but the relationship is not clear. A role expectation of autonomy, with its focus on personal responsibility, would logically seem more likely to trigger either moral distress or moral heroism.

Although an advocacy role conception was strongly associated with whistleblowing, it is clear that other factors must be associated with this problem construction. Of the 39 whistleblowing stories in the 4 combined data sets, 28% involved advocacy alone, 23% involved advocacy with autonomy and 23% involved advocacy with powerlessness. I also examined various role conceptions in the combined data sets. These are shown in Figure 7.7. Whistleblowing occurred most frequently when there was a role conception of advocacy, with or without the

Figure 7.7. Effects of Role Conception on Whistleblowing (Combined Data Sets)



presence of other role conceptions. The exception was that the advocacy narratives contained fewer instances of whistleblowing when they also contained actual autonomy (or a role enactment of autonomy).

Prior to 1989, there was not much whistleblowing literature (see chapter 6). With the increased whistleblowing literature in the late 1980s and 1990s, it would seem that the proportion of whistleblowing would be higher in the 1995 data as well. This was not the case. In the 1995 narratives, whistleblowing occurred in only 3% of the problems. The category no problem also reached greatest frequency in these data, suggesting that nurses were taking autonomous action when it involved no risk. However, when there were contextual constraints, instead of whistleblowing and moral heroism they were suffering moral distress and moral outrage. This may be due to the lack of job security in the present epidemic of downsizing in healthcare institutions, making some nurses more reluctant to take risks.

Summary

This chapter answered the fourth research question: How does the context created by the interaction of culture and role influence the ways in which nurses

experience and construct ethical problems in four different time periods (1934, 1979, 1989 and 1995)? Role discrepancy and cultural dissonance are more strongly associated with the construction of specific action problems than with decision problems. Moral uncertainty occurred more frequently in the data where the predominant role conceptions were appearances, cooperation, powerlessness, obedience and subservience; and in a context of cultural congruence. Moral dilemmas tended to occur in the same proportion in all time periods, regardless of context or role conception.

Action problems, in general, occurred least frequently in the 1934 data, and seem to be affected by the role conceptions of autonomy, advocacy and powerlessness. The constructions of no problem and moral heroism, which both include implementing the moral decision, are associated with actual autonomy and, to a lesser degree, advocacy. Moral distress is associated with powerlessness and/or cultural dissonance and role discrepancy with regard to autonomy (and sometimes advocacy). Moral outrage and whistleblowing are more strongly associated with an advocacy role conception, either alone or when it occurs with powerlessness or ideal (but not actual) autonomy.

CHAPTER 8
THEORY, IMPLICATIONS AND SUMMARY

This chapter revisits the research questions and discusses the implications of this study for nursing research, practice and education. The purposes of this study were achieved to a satisfactory degree. It has shown the Wilkinson bifocal model to be useful for categorizing problems in different settings and contexts—all problem types were found in all 4 periods (except for whistleblowing in the 1934 data)—and it has explored the historical-cultural context of nursing ethics. Time will reveal the degree to which it increases sensitivity to the moral dimensions of nursing care, and time will disclose its influence—if indeed there is any—on the practice context.

Research Questions

The following are the four specific questions asked in this study:

1. What are the similarities and differences in themes of nursing culture, institutional culture and popular culture that are reflected in ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)? Differences in the 4 sociohistorical contexts studied included changes in the status of women, healthcare structure and technology, patient decision-making, nursing education and nursing work. Some things, however, remain the same: (a) Hierarchies still exist in nursing, (b) power imbalances still occur among the different health professions, (c) gender discrimination continues, (d) most nurses still are employees whose primary relationship is with employing organizations, not autonomous professionals whose primary relationship is with clients, and (e) healthcare organizations still view nurses as a labor pool counting against, rather than for, the bottom line. In addition, although the different contexts offered different constraints and supports for nurses to actualize their role perceptions, data from all 4 eras reflected a practice environment that inhibits more than it empowers nurse involvement in ethical decisions and actions.

2. What are the similarities and differences in themes of nurses' role conceptions that are reflected in ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)? Seven major role themes were identified: advocacy, autonomy, powerlessness, obedience/rule-following, enforcement, knowledge, and teaching for empowerment and self-care. Advocacy, autonomy and powerlessness were weakest in the 1934 data. Powerlessness was strongest in the

1989 data. In general advocacy and autonomy became progressively stronger in the newer data except for 1989, when autonomy was weaker than in the 1979 and 1995 data.

3. What are the similarities and differences in the fit between the Wilkinson bifocal model of nursing ethics and ethics narratives of nurses from four different time periods (1934, 1979, 1989 and 1995)? There were many more decision problems in the 1934 data than in the more contemporary data. One of these, moral uncertainty, was overwhelmingly the most frequent problem in the 1934 data; it was nearly nonexistent in the other periods. There were relatively few moral dilemmas in any time period (5-8%), and their frequency was similar in all periods.

Conversely, the 1934 data contained strikingly fewer action problems than recent data, and they were of a different nature. The 1934 action problems were primarily moral judging (13%) and moral outrage (8%). Excluding the no problem construction, the contemporary action problems were primarily moral outrage, moral distress and moral heroism. No problem was more frequent in the contemporary than in the 1934 data. Whistleblowing was not seen in the 1934 data, and except for moral judging and moral weakness, was the least frequently reported action problem in all periods.

It was also found that a nurse's problem construction changes with time and thought, and that moral outrage and moral distress can be resolved by taking action—which transforms them into either moral heroism or whistleblowing, depending on the nature of the action taken.

4. How does the context created by the interaction of culture and role influence the ways in which nurses experience and construct ethical problems in four different time periods (1934, 1979, 1989 and 1995)? The interrelated role themes of advocacy, autonomy and powerlessness were especially important concepts in interpreting patterns of problem construction. Role discrepancy and cultural dissonance surrounding these themes were especially associated with the construction of certain action problems. No problem and moral heroism were associated with actual autonomy and, to a lesser degree, advocacy. Moral distress was linked to powerlessness and/or cultural dissonance and role discrepancy with regard to autonomy. Moral outrage and whistleblowing were related to an advocacy role conception, either alone or occurring with powerlessness.

The frequency of moral outrage, moral distress and moral heroism in the contemporary data probably demonstrates a cultural shift in nursing to personal responsibility and decision-making. The decision problem, moral uncertainty, occurred most often in the 1934 data, where the predominant role conceptions were appearances, cooperation, obedience and subservience.

Implications for Future Research

This study provides the beginning outline for a program of ethics research. This section includes model statements that are well enough developed to provide research questions, as well as discussing implications for other related research.

Bifocal Model Statements

The following theoretical statements were supported by this study and merit further testing. Empirical and theoretical support have been provided throughout this report, but a few literature citations are also included here.

Problem Construction (Process)

- The context of a moral situation influences the nurse's construction of the moral problem—specifically, the type of problem that is constructed (e.g., moral distress, moral dilemma).
- Given the same ethical case or set of "facts," played out in the same cultural context, two different nurses may make different problem constructions (i.e., problem construction is a result of the interaction of individual and contextual factors).
- For a given situation, the type of problem constructed is not static, but changes over time as the nurse obtains information and/or continues to reason about the problem (e.g., a problem may start as a moral dilemma and progress to no problem or moral distress).
- Nurses sometimes manipulate the system to implement their moral decisions. If they are able to do that, they are less likely to experience moral distress and moral outrage.

Problem Typology

- There are two major kinds of problems: action problems and decision problems, each with a number of sub-types.
- In current nursing practice, action problems are far more frequent than decision problems.

- The following sub-types of moral problems exist (as defined in this work): moral uncertainty, moral dilemma, moral distress, moral outrage, moral judging, moral weakness, moral heroism, whistleblowing, and no problem; each can be recognized by its unique pattern of defining characteristics or dimensions.
- Most nursing ethics problems are not true dilemmas.

Effects of Role Conceptions on Problem Formulation

- Nurses whose ideal role conception includes autonomous decision-making are less likely to formulate decision-focused ethical problems and are more likely to experience ethical problems as action-focused.
- Nurses whose ideal role conception includes advocacy are likely to experience action-focused problems when the context frustrates enactment of the advocacy role.
- Nurses who experience action problems are more likely to experience moral distress than moral outrage if professional autonomy is also a strong aspect of their role expectation.
- The action problems, moral distress and moral outrage, are associated with powerlessness.
- Perceptions or feelings of powerlessness may be antecedent to a problem construction of moral distress, or they may be a dimension of the moral suffering that results from moral distress.
- Nurses who have a role conception of obedience (rule-following) and whose ideal role conceptions are low in autonomy and advocacy are more likely to construct moral problems as no problem or moral outrage rather than as moral distress, moral heroism, or whistleblowing.

Effects of Moral Suffering on Nurses and on Patient Care

- Moral suffering results in changes in patient care—some positive, some negative. For example some nurses avoid the patient; others give care mechanically, avoiding emotional investment. Others expend more effort than usual in attempting to compensate the patient for the unhappy situation (e.g., Wilkinson, 1985; Fenton, 1987; Rodney, 1988).
- Nurses do not, as a rule, perceive that they are supported by managers, supervisors and administrators in moral situations.

Other

In addition to the testing of model statements, the following are additional research possibilities suggested by this study:

- Previous research has been inconclusive as to whether ethics education actually promotes ethical practice (Chafey, 1992). Therefore, further research might clarify this relationship by exploring the effect of ethics education on nurses' ability to make and implement their moral decisions, or on their moral suffering.

- This study should be extended using interviews and/or participant observation, so that probing questions could be asked and fewer inferences made in classifying moral problems. A structured interview instrument might be helpful.

- Instrument development is needed to explore nurses' problem constructions and determine the nature of their role expectations.

- Further research is needed to confirm and develop connections suggested by this study between bifocal model problem constructions and the concepts of context, culture, role, and values. Some correlational studies should be done between role conceptions and problem construction, at both individual and group levels.

- It is important to determine why some nurses implement their moral decisions in the face of contextual constraints, while others remove themselves from the decision-making process altogether. A phenomenological study of moral heroes might accomplish this goal.

- Nurses who are coping successfully with moral suffering should be studied to see what supports their coping (e.g., the effectiveness of individual or group support).

- This study supports Andersen's (1990, p. 11) recommendation for research to "clarify the incidence, patterns and effects of whistleblowing among nurses" and for other methods, such as "path analysis and time series designs to explore the phenomenon and effects of whistleblowing over time." This suggestion would also apply to other problem constructions, such as moral heroism and moral outrage.

Implications for Nursing Practice

This study suggests that practice contexts need to be changed if the moral suffering of nurses is to be reduced. The following are some actions that

administrators and staff nurses might take to create an ethical practice environment and to enhance their own moral agency.

One suggestion would be to use the "Decision Tree for Wilkinson Bifocal Model Sorting" (Appendix D) to help nurses identify elements of an ethical situation that caused them the most difficulty (e.g., become aware that they are focusing on the actions of others instead of their own). With a clearer analysis of a situation, a nurse could determine what she, personally, needed to do to either (a) change the situation or context or, (b) cope with her feelings in an unchangeable situation. This instrument has been used in this manner with graduate students at the University of Kansas School of Nursing (P. D. Williams, personal communication, June, 1996).

This study has demonstrated that contemporary practice environments contribute to the formulation of action problems and subsequent moral suffering—and that nurses' moral suffering has a negative impact on patient care. Therefore, every effort should be made to create work environments that promote nurses' wholeness/ integrity and empower them to function as autonomous patient advocates. McDaniel and Stumpf (1993) identified three types of organizational culture: (a) constructive, (b) passive-defensive, and (c) aggressive-defensive. Constructive culture is based on "achievement, self-actualization, encouragement of humanism, and affiliative norms" and encourages interaction between members (p. 54). A positive, constructive organizational culture would be good for both patients and nurses because it would empower nurses to become involved in moral issues, and would remove many of the constraints to implementing their moral decisions. The following are ideas for nurse managers and administrators who wish to promote a morally facilitative practice environment in their organization. Nurse managers and administrators should:

1. Devise strategies that encourage open discussion and nurse participation—for example, instituting nursing ethics rounds or a nursing ethics committee. This can empower nurses and promote cultural congruence, thereby decreasing the number of action problems. It is probably not adequate to set up a discussion group for ethical problems and assume that a democratic culture has been achieved. Berger and colleagues (1991) noted that "the group discussion approach often used to help nurses cope with disturbing ethical issues may not be appropriate for the bureaucratic issues identified in [their] study . . . . A more effective strategy might be to develop a *shared governance* model that promotes staff participation in decision making on the allocation of resources, scheduling, and other issues of concern" (pp. 520-521).

2. Insist on adequate staffing levels and training to permit quality care (Meyers, 1994). In a survey of 309 community health nurses, about half complained that there was inadequate administrative support for a work environment that facilitated quality patient care (Aroskar, 1989). Davis (1989) found that high turnover, and part-time or pool staffing prevented consistent communication and cohesive action, and ultimately patient advocacy. In terms of this study, inadequate staffing levels function as a constraint to both moral decisions and moral action.

3. Examine agency policy formation and implementation. Does it constrain or enhance moral practice? Are there policies about "patient care conferences and multidisciplinary discussions of patient treatment goals . . . DNR orders, withdrawing or withholding treatments, and . . . pain control" (Meyers, 1994, p. 109)? How were the policies developed and by whom? There "should be an issue by issue discussion about such topics as who writes 'do not resuscitate' orders, pain management, informed consent procedures, and the use of placebos" (Pence, 1994, p. 5).

4. Think in terms of system-wide changes and political action. Ultimately, there must be reform of the entire health care system in order to (a) foster greater professional autonomy for nurses (Pence, 1994), and (b) create a situation that does not require nurses to be moral heroes in order to fulfill their advocacy role (Cahn, 1987). This is not a new idea. Fifteen years ago, Mitchell (1981) said:

> We cannot act morally if we have not . . . constructed a moral system which enables and supports that act . . . . It is hard to perform an honest act within a system which supports not honesty but deception. Right acts depend upon a good self and a just system. (p. 7)

Other nurse ethicists who have linked a viable nursing ethic to an explicit agenda of sociopolitical reform include Parker (1990), Andersen (1990) and Yarling and McElmurry (1986a).

Individual Initiatives

It would be ideal to create practice environments that support nurses' moral agency. However, until we reach that Utopia, nurses will continue to experience moral suffering in their daily work. When the causes cannot be eliminated, nurses must do what they can to deal with their symptoms—for example, talking with supportive colleagues, forming a support group, practicing positive self-talk, and finding the intrinsic rewards in patient care. Many nurses have said that when they could not stop procedures that prolonged life and/or patient suffering, they were

sustained by the knowledge that they provided support and comfort to the patient insofar as possible.

However, even though it is difficult for staff nurses to devote the time and energy necessary to effect system changes, nurses are not merely victims of their socialization, nor passive pawns of uncaring organizational cultures. Moral actions are shaped by the cultural context, but ultimately the individual chooses and acts. Even though individual power to effect system changes may be limited, the following are some ideas for nurses who wish to assert their own individual moral agency while waiting for external change to occur.

Staff nurses should communicate their wishes and ideas through the nursing and political hierarchies. They should become politically active at whatever level possible—for example, writing to legislators about issues that affect nursing. If nurses are to assure the ability to advocate for clients, they must work for passage of legislation which contains "express provisions which protect a nurse from termination" in situations of moral heroism and whistleblowing (Kraemer, 1993, p. 9). Andersen (1990) has suggested petitioning the International Council of Nurses and other nursing associations to "lobby for legislation to protect nurse whistleblowers acting in agreement with standards of professional practice and the code of ethics" (p. 10). Such legislation does exist for nurses employed by various government agencies.

Ideally, of course, nurses should stop using subversion to accomplish advocacy. Munhall's (1990) ethical analysis of Hutchinson's (1990) grounded theory raised some questions about responsible subversion. Would it be better to question and change the rules instead of covertly breaking them? What if all nurses ignored the rules? Is rule-breaking the only course of action available? Has the nurse exhausted all other possibilities? There is innate value in communication and collaboration as opposed to the strategy of system subversion. "'Back door advocacy' belies the mutual respect and threatens the collegiality required for collaborative practice. It also requires an ethical compromise on the part of the nurse" (Meyers, 1994, p. 100).

On the other hand, if the practice environment prevents them from meeting patients' needs, nurses may need to consider using responsible subversion. This is controversial advice, but many believe that nurses must manipulate the system in order to protect and advocate for their patients. Nurses in Hutchinson's (1990) study who had certain kinds of knowledge, ideologies, and experience considered their rule-

breaking to be responsible because they viewed themselves as patient advocates. However, "their means are subversive because they violate hospital policies or medical orders" (p. 4).

It is important for nurses to assume the mantle of moral agency, resisting the tendencies to self-deception and moral apathy that occur from organizational ambiguities and pressures to conform. They need to be aware and alert, and continue to identify situations that call for moral choice, even when the likelihood of implementing the decision is slight. In a healthcare environment in which technology and the bottom line are of paramount importance, patients need the constant, humanizing, caring presence that nurses can bring to the bedside. But only nurses who remain engaged and aware can provide such a presence. For many this will entail an internal struggle to free the mind from decades of socialization into subordinate dual roles as nurses and women (Muff, 1988). It may help to recall that nurses usually meet Mitchell's (1984) criteria for deciding who should be involved in a moral decision: (a) those who bear the burden of care and conscience, (b) those with special knowledge, and (c) those caregivers with the most continuous, committed and trusting relationships with the family.

Nurses should try to be open to other moral points of view. The goal is to promote the best outcome for the patient, not to prove that one is right. Intellectual humility would suggest that one cannot be absolutely sure one's answer is right, nor that it is the only possible right action. This approach can relieve moral suffering by enabling nurses to relax a rigid position and compromise with integrity when necessary. Also, being open to other perspectives and obtaining input from others can help one to seek and find alternative actions. In most situations, there are several actions that might be taken—not just one or two—so nurses should try to avoid dichotomous, "either-or," thinking. This suggestion is especially useful when one is experiencing a moral dilemma, in which there seems to be no "right" action.

Nurses should try to find a balance between complete individual autonomy and collaborative practice. Curtin (1986) urges finding a balance between "unbridled individualism and insistence on absolute autonomy . . . . and the cooperative action" needed in contemporary healthcare settings. "What nurses must demand is room for professional decision making about nursing care, and what they must learn to do is to function effectively in an interdependent world" (pp. 97-98). The quest for nursing autonomy is a quest for parity, not dominance.

Meyers (1994) has suggested that nurses "address the hierarchical, patriarchal nature of the health care delivery system through . . . competence, communication, and collaboration" (p. 100). If it is impossible effect a practice environment in which nurses can act morally, they may need to "terminate [their] employee status with the hospital, move outside the hospital, and serve hospital patients from the vantage point of some new nursing-controlled organization" (Yarling & McElmurry, 1986a, p. 72). This may seem radical, but it may be the only way to exercise moral agency in an oppressive context.

Implications for Nursing Education

This study has implications for educators in terms of curriculum development and teaching strategies. For example, the study suggests a need for nurses to study liberal arts, as advocated by Fetsch and Mintun (1994), who maintained that a strong foundation in liberal arts is needed to assure ethical practice "because empowerment for self-determination is grounded in a recognition of autonomy and respect for individuals" (p. 18). Other implications are to include ethics in nursing curriculums and to engage in educational reform.

Including Ethics in the Curriculum

Although previous research has not provided conclusive evidence that ethics education actually promotes ethical practice (Chafey, 1992; Ketefian, 1989), some studies have connected variables such as advanced degrees, specialty training and education level to nurses' involvement in and quality of ethical decision making (Kim, 1989; Martin, 1989). In the framework of this study, this means that ethics education has been shown to improve moral decisions but not to guarantee moral action. This study also suggests that this is not surprising, in view of the current repressive practice context.

Many nurses receive little or no ethics education. In Meyers' (1994) study of moral suffering, "only six of the nine participants reported having had any ethics education at all, and that ranged from 'two inservices at work' to a course in a baccalaureate program" (p. 101). Participants in that study were usually able to identify a situation that constituted an ethical problem, "but were not able to articulate the problem more clearly" (p. 101). Even though a direct correlation between ethics education and ethical practice has not been established, given the findings of this study (e.g., regarding the need for ethical awareness and the efficacy of knowledge in

effecting moral decisions), I would recommend including ethics content in the curriculum. When teaching ethics, it might also be helpful to include a narrative ethics approach rather than relying solely on the principles and arguments approach.

Andersen (1990) has urged faculty to role model advocacy behaviors and provide specific instructions about advocacy and whistleblowing, including current sources of support for whistleblowers. This applies to all action problems requiring patient advocacy.

Critical Thinking and Educational Reform

Although accrediting agencies exhort both schools and hospitals to encourage critical thinking among nurses, many believe that neither context actually does so. For example:

> Currently neither nursing education nor the health care environment truly supports nurses' use of the proposed skills. Although the rhetoric of nurse academicians includes ideals of advocacy, autonomy and assertiveness, the traditional nursing academic structure does not support the development of these skills. In fact the approach most common in nursing education today leads students to passively accept that (a) the teacher is the authority; (b) students can be dominated easily; and (c) the status quo can be maintained. (Gould and Bevis, as cited in Fetsch, 1989, pp. 17-18).

Educational reform is a must. If radical curriculum reform cannot be achieved immediately, each nurse educator can begin change with her or his own teaching methods. Active and participatory learning strategies help to engage students in thinking and problem solving. In order to facilitate divergent and critical thinking, classes should use a democratic approach based on fairness and the dignity and rights of the learner. As discussed in chapter 4, nurses have historically been educated in a rigid and authoritarian environment; teaching styles have rewarded memory and the right answer more than creativity and critical thinking, and have promoted subservience and appeal to authority for approval (Group & Roberts, 1974). Little wonder that many nurses look to policies and legalities for absolute answers to their ethical questions; and little wonder that when they encounter a constraint to action, they cannot think their way either through or around it.

Educators should empower nurses to function as patient advocates. The following educational reforms would help to prepare and support nurses to change processes in their practice contexts that inhibit and constrain moral action: (a) Replace the current content-driven, behaviorist paradigm with a concept-driven curriculum; (b)

include critical thinking in the curriculum, and use learning activities that require it; and (c) decrease the emphasis on technology and technique and increase the emphasis on thinking and inquiry, decision-making and professional socialization (Fetsch, 1989, pp. 17-18; Gould & Bevis, 1992; Paul, 1993; Wilkinson, 1996).

Other

The preceding suggestions assume that it is still possible to improve education and practice environments. However, nurse educators who conclude that supportive practice environments are impossible to achieve, will need to rethink their practice of socializing students for advocacy and autonomy roles they cannot enact in practice. To continue doing so is to set them up for the frustration and powerlessness that accompany moral distress and moral outrage. In my 1985 qualitative study (Wilkinson, 1985; 1987/88), nurses who believed they were responsible for making moral decisions were the ones who were likely to experience moral distress. Conversely nurses in that study who believed decision-making was someone else's responsibility did not tend to experience moral distress. This does suggest that one way to diminish moral suffering among nurses is to stop socializing them for role expectations of autonomy, advocacy and moral decision-making. Because this approach essentially abandons patients and leaves them without an advocate in an increasingly unresponsive healthcare system, I believe it should be considered only as a last resort.

In their philosophical analysis of the moral foundations of nursing, Packard and Ferrara (1988) asserted that nurse educators are:

> trapped by circumstances, tradition, and the profession to bolster and perpetuate hospital jobs for student nurses . . . . The nurse educator prepares young people for nurses' jobs that the educator left and may regard with suspicion. One observes that hospital nurses are not free to be moral, but neither is the nurse educator. The educator assumes the responsibility of preparing another wave of students to replace nurses who willingly leave the hospital. (p. 68)

Educators may need to consider whether it is moral to prepare students to work in hospitals at all, given that (a) hospitals are hiring fewer RNs, and (b) turnover and burnout are high among hospital nurses because of the frustration and disillusionment many experience when they cannot enact their role ideals.

Summary of Study

The 4 sociohistorical contexts studied differed in some important ways, but were similar in others. Therefore, as expected, there was some variation in the pattern of problem categories in the different periods. This supports the assertion that context influences problem construction, especially with regard to whether moral situations are constructed as decision problems or action problems.

The narratives analyzed in this study reinforced that problems are constructed by people in living, dynamic contexts. Moral problem construction refers to how a person experiences, "defines or interprets the situation and what she or he focuses on as relevant to the problem" (Brown et al., 1989). This was illustrated by stories with nearly identical "facts," but with different constructions made by different nurses (for example, see page 1). Both moral decisions and moral actions are determined by interaction between the individual and the environment or context. Some of the determining factors are unique to the person, others are specific to the context. Making a moral decision does not automatically result in doing a moral action. For many reasons, nurses may not carry out their moral decisions.

The most striking findings of this study are the overwhelming prevalence of the action problems (especially moral distress, moral heroism and moral outrage) in the most recent data set. These problems create moral anguish among nurses, and therefore the potential for loss of integrity and deteriorating patient care. Whistleblowing, too, produces intense moral suffering, but it seems to occur infrequently.

The frequency of problem constructions that create moral suffering (i.e., action problems) suggests that practice contexts need to be changed. Because all facets of the discipline of nursing are needed to effect change, this study has implications for nursing research, practice and education. I believe, with Ray (1989, p. 31) that "understanding and changing the emerging corporate culture of the health care system to benefit humankind is the most critical issue facing nursing educators, administrators, and practitioners."

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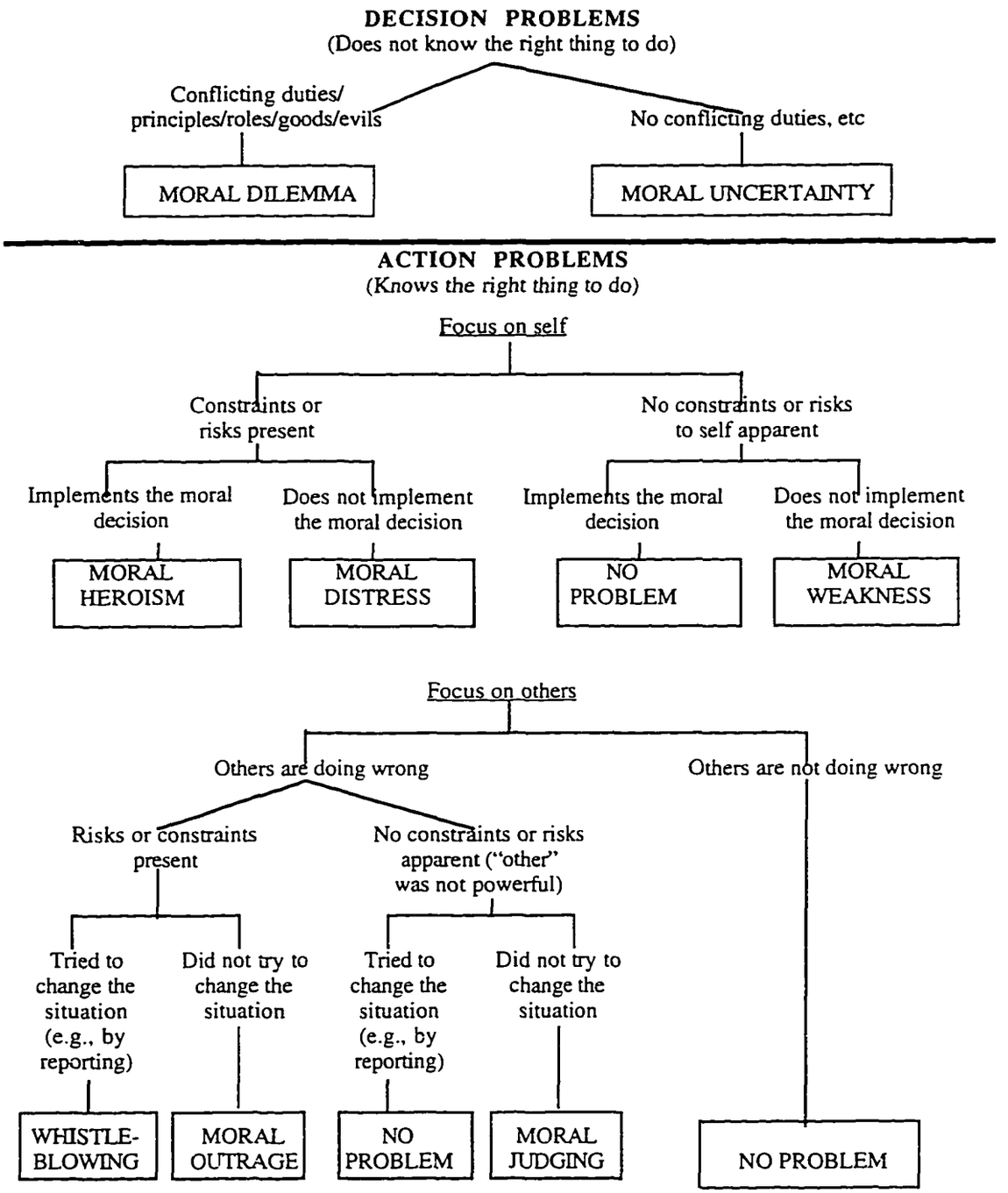
APPENDIX A

WILKINSON BIFOCAL MODEL OF NURSING ETHICS

USED IN PHASE 2

Wilkinson Bifocal Model of Nursing Ethics Used in Phase 2



APPENDIX B

DEFINITIONS OF TERMS

Definitions of Terms

This appendix defines major theoretical terms and terms that may be used in a manner peculiar to this study. Other terms, for example the culture themes and many of the role themes, were defined as they were introduced in the report. The following definitions assume that the narratives analyzed pertain to a patient-care situation and involve an ethical issue. I have provided references for definitions developed from sources other than my 1985 and 1993 work, or that are not peculiar to this study.

Action-focused problem - A situation in which the nurse is confident in her/his judgment about what is right, but is prevented by actual or perceived constraints from carrying out that moral judgment. Action-focused problems consist of seven sub-types: (1) moral distress, (2) moral heroism, (3) moral judging, (4) moral outrage, (5) moral weakness, (6) whistleblowing and (7) no problem.

Actual role - See role enactment.

Advocacy - The articulation and defense of the rights and interests of another. This analysis was limited to consideration of nurses advocating for patients, and was concerned with the nurse's conception of advocacy as an appropriate part of the nursing role. Generally, one must possess a degree of autonomy in order to function as an advocate (Winslow, 1984).

Autonomy - Autonomy as a part of a nursing role conception implies that it is appropriate for nurses to make decisions, including ethical decisions. It implies possession of a competency and the freedom to exercise the competency; and it implies some degree of independence and accountability (Dwyer & Schwartz, 1992; Mundinger, 1980). Autonomy may be evidenced by statements or by observation that the nurse does do some of these things. Discussion of autonomy, in this study, is limited to the moral and professional autonomy of nurses, individually and collectively, and does not include considerations of patient autonomy.

Confessing Sin - See *moral weakness.*

Culture - The set of shared values, beliefs and meanings within society and organizations that are transmitted among people from one period to the next and used to define reality (Reilly & DiAngelo, 1990). Culture consists of common beliefs and expected behaviors: "Each culture consists of specific values and behaviors, which are melded together in a unique pattern that is different from that of any other group" (Coeling & Simms, 1993, p. 47).

Decision-focused problem - A situation in which the main difficulty for the nurse is in determining the right action to take. The question is: "What is the right thing do?" Decision-focused problems consist of two sub-types: (1) moral uncertainty and (2) moral dilemma.

Enforcement - A role conception which includes the belief that an aspect of the nurse's role is to help enforce rules, policies, and so forth, by documenting or reporting to someone in authority what other caregivers do—especially as it relates to incompetence, bad ethics, of patient care. It is similar to "tattling" in the vernacular, except it is not necessarily done surreptitiously. It embodies the idea that when someone breaks the rules or fails to follow policy, the nurse has a duty to report the incident. Enforcement is limited to documenting and reporting, and does not imply active interventions such as confronting or physically restraining another caregiver.

Ethics - In the strict sense, refers to "the scientific and scholarly observations, analyses, and discussions that professional scholars of morality produce in their study of morality" (Jameton, 1990, p. 447). However, Jameton noted that *ethics* can be used exactly equivalent to *morality*, and I did not draw strict distinctions between them in this study.

Ideal role - Nurses' perceptions of what the nursing role ought to be.

Moral dilemma - A decision-focused problem construction that occurs in a situation when two or more moral principles clearly apply, and the principles call for mutually inconsistent and equally unsatisfactory actions (Jameton, 1984; Levine, 1989; Mitchell, 1990). The actions seem almost equally right or equally wrong; so no matter what the nurse does, an important value must be sacrificed. Therefore, the nurse cannot decide clearly what is right.

Moral distress - An action-focused problem construction in which the nurse knows the right thing to do, but cannot pursue that action because of institutional or other contextual constraints, either perceived or real. The nurse focuses on her/his own actions in the case (as compared to moral outrage, where the focus is on the actions of others). The central question is: "What risks am I willing to take in order to do what is right?" The nurse makes but does not implement a moral decision.

Moral heroism - An action-focused problem construction in which the nurse is confident of having made the right moral decision, but contextual constraints pose personal risk to the nurse if the decision is implemented. The nurse carries out the decision regardless of the risks or threats to self. In this type of problem one is

concerned with one's own actions rather than the actions of others (based on Cahn, 1989). The action the nurse takes is something other than reporting someone else to a nurse administrator. Going beyond nursing administration to report someone to the medical chief of staff or to hospital administrators is a special form of moral heroism called whistleblowing.

Moral judging - An action-focused problem construction in which the nurse believes that others with equal power, for example other nurses or perhaps the patient's family, are acting immorally. There is no risk to self and no other constraint, but it essentially does not occur to the nurse to intervene. She is more intent on pointing the finger at the "bad others" than on considering whether she could do anything to change the situation.

Moral outrage - An action-focused problem construction in which the nurse believes that others are acting immorally, but feels powerless to stop them or feels the risk to self is too great. The nurse does not participate in the act, and may not consider that intervening is even possible, and consequently does not feel responsible for the situation. The resulting painful feelings (usually anger) are directed at the "immoral others." The nurse is concerned with the wrongdoing of others, not with her own responsibility in the situation. When the immoral others are peers, the problem construction is moral judging, not outrage, unless the failure to act is definitely based on risk to self or a constraint such as having tried and failed to change things in the past. Moral outrage usually is concerned with the actions of others who are more powerful than the nurse.

Moral uncertainty - A decision-focused problem construction, in which the nurse is not sure which principles or values apply in the situation, or perhaps cannot even clearly identify the nature of the problem.

Moral weakness - An action problem in which the nurse knows the right/wrong thing to do, but does not do the right thing; not because of constraints or risk to self, but out of character flaws such as weakness, laziness, lack of self-control, and so forth. In Phase 1 this problem construction was initially labelled *confessing sin.*

Morality - Consideration of and concern about issues of right/wrong, good/bad, should, ought, and so on. Morality is concerned with important social values or norms (e.g., respect for life, honesty). As distinguished from *ethics*, morality refers to principles and values to which people are committed, whereas ethics

refers to the systematic study of those values and principles. The terms morality and ethics can be used interchangeably because there is extensive overlap between them (Jameton, 1984, pp. 5-6). They are used interchangeably in this study.

No Problem - An action focused problem construction in which the nurse knows the right thing to do, and does it at no risk to self and with no contextual constraints. The term, *no problem*, does not necessarily indicate that it is easy to determine the right thing to do; however, once the nurse makes the moral decision, it is implemented without risk or constraints.

Obedience - A role theme reflecting the belief that nurses ought to follow the rules and comply with the requests and orders of "superiors." It includes a sense of duty or obligation to the patient, the physician, the profession and/or the institution. Obedience includes the notion of loyalty (except for loyalty to peers) and the necessity to follow the orders of so-called superiors (e.g., physicians and nursing supervisors).

Organizational culture - The "taken-for-granted and shared meanings people assign to their work surroundings" (Fleeger, 1993, p. 39). According to Schein, organizational culture is "the pattern of basic assumptions and shared meanings (values) that a group develops to survive their tasks and that works well enough to be taught to new members" (as cited in Coeling & Simms, 1993, pp. 46-47). Common to those two definitions are the concepts of work and shared meanings.

Powerlessness - A role theme reflecting a subjective feeling of ineffectiveness or lack of control in a situation. It reflects a belief that the nurse is *actually* without power, not that nurses *ought* to be without power. It is an actual rather than an ideal role conception. It may be represented by narratives in which the nurse was unable to change the course of events even though she took some action to try to do so. However, taking action is not a necessary condition for the existence powerlessness.

Problem construction - How a person defines or interprets a moral situation, including what he or she focuses on as relevant to the problem (Brown, Tappan, Gilligan, Miller & Argyris, 1989). In this study, the term also refers to the 9 problems in the Wilkinson bifocal model typology: moral uncertainty, moral dilemma, moral distress, moral heroism, moral judging, moral outrage, moral weakness, whistleblowing and no problem.

Role conception - Nurses' perceptions of what the nursing role is or ought to be. A role conception indicates that nurses believed that function to be an appropriate

part of the nursing role, regardless of whether they were actually able to enact that function.

Role enactment - The extent to which the nurse perceives he is able to carry out his role conception in the practice environment. Same as *actual role*.

Rule following - A broad role theme indicating that the nurse believes that a nurse's duty is to follow rules—of whatever source or type—or that the duty to do as ordered overrides other duties. The themes of obedience and subservience are more specific instances of rule following.

Whistleblowing - For the purposes of this study, this action-focused problem construction is considered a special case of moral heroism, in which the nurse believes that other health care providers (either individuals or organizations) are doing wrong, believes she has a personal responsibility to make a disclosure (usually a public disclosure) of the wrongdoing, and implements this decision despite personal risk or threat. Whistleblowing frequently is done to expose negligence, abuses, or dangers to the public welfare, but may also be done to expose personal victimization, as in the case of sexual harassment (Andersen, 1990; Theodore, 1986). Typically, the whistleblower exhausts all sources for problem resolution before "going public" (Petersen & Farrell, 1986)—however, in this study, neither "exhausting all sources" nor "going public" were *necessary* for coding whistleblowing. Whistleblowing in this study included reporting the problem to someone outside the nursing hierarchy but still within the organization, for example hospital administration or the medical board. In special circumstances it may even include reporting to the nursing supervisor or chief nursing officer (see chapter 6).

APPENDIX C

SORTING RULES/CRITERIA

SORTING RULES/CRITERIA

Also refer to "definitions" sheet and decision tree.

I. **BIFOCAL MODEL** *Must be present

No Problem (np): *Knows right thing to do; did it, at no risk and with no constraints; or knows it's wrong and refrains from doing it, no risks, no coercion.

DECISION FOCUSED PROBLEM (d):
*Has not decided what is the right thing to do; or indicates does not know the right thing to do; or is asking "what should have been done?" about an action already taken. Can be a decision problem even if nurse took action - as long as she is still unsure of what was the right thing to do.

SUB-CATEGORIES

Moral Uncertainty (u)
(*Does not know the "right" action to take, but the problem is clearly not a "dilemma".)
Additionally, the following may be present:
1. Cannot clearly identify the nature of the problem
2. Unsure what principles or values apply
3. May be unsure of the moral nature of the problem
4. Just has a vague feeling something isn't "right" but not sure what

Moral Dilemma (dil)
(#1 and #2 Must be present. In addition, at least one of 3-6 must also be present)
*1. Does not know the "right" action to take.
*2. Can identify the nature of the problem; aware it is a moral problem; aware there is a decision to be made
3. More than one principle/value apply
4. Principles/values conflict
5. The principles/values call for mutually inconsistent actions. Whatever you do, an important value/principle will be sacrificed.
6. Choosing between 2 equally good or 2 equally bad actions

Note: It can be a dilemma even though the nurse did choose and take an action. Often it is necessary to act whether or not you know what is "right."

Note: Be careful not to confuse a dilemma with "knowing the right thing to do, but being torn about whether to do it because it will have unhappy consequences for someone". For example, "I knew that, for the good of her patients, I should report that she was stealing drugs, but I was torn because it probably meant she would lose her job and I felt sorry for her." This is not a dilemma. It is an action problem with a constraint—concern for what will happen to someone.

ACTION FOCUSED PROBLEMS (a)
Knows the "right" thing to do, or has made a decision about what to do, or what ought to be done by someone else (in the case of outrage and whistleblowing). Because the nurse knows the right thing to do, the focus of the problem is on what she or someone else actually did or will do, whether acting will put her at personal risk, etc. The "problem" is in the acting.

SUB-CATEGORIES

Moral Weakness (Called "confessing a sin" in Phase I)
("Knew what was right, or wrong, to do. But failed to do the right thing, or did the wrong thing, out of weakness, human frailty, etc. #1 & #2 must be present also.
*1. Focus is on own actions.
*2. Was not coerced into doing wrong. No contextual constraints or risks that caused her to do wrong.
3. May also simply be confessing that she was tempted to do wrong. If she goes ahead to say she resisted the temptation, then this reverts to "no problem" instead of "confessing". Some, however,will just be a statement that "I was tempted to do X..."

Moral Distress (dis)
*In addition to knowing what is the"right thing to do," starred items below must be present:
*1. Unable to implement decision because of contextual constraints (constraints can be real or perceived; external or internal, such as self-doubt about own knowledge)
*2. Concerns the nurse's own action - If not explicitly stated, at least cannot indicate that the concern is primarily with the actions of someone else.
3. Believes self responsible for own actions in the case (may be only implied)

Moral Hero (hero)
This is a special case of moral distress. 1-3 must be present.
*1. Knows right thing to do. Decision made.
*2. Perceived risks to self, or contextual constraints to implementing decision.
*3. Implements her decision despite perceived contextual constraints/risks.
4. Focus is more on her own action than on actions of others

(If the "right thing to do" involves reporting someone else to the authorities, see "whistleblowing" below)

Moral Outrage (out)
*In addition to knowing what is the"right thing to do," starred items below must be present:
*1. Concerns someone else's "immoral" action. Believes someone else is "doing wrong."
*2. Feels powerless to intervene or prevent the action (if she considers the possibility at all)- may be only implied. Focuses more on the bad others than on what she ought to do about it.
3. May fail to act because of external or internal constraints.
If nurse goes on to say, "How should I respond to those bad persons," or "what should I do?" this reverts back to "decision problem—uncertainty" because she has then changed the focus from the "bad others" to her own moral actions.

Whistleblowing (w)
A special case of moral outrage, and is similar to moral hero. Some of these may not be explicitly stated by the nurse; e.g., if #2 is stated, it implies #1.
*1. Knows what is right/wrong to do
*2. Believes someone <u>else</u> (person or institution) acting immorally, or wrongly.
*3. Believes she should "tell," usually in order to protect others—usually involves eg, reporting to the supervisor, reporting to the medical board, etc.
*4. Perceives (real or imagined, internal or external) constraints to doing so. Constraint frequently is that the bad person is powerful (eg, a physician).
*5. Blows the whistle, despite risks to self. May not narrate what the dangers are. Researcher can infer dangers/risks.

Moral Judging - A special case of moral outrage.
*1. Knows what is right/wrong to do

*2. Believes someone else (person or institution) acting immorally, or wrongly.
*3. Little, if any, thought that she should act, even to report the person.
*4. No mentioned or easily inferred constraints to acting.
*5. Usually involves a peer or someone below the nurse in the power hierarchy.

II. ROLE THEMES (MAJOR)

"Role" should reflect the nurse's own, individual perceptions of what ought to (ideal role) or actually does (perceived role) constitute the nursing role. You can code statements indicating the nurse's belief or actions/behaviors that are indicative of her role perception/enactment.

None- Means no role content is present
O- Means role theme does not fit any of the following descriptions. Code "O" and create a new term. E.g., "o.counseling".

Autonomy (au)- Indications that autonomy is a part of the ideal nursing role and/or that the nurse perceives she has some autonomy in her actual role; or in the story, she demonstrates some autonomy. E.g., indications that nurses should make decisions, control their practice; indications that nurses should be/are independent, accountable, think for themselves; that they are competent; and/or indications that the nurse actually does do some of these things. Indications of lack of autonomy are coded "Other," "powerlessness," etc.). [NOTE: When Autonomy is present, also check for Advocacy and Knowledge.]

Advocacy (ad) - Believes nurses should protect patients' rights and interests, as a part of their role (whether or not the nurse was actually able to do so). May take the form of responsibility of duty statements (e.g., "I felt I owed it to the patient."). Can be a statement or an action. Advocacy is the articulation and defense of the rights/ interests of another (patients, in this study). For example, intervening for the patient with the system or more powerful others. Do not code protecting the patient simply by performing good nursing care (e.g., *monitoring for complications*).

Example (Belief): "Is it right for a nurse to watch a doctor making a serious mistake which may mean the patient's life and remain silent? Would it not be better to question him or report it rather than be "ethical" and be silent?"

Example (Behavior): . . . *one hour later he still hadn't arrived, so I called him a* second time. He said that he was busy. . . I didn't answer him at all but just hung up the receiver. *I gave the clysis myself.*

Enforcement (enforce) -Indications that a part of the nurse's role is to help enforce the "rules" *by documenting or reporting to someone in authority* what other workers do— especially as it relates to incompetence, bad ethics, or patient care. It is similar to "tattling" except it isn't necessarily done surreptitiously. It embodies the idea that when someone breaks the rules or fails to follow policy, the nurse has a duty to report the incident.

Knowledge (know) —Statements from which you can infer (by words or reported behaviors) that the narrator believed knowledge to be an important part of the nursing role. May take the form of reports that the nurse evaluated the medical care and deemed it appropriate or inappropriate. That would assume that the nurse had enough knowledge to pass such judgment. **Summoning**— is a special case of "Knowledge" in which the nurse uses her knowledge to evaluate changes in patient condition and determines that a

physician should be present. (NOTE: When Knowledge is present, check for Autonomy as well.)

Obedience (obey)—An expression that the narrator believes nurses ought to follow the rules and comply with the requests and orders of "superiors." Includes a sense of duty or obligation to the patient, the physician, the profession, and the institution. Unlike the task-oriented theme, "Doctor's Helper," Obedience includes loyalty and the necessity to follow orders *without questioning.* Example: Pt. disobeys the doctor's orders; tells the nurse not to mention this to the doctor. She feels it her duty to disregard the wishes of the patient and tells the doctor the truth." This tends to refer more to following doctors orders than to institutional policy

Powerlessness (power) — A feeling of ineffectiveness or lack of control in a situation. It may be represented by narratives in which the nurse was unable to change the course of events even though she took some action to try to do so (however, taking action is not a necessary condition for coding "powerlessness".) Reflects a belief that the nurse is actually without power—not that nurses ought to be powerless. It is an actual rather than an ideal role conception. Example: "A doctor walked into a ward and asked me to drape a patient. . . I went to get the gloves for him and he said to never mind them—they weren't necessary. The next day the same thing happened. I had the gloves ready to hand them and he refused them."

Rules (rules)—Rule follower. Believes nurses' duty is to follow rules; or that the duty to "do as ordered" overrides other duties. May say, "I had no choice; I have to follow orders." Or may say, "It is the doctor's (or hospital policy) responsibility to decide." Use this only if "Obedience" or "Subservience" do not fit. (Note: In the 1995 data, this is broader. It is less of a "blind" following of rules, and the nurse seems to befollowing the rules because she has thought about them and agrees with them either consciously or unconsciously. She may talk about them as creating difficulty, but doesn't follow them just because "You ought to follow the rules," but because it makes sense to do so.) Compared to "Obedience," this tends to refer more to institutional policy or laws than to orders from physicians or supervisors.

Teaching (tchg) - This is not just any patient teaching. This is teaching done for the purpose of empowering patients to make decisions or perform self-care.

III. ROLE THEMES (MINOR)

Appearances (ap)—Reflects the belief that a nurse ought to be concerned about her/his reputation, incurring disgrace, and maintaining dignity or propriety. Can be inferred from reports of concern about what others think about her (or others') character. May be individual/personal, or about the reputation of the profession, hospital or school. The theme reflects that one's behaviors are subject to the judgments of others and that one should always act in ways that will not incur negative judgments from others. Example: "Is one justified in reporting a nurse to high authorities when you are positive she is disgracing the profession?"

Assertiveness (as)—Is present when a nurse complies with rules or orders, but speaks honestly and directly to "superiors" (usually a physician) about her feelings, wishes, or objections. If the nurse actually broke the rule or refused to follow an order, you should code "Autonomy" rather than "Assertiveness." A nurse might be assertive but still powerless (lacking in autonomy). Example: "I explained that the patient appeared to be well.

. . . In spite of my protests, he emphasized that he wanted the IV given and maybe the son would think twice before calling him again."

Competence (comp)— The sense and expectation that the nurse will and should know how to (and be motivated to) do things correctly—will follow procedures for skills and care. Includes the concepts of accuracy, knowledge, efficiency, responsibility, and conscientiousness. Implies that the nurse will be capable, skillful, proficient, adept, and qualified. Can identify by inference. For example, a nurse who made a mistake (in 1934) was expected to report it; so the inference is that nurses should not make mistakes—that is, they were expected to be competent.

Cooperation (coop)—Primarily involves peer relationships. Includes fairness, responsibility to peers, class spirit, and consideration. Nurses should "do their fair share of the work." Usually reflects the narrator's Ideal Role conception.

Gentleness (gent)—The idea that nurses should be patient, nice, kind, tactful, uncomplaining, uncritical, and humble. Includes both attitude and communication style. Nurses should not "rock the boat" or make demands. Should be passive, indirect, keep the peace, and not be bossy. Example: "I tolerate this nurse merely to keep order on the floor."

Honesty (hon) —Means that nurses should not lie or steal. They should tell the truth, especially to superiors and in the patient's chart.

Loyalty (loy) —The nurse should support peers and be concerned about their safety. May involve protecting or defending peers from supervisors and others in authority. Different from cooperation in that it is not limited to peer relationships. Loyalty may include loyalty to the profession or institution (slightly different from "appearances".)

Morality (mor) —Includes concepts of purity, modesty, and integrity. Overlaps somewhat with "Appearances" but is concerned more with character than with the opinions of others. May be inferred from statements about proper/improper behavior, such as reports that someone was smoking or using vulgar language.

Religiosity (rel) —Extends "Morality" to tie morality and nursing both to religion.

Subservience (sub) —Includes the idea of deference, submissiveness and respect for authority. Distinct from Obedience; it is not merely the duty to obey, but extends to include a deference to persons, rather than God, institutions, or rules. For example, calling superiors by their titles, handing the chart to the doctor. . . Includes the idea of being "doctor's helper." Example: "If older nurses are making a break in technique, would it be a very serious offence for a younger nurse to correct the break?" (Implies younger nurses should defer to older nurses.)

Summoning (sum)—Special case of "Knowledge." The nurse uses her knowledge to judge changes in patients' conditions that necessitate medical consultation. Focuses on the difficulty the nurse has in persuading the physician to come see the patient. Existence of Summoning may be evidence of powerlessness and lack of autonomy (but not always).

IV. CULTURE THEMES

In order to infer that a value or belief is cultural (as opposed to individual), there must be an indication that it is commonly held or practiced by others in the group or subgroup, and not just a psychological trait of the narrator. Shared expectations or norms

Behaviors may be regarded as cultural if the nurse is telling about the actions of others and it is reasonable to assume that this was a "normal" behavior at that time. For example, the nurse would talk about it as though it was not an unusual thing to so (e.g., "John went to pay his taxes; another nurse called the physician to tell him the patient was worse.")

Sort initially into broad categories (**in**=Institutional culture; **nsg**=Nursing culture; **p**=popular culture, broader than healthcare; **c**=culture that doesn't fit any of these; **none**=no cultural content). Then sort into the following subcategories, most of which are self-explanatory.

Popular (wider) Culture (p)

The Economy (econ)	—In general; not healthcare specifically
Public perceptions of nurses (percep)	—Image of nurses in the community
Legal concerns (legal)	—E.g., In 1934 data, no one mentioned fear of lawsuits
Women's Issues (sex)	—Instances of sexism in the hospital may reflect societal attitudes. E.g., "Is it proper ethics for nurses in the ward to call the men by their first names?" This is broader after 1979 and should be usedalso for indications of women's roles and other women's issues.
Miscellaneous (misc) -	—A popular culture theme other than the above (p.misc)

Nursing Culture (nsg)

Cutbacks (cut)	—Staffing problems, workplace redesign, downsizing concerns. This is more specific than "Resource Allocation" in the Institutional Culture, but may be a part of that.
Cultural diversity	—The idea that the nurse should be aware that a client's culture influences his needs/decisions—that awareness of culture is important
Incompetent or unethical physicians (incomp)	—Reports of this, regardless of how nurse handled it
Letting die (die)	—The notion that it is permissible, maybe even preferable, to let a patient die rather than prolonging life with futile treatments. Compared to "Heroic Measures," this tends to be what people thought about the futile treatment, not just a description of the treatment/situation
Nature of the work (work)	—E.g., "Should supervisors make rounds with doctors who have private duty nurse?" Technology, settings (e.g., school, clinic)
Nurse-patient communication (NPCom)	—Self explanatory

Nurse-patient alliances (NPAlly)	—Usually covert plans of patient and nurse to get the patient's wishes carried out. E.g., The nurse cannot persuade a physician to stop a treatment, but tells the family they should put pressure on the doctor; or the nurse suggests that the patient get a second opinion.
Nurse-physician communication (NMDCom)	—Direct or indirect? How does doctor respond?
Nurse-physician collaboration (coll)	—Look for absence of this. If you see collaboration, note who/what the nurse was (e.g., administrator, head nurse, public health).
Nursing education (ed)	—What was it like?
Professionalism (prof)	—Statements about licensing, professional behaviors; the idea that nurses are somehow special and set apart from the general public. Related to "Appearance" role theme but not identical—Professionalism may include appearance, but is more than that
Power imbalances (power)	—Between physician & nurse, physician & patient, nurse & patient...
	Healthcare Culture
Ethics committees (EthCom)	—Any mention of this?
Heroic measures (prolong)	—Stories about life-prolonging, futile treatments, etc. Was it common or not? Compared to Letting Die, this tends to describe what was happening (in the way of unnecessary treatment, etc.), not what people thought about it.
Hierarchy, nursing (hier)	— Nurse-nurse relationships, supervisors, instructors, etc.
Institutional rules and control (orgrules)	—What were they about? What was controlled?
Patient decisions (PtDecis)	—How much control does the institution give patients over whether to have heroic or life-prolonging treatments, etc.?
Quality assurance committees (QA)	—Any mention of these?
Resource allocation (resource)	—Concerns that cost control measures are harming the quality of patient care, overall, not just "on my floor". Includes concerns about staffing and work conditions, as well as the resources consumed by unnecessary/futile treatments.

APPENDIX D

DECISION TREE FOR WILKINSON BIFOCAL MODEL SORTING

Decision Tree for Wilkinson Bifocal Model Sorting

Read the case all the way through before beginning.
First decision: Is the focus of the moral decision or action on self or other? ("Self" is the decision-maker, whether it is the narrator or a nurse she is telling about in the story.) State in one sentence: "She is mainly worried about (self/other)" or "Her main concern is about (self/other)."
IF: Self—> Go to #1. IF: Others—>Go to #7.

FOCUS ON SELF

1. Does she know what is right/wrong? Or has she made a decision about what is right/wrong?
(Yes=Go to 2. No=Go to 3)

If YES

2.Are there constraints or risks to self? Constraint can be inner or outer, e.g., lack of confidence.
(Yes—>Go to #5)
(No—>Go to #6)

5.Did the nurse do the "right" thing (carry out her moral decision)?
(Yes=M.HERO) (No=M.DISTRESS)

6.Did the nurse do the "right" thing (carry out her moral decision)?
(Yes=NoPROBLEM) (No=M.WEAKNESS)

If NO

3.Is the nurse aware of conflicting duties, principles, roles, goods, evils? May infer this if it is rather obvious. Otherwise needs to be stated. Is she "caught between a rock and a hard place?"
(Yes=DILEMMA)
(No—>Go to #4)

(Note: If #3 is NO, then it is #4 by default; no other evidence needed.)

4.Or is it a sort of vague problem; can't clearly identify the moral nature of it or the principles or duties involved? A straightforward "Here's what happened, tell me what to do" also fits here.
(Yes=M.UNCERTAINTY)

FOCUS ON OTHERS

7.Does she think others are doing wrong? **(Yes—>Go to #8. No=NO PROBLEM)**

8.Is she aware (obviously aware, if not stated) of risks to self, or internal/external constraints? (Powerlessness is a constraint. Feeling that action is futile is a constraint.)
OR
Is the "other" someone with more power (e.g., MD as opposed to another nurse)? However, it can be another nurse as long as there are constraints such as futility of past actions. Usually "another nurse" gets a NO; but if there are constraints, it gets a YES.
(Yes—>Go to #9) (No—>Go to #10)

9.Did she try to change the bad actions, e.g., by reporting to someone or confronting?
(Yes=WHISTLEBLOWING)
(NO=M.OUTRAGE)

10.Did she try to change the situation, e.g., by confronting the nurse or reporting her?
(Yes=NO PROBLEM)
(No=M.JUDGING)

NOTE: If what she did was to form a covert alliance with the patient, e.g., tell her to get a 2nd opinion, tell her the truth, or do something "sneaky," it is probably more like "moral hero" because it puts the focus back on the nurse's actions. Merely reporting or going to the chief of staff, for example, keeps the focus on the "other" (even though reporting is acting). This is a hair-splitter.

FINAL STEP: Compare your conclusion to "Definitions and Examples" sheet.

APPENDIX E

SORTING CODES

SORTING CODES - Key

I. **GENERAL CODES** - each narrative has a code to identify the year it is from, and its location within that year's data (e.g., "34.2" - from page 2 of the 1934 thesis)

Year	-	(34, 79, 90, or 95)
Page or sequence#	-	page number of that document (except for the 1995 data). The 1995 narratives are numbered sequentially from 1, in the order in which they were received. E.g., "95Mercy.54" means this is narrative No. 54 and that it came from Mercy Hospital.
Source	-	Indicates the researcher, hospital, etc., from which the data came (e.g., 95Corley, or 95Mercy). See data management book for complete listing of sources.

II. **BIFOCAL MODEL** - (e.g., "a.out" = action problem, moral outrage)

Major Categories

- **np** - No problem. Knows what is "right" and did it (skip subcategory; go to role)
- **a** - Action-focused problem
- **d** - Decision-focused problem
- **uc** - Unable to classify as to action or decision focus

Subcategories

- **dil** - moral dilemma
- **dis** - moral distress
- **j** - moral judging
- **hero** - moral hero
- **out** - moral outrage
- **u** - moral uncertainty
- **w** - whistleblower
- **weak** - moral weakness, confessing a "sin"
- **a.uc or d.uc** - unable to classify into subcategory

III. **ROLE THEMES**

- **none** - no role theme present
- **o** - role perception: other

Major Themes

- **au** - role perception: autonomy
- **ad** - role perception: advocacy
- **enforce** - enforcement
- **know** - knowledge
- **obey** - obedience
- **power** - powerlessness
- **rules** - role perception: rule follower
- **tchg** - teaching to empower or self-care

Minor Themes

af	- affective, caring role	**loy**	- loyalty
ap	- appearances	**misc**	- of interest, but not frequently found
as	- assertiveness	**mor**	- morality
comp	- competence	**rel**	- religiosity
coop	- cooperation	**sub**	- subservience
gent	- gentleness	**sum**	- summoning
hon	- honesty		

IV. CULTURE THEMES

Initial Sorting

in	- culture: institutional	**c**	- culture: other
nsg	- culture: nursing	**none**	- no culture theme present
p	- culture: popular		

Subcategories

Institutional (Healthcare) Culture

orgrules	- Institutional rules and control
cut	- Cutbacks, workplace redesign, downsizing
die	- The idea that it is permissible to not treat
EthCom	- Ethics committees
prolong	- Life-prolonging, futile treatments, etc.
PtDecis	- Patient decisions
QA	- Quality assurance measures, groups
resource	- Resource allocation, cost control measures, staffing

Nursing Culture

coll	- Nurse-physician collaboration
cult	- Cultural diversity
ed	- Nursing education
hier	- Nursing hierarchy, nurse-nurse relationships
incomp	- Incompetent or unethical physician
NMDCom	- Nurse-physician communication
NPAlly	- Nurse-patient alliance
NPCom	- Nurse-patient communication
power	- Power imbalance (MD-nurse, MD-pt, nurse-pt)
prof	- Professionalism
work	- The nature of the work

American Culture

Econ	- The economy, in general (not just healthcare)
Percep	- Public perceptions of nurses
Legal	- Legal concerns, any ref. to laws, statutes, suits
Sex	- Sexism and other women's status comments
Misc	- Miscellaneous

APPENDIX F

SAMPLE OF MODEL-SORT TABLE

Sample of Model-Sort Table

SORTED #1-98, 6-4-96	ID#	Problem	Role	Culture
	1	a.dis	power know rules	in.misc PtDecis power work legal
	2	a.dis	know	work prolong die
	9	a.dis	au (perceived) know	EthCom prolong die
	13	a.dis	rules	legal
	37	a.dis	power	PtDecis die prolong
	41	a.dis	hon obey	NPCom
	48	a.dis		die prolong
	62	a.dis	know power obey ad sum power loy	NPCom hier work orgrules NMDCom incomp power PtDecis
	63	a.dis	au (perceived) know coop power	legal orgrules coll prolong work die NMDCom
progression: outrage to distress to blow whistle. Coped by leaving. No change after blew whis, so also distress	77	a.dis	rules know ad hon	incomp resources NPCom work prolong power (MD-pt)
	81	a.dis	obey power	legal die PtDecis

APPENDIX G[1]

SAMPLE OF INFORMATION AND

INFORMED CONSENT LETTERS—

[1]Content of letters, informed consent forms and questionnaires differed slightly because procedures varied depending upon the source and type of data. Copies of all original materials sent to each data source are on file and available for inspection; as are all permission letters from the individual sources.

Judith M. Wilkinson, MA, MS, RNC
[redacted]

DATE_____

Co-Chairperson, Research Committee
Address_____

Dear _____:

Thank you for agreeing to take my request for data to the nurses in your hospital. As we discussed on the phone, the purpose of my study is to compare across different time periods nurses' narratives of ethical problems they encounter in their practice.This is being done to work toward a theory of how the practice context affects nurses' experience and construction of ethical problems.

Participation in this project would involve the nurse's writing a response to an open-ended question: "Tell me about an ethical problem you have recently experienced in your practice; tell what happened, what you did (or did not do), and why; tell what you were thinking and feeling." Participants would not be identified; they would be instructed not to put their names on their stories, and not to mention names or identifiable places in the stories.

I will need to obtain permission from the University of Kansas Human Subjects Committee to carry out this phase of the data collection. In order to do that, I will need a letter from your Chief Nurse Executive approving of our recruiting your nurses for the study. I have enclosed a sample letter, which he/she could put on your letterhead. Feel free to change the wording.

I am enclosing 50 copies of the information sheet and questionnaire that should be given to the nurses. Also enclosed are 50 stamped, self-addressed envelopes they can use to return their responses directly to me. Please call or e-mail [redacted]) if you need more of any of these items.

Congratulations on finishing your research and master's degree. Thanks again for your help.

Sincerely,

INFORMATION SHEET
Study to Analyze Nurses' Ethics Problems from 4 Historical Periods

Introduction and Purpose - You are invited to participate in a study being conducted for the purpose of developing a contextual theory of nursing ethics. Nurses' stories of ethical problems they experience in their practice will be analyzed. The study is being done by Judith M. Wilkinson, working under the direction of Dr. Ann Kuckelman Cobb, at the University of Kansas Medical Center School of Nursing, to fulfill dissertation requirements for a Ph.D. in Nursing.

Procedure - Participating in the study involves writing a response to the question on the attached sheet of paper. The question asks you to describe an ethical problem you have recently (in the past year) experienced in your nursing practice. You will place your story in a sealed envelope and take it to a place designated by , who has agreed to collect the envelopes and mail them to me. Alternatively, you can mail your story directly to me in a stamped, self-addressed envelope that is being provided.

Risks and Benefits - There are no risks and no direct benefits associated with participating in this study. Your participation may lead to a better understanding of the effect of the practice context on nurses' experiences of ethical problems. There are no financial costs and no payment for your participation in this study.

Anonymity and Confidentiality - Participation is completely voluntary. Please do not put your name on any of your papers and do not use other names or places in the story that could be identified by others. If you inadvertently do include identifiable names or places, I will not quote them in the dissertation. Stories will be coded only so they can be identified by "type" (e.g., RN-BSN students, nurses at a convention, stories quoted from a published document, etc.). Therefore, the confidentiality of your responses will be protected.

The investigators will keep secret all research related records and information from this study. However, as a part of data analysis, your journals may be read by Ann Kuckelman Cobb, Ph.D., R.N., Chairperson of the investigator's research committee at the University of Kansas School of Nursing. In addition, they will be read by and discussed with at least one other person, a nurse colleague, for the purpose of helping the researcher understand the data. Your stories may be quoted in the final research report. In addition, they may be used for secondary analysis in future research.

Consent - Receipt of your story will be taken as your informed consent to participate in this study.

Questions - You may keep a copy of this information sheet. If you have any questions about the project, you may call the researcher, Judith M. Wilkinson, at [redacted] or [redacted], or contact Ann Kuckelman Cobb, Ph.D. at [redacted]. If you have any questions about your rights as a research subject, you may call (913) [redacted] or write the Human Subjects Committee, University of Kansas Medical Center, 5012 Wescoe, 3901 Rainbow Boulevard, Kansas City, KS 66160-7700.

If you decide to participate, please follow the instructions on the questionnaire. Thank you for your help.

Date_____

_____
Judith M. Wilkinson [redacted]
(Investigator's signature and phone number)

SAMPLE PERMISSION LETTER

[date]

Judith M. Wilkinson, MA, MS, RNC
[redacted]
Shawnee, KS [redacted]

Dear Ms. Wilkinson:

I understand that you are designing a research study to analyze nurses' narratives of ethical problems they experience in their practice, for the purpose of developing a contextual theory of nursing ethics. Further, I understand that you would like to use the narratives of RNs who work at _____.

This letter will authorize you to request anonymous stories from our nurses to use your study. I understand that the nurses will be asked to reply to an open-ended question and describe their ethical problem experiences. _____will collect their responses and send (or bring) them to you, or they may mail them to you individually. It is understood that complete anonymity will be maintained regarding individual responses and that the nurses will be fully informed about the voluntary nature of the study and about what they will be asked to do if they decide to participate.

At the present time, I have no questions about the study. If I do, I will call you at [redacted] or ([redacted] ext. [redacted].

Sincerely,

[chief nurse executive]

QUESTIONNAIRE

Study to Analyze Nurses' Ethics Problems from 4 Historical Periods

If you decide to participate, please follow the instructions below. Thank you for your help.

1. Write on this paper (front and back) or on a separate piece of paper. You can type or write.

2. Describe a moral/ethical problem you have experienced in your practice in the past year. Tell the story of what happened. Describe it as fully as you can. For example:

   A. Who was involved (don't give actual names)?

   B. What did you believe was the right (morally correct) thing to do? Explain why you thought this was right.

   C. What, if anything, did you actually do? Was it the same as or different from what you believed was the right thing to do?

   D. If you did not do what you believed to be right, what kept you from it?

   E. What were your thoughts and feelings before, during and after the incident?

3. Do not use any identifiable names or places in your stories. However, you could, for example, say, "This took place in the ICU in the spring of 1995." You can identify people by their roles; for example, the physician, another nurse, the patient, the patient's wife, and so on.

4. Put your story in a sealed envelope marked "Wilkinson" and give it to _____ .Or you can mail it in one of the stamped envelopes addressed to Judith M. Wilkinson, which you will find in a place designated by____.

5. DO NOT put your name on the envelope or on any of the papers.

APPENDIX H

EXAMPLE OF NURSING SCHOOL RULES, FROM VAUGHAN'S 1934 STUDY

SCHOOL E

The nurse, like the soldier, must be always ready to obey orders promptly and cheerfully, therefore from the beginning of her course, certain obligations will be required of her that, if well observed, will train her to answer at all times, and without delay, the call of duty.

Nurses rise at 6:00 o'clock, A.M.
Roll Call, 6:25
Breakfast, 6:30
After breakfast nurses go on duty at 7 o'clock.

If unable for duty, the nurse should report at once to the Sister Superintendent. No nurse should go off duty without permission of the Superintendent. When off duty, she is not allowed to visit any department other than that in which she is engaged.

The nurses' rooms must be open for inspection and the occupants are required to keep them in such condition, that they may always present an orderly appearance.

Two late permissions per week, Sunday and Wednesday, 11 o'clock, p.m.

Nurses are cautioned not to leave money or jewels exposed in their rooms.

Nurses must not leave the hospital grounds in uniform, except with special permission.

All intercourse with doctors, patients and visitors must be strictly of a professional nature.

Nurses are not permitted to receive phone calls while on duty.

Unnecessary conversation or other waste of time must be avoided.

Nurses are strictly forbidden to loiter around the front entrance, elevator, corridors and chart desks.

Loud talking or laughing, being unprofessional, is not permitted throughout the hospital.

Nurses must not leave their duties without permission from the Sister in charge. When off duty nurses must not visit the wards or other departments of the hospital without permission of the Sister Superintendent.

Nurses must not obtain medicine, or seek medical advice without permission from the Sister Superintendent.

Should a nurse feel that she has serious cause for complaint, she should make it known to the Sister in charge or to the Superintendent, who will give the matter prompt attention. Self-respect and propriety of deportment, forbid the making of grievances a subject of conversation at table or elsewhere.

The right will be reserved to suspend or dismiss any nurse in the school for any cause which may be deemed sufficient by the Sister in charge.
I hereby agree to abide by the foregoing rules.

SIGNED _____