ETHICAL DILEMMAS OF NURSE EXECUTIVES:

A DESCRIPTIVE STUDY

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Date MAY 6 1991

Submitted in partial fulfillment of the requirements

for the degree of Doctor of Education

Teacher's College, Columbia University

1991

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ABSTRACT

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Caroline E. Camuñas

This research was designed to describe the ethical dilemmas and to identify the facilitating and inhibiting factors perceived by nurse executives when making decisions that have ethical implications. As there has been little research in this area the study was a descriptive study one.

A questionnaire was sent to a nationwide random sample of 500 nurse executives who were members of the American Association of Nurse Executives (AONE). Because of the homogeneity of the group, statistical analysis yielded no significant differences. Content analysis of open-ended questions uncovered three major findings: (1) nurse executives experience dilemmas about a wide range of topics, (2) resources used to resolve dilemmas are varied and diverse, (3) dilemmas are experienced in many situations. In addition, it was found that the most important factors influencing decisions that have ethical implications were the superiors of the nurse executives and the politics within the institution. The most frequently encountered ethical dilemmas involved allocation of resources and quality of care issues. These were encountered in such different situations as short-term, long-term and strategic planning, performance appraisal, and other management functions. To resolve their dilemmas, nurse executives most

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frequently relied on their personal values and those of administrative and nursing colleagues. They used other resources when appropriate. Available resources seemed to be sufficient.

The results have implications for nursing administration, nursing education, and staff development. They underscore the need to know more about ethical decision-making and moral reasoning as they relate to administration and organizational climate. Findings show a need for general ethics and ethical decision-making as well as bioethics to be taught at both graduate and undergraduate levels. Changing the dominate ethos of the profession from the traditional, idealized goal-driven model to a resource-driven model would help to reduce conflict for all nurses. The results also indicate that staff development should incorporate ethical management issues into its programs.

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Acknowledgments

There were many colleagues, family members, and friends who encouraged and facilitated the completion of this research study. Although it is not possible to acknowledge all by name, several people merit special recognition.

I extend sincerest thanks to Dr. Elizabeth H. Tucker, my advisor and sponsor, for her assistance, encouragement, and availability throughout the endeavor. To Dr. Elizabeth M. Maloney, a committee member, goes my appreciation for her encouragement during this study. I also thank Dr. Marvin Sontag, a reader, for his advice and understanding and Dr. Sheila Melli, a reader, for her interest and understanding. For her role as mentor and for her friendship, I express my gratitude to R. Alberta Rayner. To Jorge Camuñas, my husband, I give my loving thanks for his encouragement, patience, and support during this study and in my professional and academic endeavors.

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Chapter I

THE PROBLEM

Society and health care are undergoing rapid changes resulting from technological advances and economic constraints. These, together with the Vietnam War and Watergate, have led to an increased concern about ethics. Major health care ethical problems and controversies are frequently in the news. These situations revolve around care for the dying patient, Baby Doe cases, health care costs, organ procurement, reproductive technology and surrogate parenting, AIDS, human gene therapy, and abortion (Alward & Camuñas, 1991). As technology and knowledge increase, ethical difficulties are bound to become more pronounced; not only can we do more, but the stakes are higher. It is now accepted that health care organizations are businesses and must be administered as such. This raises the possibility of ethical issues arising in the daily administrative practice of nurse executives in acute care hospitals as distinct from those directly related to individual patient care. Additionally, all professionals, whether lawyer, nurse, physician, educator, legislator, or business executive are being held accountable for the ethical basis of their actions.

Ethics as a topic is appearing in the nursing literature with increasing frequency. Most of the research is related to ethics of patient care and the decision making of clinicians. Nursing research has consistently suggested that the workplace strongly influences the individual's judgments (Crisham, 1981; Ketefian, 1981a, 1981b; Mayberry, 1986; Murphy, 1976, 1978). Decisions are often made more difficult by

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administrative policies and organizational structure. Nurses' responses to situations are similar to those seen in business. That is, they generally display obedience to authority and the need to maintain harmony with the institution and with those in authority. According to Murphy (1978, p. 102) this need is pursued "even when rights of patients are being violated."

There is an expanding body of literature that discusses and affirms an ethical component to nursing management (Alward & Camuñas, 1991; Aroskar, 1984; Bowie, 1982; Christensen, 1989; Fry, 1983; O'Leary, 1984; Newton, 1982; Silva, 1983, 1990). In a survey of ethical issues in administrative decision making, Sietsema and Spradley (1987) found that nurse executives experience ethical dilemmas in their practice. Issues presenting such dilemmas identified by this survey are: (1) allocation and rationing of scarce resources, (2) access to care for the indigent, (3) staffing level and mix decisions, (4) employee selection, hiring, demotion, termination, and promotion, (5) treatment versus nontreatment, (6) downsizing, (7) diversification of services, (8) marketing/advertising services, (9) developing/maintaining standards of care, (10) incompetent nurses and physicians, (11) employee relations, and (12) labor negotiations with professional nurses. Each of these ethical issues is concerned with business management.

Ethical considerations often make decision making difficult. Eliminating them from the process would simplify the task of management. In his classic book, Capitalism and Freedom, Milton Friedman (1962) suggested doing just that arguing that the interaction between business and society should be left to the political process. Friedman (p. 133) stated that "Few trends could so thoroughly undermine the very

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foundation of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible." This is a deceptively simple, naïve approach. Business is part of the social system and must be held responsible and accountable for its actions in the same way as other segments of society. It is also impossible to separate the economic aspects of major decisions from the social consequences. In addition, business people have to evaluate the economic and social consequences of decisions as best they can in a limited time and with limited information (Cadbury, 1987; McCoy, 1983).

In fact, research has shown little support for Friedman's stance. In a landmark study of business ethics, Baumhart (1961) found that 73% of his respondents, subscribers to the Harvard Business Review, agreed that corporate executives must act in the interest of employees and consumers as well as in the interest of shareholders. The group to whom executives felt the greatest responsibility in Brenner and Molander's study (1977) was the customers. Stockholders were second and employees were third. Society at large and elected government ranked fifth and seventh. Reilly and Kyj (1990) called for redefinition of the basic principles of business and economics to integrate ethics and corporate responsibility in order to achieve an ethical responsible business environment.

Baumhart (1961) identified the major ethical problems faced by business people as: (1) gifts, gratuities, bribes, and call girls, (2) price discrimination and unfair pricing, (3) dishonest advertising, (4) miscellaneous unfair competitive practices, (5) cheating customers, unfair credit practices, and overselling, (6) price collusion by

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competitors, (7) dishonesty in making or keeping a contract, and (8) unfairness to employees and prejudice in hiring.

Brenner and Molander (1977) identified the same undesirable practices; only the order of importance had changed for several items. Ethical maxims used by business are not sufficient to handle the judgments required (Table 1.). When business and health care are combined the ethical implications become great.

Problem Statement

What are the ethical issues nurse executives encounter in their work and what are the facilitating and inhibiting factors that nurse executives perceive when making decisions that have ethical implications?

Rationale for Study

Nurse executives working in hospitals experience ethical dilemmas in their daily practice as do executives outside hospitals. These dilemmas often go unrecognized, unexplored, and unsuccessfully resolved. This can result in management and patient care problems stemming from a less than optimal ethical climate.

The rationale for this study is based upon the work of Lawrence Kohlberg and of Carol Gilligan and their concern for the principled resolution of ethical dilemmas. Kohlberg (1976) used moral philosophy to address the relativity of values and to resolve value conflicts. He defined the essential structure of morality as centering on the principle of justice. In contrast, Gilligan (1982) used the principle of responsibility to achieve conflict resolution.

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Table 1. Ethical Maxims Used by Business

The Golden Rule:	Act in the way you would expect others to act toward you.
The Utilitarian Principle:	Act in a way that results in the greatest good for the greatest number.
Kant's Categorical Imperative:	Act in such a way that the action taken under circumstances could be a universal law or rule of behavior.
The Professional Ethic:	Take only action which would be viewed as proper by a disinterested panel of professional colleagues.
The TV Test:	A manager should always ask "would I feel comfortable explaining to a national TV audience why I took this action?"

Source: Laczniak, G.R. (1983). Framework for analyzing marketing ethics. Journal of Macromarketing, 3(1), 7.

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Human life is one of the ten basic moral issues Kohlberg (1976) believed are common to all societies even when the practices associated with the them may differ radically from one society to another. These issues are: (1) laws and rules, (2) conscience, (3) personal roles of affection, (4) authority, (5) civil rights, (6) contract, trust, and justice in exchange, (7) punishment, (8) the value of life, (9) property rights and values, and (10) truth. The function of these value concepts is to regulate social behavior. We start developing them as children by interacting with others and discovering that we need to get along with them. These issues also arise in the daily work of nurse executives.

Kohlberg's cognitive development model was grounded in Piaget's (1965) theory of justice as the core of morality. While Piaget's model had two stages, Kohlberg's model had three levels, each with two stages. A major difficulty with Kohlberg's theory was that his research subjects were college-educated men. (This criticism was also made of the work of Piaget. Piaget studied the development of boys to the almost complete exclusion of girls.) Subsequent studies of women, using Kohlberg's model failed to demonstrate that women proceed in moral development beyond Kohlberg's Level II, Stage B.

Gilligan (1977, 1979, 1982) criticized Kohlberg's work, arguing that because of the different social development of women, their moral development was also different from men's. Gilligan asserted that women have coped with their traditional powerlessness by developing a sense of responsibility based on caring rather than on individual rights, which is more typical of men.

Empirical research results using Kohlberg's cognitive developmental model have not been conclusive; some studies have

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supported and other studies refuted it (Omery, 1983). However, despite the concerns about it, there is sufficient empirical support for the use of Kohlberg's model in nursing (Silva, 1990).

Investigators using Kohlberg's model have begun to validate that moral development can be learned, that moral reasoning can be enhanced through increased education, increased critical thinking, and repeated exposure to an ethical dilemma (Crisham, 1981; Ketefian 1981a, 1981b; Reid-Priest, 1984). The leadership that nurse administrators provide in the establishment and maintenance of an ethical climate may directly affect the quality of moral reasoning and ethical decision-making throughout the institution.

It is important to identify the ethical dilemmas in administration encountered by nurse executives. One must confront often very complex issues and broaden viewpoints, in order to avoid what Hedin (1989) called a "sterile ethical field." Once these common dilemmas are identified, acknowledged, and analyzed, a nursing administration theory which includes ethical decision-making may be developed.

Purpose

The purpose of the study is to describe the ethical issues nurse executives encounter in their work and to identify the facilitating and inhibiting factors that nurse executives perceive when making decisions that have ethical implications.

Research Questions

(1) What ethical issues or problems do nurse executives encounter in their administrative practice?

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(2) In what situations do nurse executives experience ethical dilemmas?

(3) What resources do nurse executives use for assistance in making ethical decisions or resolving ethical dilemmas?

(4) Are available resources for resolving ethical dilemmas sufficient?

Definitions

Ethics: a system of moral principles; the rules of conduct recognized in respect to a particular class of human actions or a group or culture; the branch of philosophy dealing with values pertaining to human conduct with respect to rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.

Value: an operational belief; an ideal, custom, institution of a society toward which the members of the group have an affective regard; any object or quality desirable as a means or as an end in itself.

Morals: rules of right conduct.

Corporate social responsibility: a set of generally accepted relationships, obligations, and duties that relate to the institution's impact on the welfare of society.

Dilemma: a situation requiring a choice between equally undesirable alternatives; any difficult or perplexing situation or problem.

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Assumptions

The assumption is made that nurse executives are frequently faced with ethical issues in their administrative practice.

Limitations

The generalizability of this study may be limited because all of the participants are members of the American Organization of Nurse Executives (AONE). As members of a specialty organization, they may be different from nonmembers in important ways such as education and age. This was a homogeneous group of nurse executives.

Significance

The major contribution of this research will be the description of ethical dilemmas encountered by nurse executives in their practice so that appropriate bases and measures for resolution can be identified. Health care professionals' practice and ethical decision-making need to be well-informed and rational rather than highly individualistic, intuitive, and common sense process. By identifying moral components of role obligations, nurse executives can balance conflicting demands of their position and establish a climate that encourages and supports ethical decision making throughout the organization. This has implications for research and education as well as for nursing service.

Outline of the Chapters

The research problem introduced in this chapter is that of describing ethical dilemmas of nurse executives in acute care hospitals.

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Rationale for this study is based on the need for executives to resolve dilemmas in a socially responsible way to meet the needs of patients, staff, organization, and community. Research results are intended to benefit nurse executives by assisting them to develop and maintain an ethical environment for patients and employees. Chapter II is a review of the literature related to ethical decision making and codes of ethics. Research design and methods are discussed in Chapter III; results are presented in Chapter IV. The implications of the findings and recommendations for action and further research are discussed in Chapter V.

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Chapter II

REVIEW OF THE LITERATURE

Ethics in Business Management

Despite the disdain for, and wariness of, the ethics of businessmen, and despite the claims of some businessmen that ethical business is good business, there is a dearth of research on the subject. In the business literature attention is paid to the ethics of business in some works, such as those by Robin and Reidenbach (1987) and Laczniak and Murphy (1985). While these are enlightening and useful, much of the literature is prescriptive and ideological. While the number of empirical studies has increased in the last few years, they make up only a small part of the literature. Many of these studies have a low and perhaps unreliable response rate, use convenience samples comprised of students, do not include data concerning attitudes, and have other flaws. This lack was found to be true by Randall and Gibson (1990) in their review of 94 published empirical studies.

In 1961, Baumhart found that his respondents - 34% of the 5000 Harvard Business Review subscribers polled - had a deep concern about business people's ethical behavior. A major finding was that most business people perceived themselves as more ethical than their peers, which suggested some disdain for the practices of others. These executives stated that those likely to act ethically were those with a well-defined personal code. However, some executives did add that there are many pressures that lead to unethical behavior. The executives in

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Baumhart's study also stated that top management must demonstrate their ethical stance through their actions as well as by their verbal communications.

Brenner and Molander (1977) replicated Baumhart's study. They polled 5000 businessmen, had a response rate of 25%, and concluded that the behavior of superiors was the primary guidepost for subordinates' ethical decisions. Studies by Vitell and Festervand (1987), Conner and Becker (1975), Hunt, Wood, and Chonko (1989), Schmidt and Posner (1986), and Trevino (1986) suggested that management could influence subordinates' ethical values and behavior by emphasizing and clarifying appropriate ethical behavior for the organization.

Lincoln, Pressley, and Little (1982) surveyed Fortune 500 executives and found that the majority admitted compromising personal values to achieve organizational goals. Carroll (1978) and Posner and Schmidt (1984) studied perceived organizational pressure on individuals at different levels in their firms and found that first-line managers felt greater pressure to compromise their personal values in order to succeed in their organizations than do middle and top managers.

Studies have consistently found that people believe themselves to be far more ethical than co-workers, superiors, or peers in other organizations (Baumhart, 1961; Brenner & Molander, 1977; Tyson, 1990; Ferrell & Weaver, 1978). The Brenner and Molander study (1977, p. 68) included Baumhart's comment that "This is the sixth . . . replication . . . of questions I first asked in 1961. Each time the results have been remarkably similar, especially in the respondents' attitude that: I am more ethical than the average manager, and my department and company are more ethical than their counterparts."

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Tyson (1990) surveyed 135 business students in two groups. One group was asked to respond to ten behavioral situations from the perspective of what they thought most managers or supervisors would be willing to do to protect their jobs, and then to answer the same questions from the perspective of what they would be willing to do as a manager or supervisor. The second group was asked the questions with the order of role perspective reversed. Mean differences were statistically significant at the 0.05 level. The results suggested that respondents maintained a positive view of their ethics in relation to others and that absolute values should be interpreted carefully.

Tyson (1990) also found significant sex differences. From the self-as-manager perspective, female/male differences were statistically significant at the 0.05 level, suggesting that female managers entered the workplace with personally higher ethical expectations than their male counterparts.

Harris (1990) studied values of managers by level in one service firm. The firm had a stable organizational environment for a number of years. It had a high degree of awareness of ethics and a clearly defined corporate code of ethics and an ongoing program to promote ethical behavior in its employees. A total of 148 people were sent questionnaires. The total usable questionnaires returned was 112 (return rate greater than 75%). Harris used five constructs (fraud, coercion, influence, self-interest, and deceit). No statistically significant differences in three of the five constructs (coercion, influence, and deceit) was found. However, statistically significantly more differences were found when ethical value measures were analyzed by years with the company. People with 10 or more years with the firm were

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significantly less tolerant of unethical behavior than those with less time. Those with five or fewer years expressed greater tolerance than those with longer tenure.

Vitell and Davis (1990) studied the relationship between ethics and job satisfaction among Management Information Systems (MIS) professionals and found that job satisfaction was negatively correlated with perceptions of unethical behavior within a company. Satisfaction with supervisor, co-workers, and work itself showed statistically significant correlations. Supervisor, co-worker, and work satisfaction were found to be negative correlates of perceived unethical behavior within the industry. The findings suggest that an environment that permits ethical employees to be successful leads to the most job satisfaction.

Vitell and Davis (1990) also found a lack of significant correlation between almost all aspects of job satisfaction and the respondent's sense of social responsibility. This finding was consistent with Wood, Chonko, and Hunt's (1986) study of marketers which found that an individual's own sense of social responsibility appears to have little or no influence on job satisfaction. (Vitell & Davis, [1990] also found that unethical behavior does not seem to be related to pay satisfaction.)

Bowman (1990) found that respondents believed that ethics in the workplace could be empowering, but that most organizations and their leaders did not demonstrate a consistent enough approach to achieve an environment that supported ethical decision-making. His respondents indicated that codes of ethics could become significant factors in the decision-making process if they received sufficient use and support by

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organizational leadership, not merely by raising general awareness but through the establishment of responsive programs.

There has been little empirical research on codes of ethics. Weller (1988) discussed these codes referring to and making analogies with research on compliance with law and court decisions. The most compelling force in bringing about compliance with the law was the belief that it was morally right to obey the law. The extent to which people perceived that a law was proper was dependent in part on the degree to which those who wrote the law were perceived to have authority that was legitimate. (Weller also suggested hypotheses for developing systematic research on codes of ethics.)

Ethics in Nursing Management

There is a plethora of literature, both research and theoretical, on nursing and health care ethics relating directly to patient care. The majority of published work has focused on the moral developmental levels of nurses, nursing students, or nursing faculty (Ketefian, 1981a, 1981b, 1985; Murphy, 1981; Munhall, 1980; Swider, McElmurry, & Yarling, 1985). These studies on moral development were based on Kohlberg's cognitive developmental model (Kohlberg, 1976). The nursing studies that used Kohlberg's theory as a conceptual framework supported the idea that nurses' moral judgement reflected obedience to established policies and procedures.

The Nursing Ethics Committee (1988) at Mount Sinai Medical Center in New York City found that nurses who had less than one year of practice (38%) experienced fewer problematic ethical situations than nurses in practice more than one year. When faced with such a

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situation, the majority of staff nurses indicated that they would most frequently consult with nursing leadership, a peer, spouse, or significant other. However, most staff nurses in practice between 15 and 20 years stated that they would not seek advice from, or consult with their peers preferring to rely on their own judgment. Sixty-six of the entire study group of staff nurses indicated that they had been placed in a problematic ethical situation most frequently by a physician or peer. Although the majority of those surveyed at Mount Sinai reported that they had read the ANA Code for Nurses, only 42% could recall anything specific from the code and 23% were not sure they had read the code.

Since 1976, the American Nurses' Association has twice published its Code for Nurses (1985) in an effort to provide direction for the profession for the delivery of care. The Code for Nurses emphasized the responsibility of the nurse to the individual patient and gave less attention to the collective good. It ignored the potential for serious ethical dilemmas when cost-containment strategies, the common societal good, and the individual patient's good came into conflict. Jameton and Fowler (1989, p. 22) stated that nursing's normative ethical literature "essentially overlooks this issue and thus fails to clarify and illuminate the tension between the individual and the collective good."

Holly (1989) conducted a survey of nurses in critical care units in six accredited hospitals in New York State. These nurses reported that the majority of decisions were made by physicians or were based on hospital policy. When such decisions were in conflict with their personal and professional beliefs, 43% of the nurses stated they would

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abide by the decision, 35% needed more information, 17% would become frustrated and angry, and 5% would file a grievance.

In a descriptive study of professional and bureaucratic role conceptions and moral behavior, Ketefian (1985) found that nursing supervisors had the lowest professional categorical scores and the highest professional discrepancy scores when compared with the other respondents in the study. However, when the groups were analyzed in terms of differences in personal and professional variables, such as education, experience, work setting, area of practice, or position, the only noteworthy findings related to education. In addition, nurses over 46 years of age had statistically higher moral behavior scores than nurses between 26 and 35 years of age.

Crisham (1981) studied nursing students, staff nurses, expert nurses, and non-nursing students. The scores of more experienced nurses on the Defining Issues Test (DIT) and Nursing Dilemma Test (NDT) provided partial evidence of the effect of milieu on moral judgment. Crisham also found that the level of moral judgment about hypothetical moral dilemmas in the DIT was clearly related to level of education.

In a study of nurses' ethical decision making in situations of informed consent, Davis (1989) found that the structure of the hospitals curtailed nurses participation in the process of informed consent. Davis also found that how nurses dealt with problems surrounding informed consent depended on their philosophic orientation. This was a descriptive study based on interviews with a convenience sample of 27 nurses.

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Nyberg (1990), in a study investigating the effects of care and economics on nursing practice, found that the nurses in the study felt controlled by "the system" and unable to affect decisions.

Scant attention has been paid in the literature to ethical dilemmas in nursing administration. Empirical studies in this area have been almost nonexistent. Sietsema and Spradley (1987) surveyed chief nurse executives in the 176 acute care hospitals in Minnesota. All of the 125 respondents indicated they had a responsibility to identify ethical issues related to their administrative practice and 90% reported that they experienced ethical dilemmas in their practice.

Only 30% of the respondents reported conflict between moral obligations as executives and moral obligations as professional nurses. Sietsema and Spradley (1987) also found a statistically significant association between the presence or absence of an institutional ethics committee and the nurse executives' experiencing ethical conflict between their administrative and professional nursing roles. Those employed in hospitals without ethics committees reported conflict between those roles more frequently than did those in hospitals with ethics committees. Respondents based ethical dilemma resolution on their own and others' personal values and beliefs. The only resource frequently used as an ethical code was the Patient's Bill of Rights.

The ethical dilemmas of nurse executives are important. Henry, Moody, Pendergast, O'Donnell, Hutchinson, and Scully (1987), in their study to identify research priorities for nursing administration found that, in addition to health care costs, delivery systems, and productivity, the themes and strategies that emphasize quality of care, ethical decision-making, and equity of care were essential.

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Investigating ethical dilemmas of management would help to bring nursing administration closer to developing its own theories and strategies to improve patient care and nurses' work.

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Chapter III

METHOD

A descriptive research design was used to discover and examine the ethical dilemmas encountered by nurse executives in their administrative decision-making. For this, a survey was conducted by the researcher using a questionnaire mailed to nurse executives.

Sample

The questionnaire (Appendix A) was sent to a nationwide random sample of 500 nurse executives in acute care hospitals. The mailing list was obtained from the American Organization of Nurse Executives (AONE) in Chicago, Illinois. It was decided to use a list from AONE because it was readily available and all the people listed were nurse executives. For permission to purchase this list, the researcher submitted the survey questionnaire and the cover letter for approval by AONE.

A short explanation of the study was included in the cover letter (Appendix B). Confidentiality and anonymity were assured. Recipients were asked to complete and return the questionnaire as soon as possible in a stamped, addressed envelope included in the packet. They were told that they would not receive any follow-up reminders. Monetary incentives and follow-up reminders are the only reliably effective means to increase response rates (Camuñas, Alward, & Vecchione, 1990; Kanuk & Berenson, 1975; Yu & Cooper, 1973) but the expense precluded using them.

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It was expected that the subject was of enough interest to stimulate sufficient returns without incentives (Erdos, 1974).

Instrument

Because an appropriate instrument with which to conduct this study was not found in a search of the business and nursing literature, a two-part questionnaire was developed. This was done by adapting the instruments developed by Bowman (1990) and Sietsema and Spradley (1987). Permission was obtained (Appendix C). A pilot test was carried out using 15 subjects from 15 different institutions in 11 states and the District of Columbia. The items in the questionnaire were finalized after review by a panel of three nationally recognized experts. Internal validity was not an issue in this study because there would be no attempt to study causal relationships among variables (Brink & Wood, 1989).

Part I gathered demographic data. The information obtained included sex, age, work setting, number of years in administrative practice, geographic setting, governing affiliation of hospital, educational preparation, and professional organization membership.

Part II collected information about ethical dilemmas encountered by nurse executives in their practice. There were eight questions for which choices were listed, two of which left space to write answers not listed. These were followed by 30 questions with Likert scale answers. Finally, there were four open-ended questions asking for respondents' opinions. The number of structured questions was large and unstructured questions small because of the large sample size.

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Three forms of the questionnaire were distributed randomly. The questionnaires were identical except for question number 34. One version of this question asked the respondent to describe an ethical dilemma concerned with allocation of funds. The second version asked for a situation relating to access to care. The third version asked for a description of a dilemma about standards of care. One hundred sixty-seven questionnaires of two versions were sent; 166 questionnaires of the third version were sent for a total of 500.

The questionnaire was designed in this way because little is known about the domain of interest: the ethical dilemmas encountered by nurse executives in administrative practice. A combination of qualitative and quantitative methods were used in order to reveal some of the varied dimensions of ethics in administration. Some aspects could be uncovered by open-ended qualitative questions, others could be obtained by using structured, quantitative measures. In this study the quantitative measures were adjunctive to the qualitative. The quantitative responses were not expected to confirm the qualitative responses. Instead, the expectation was that each approach would contribute to the understanding of the problem. These strategies were selected and combined because of the contribution each would make to addressing the research questions and not because of the possibility of their balancing strengths and weaknesses or confirming results. Using two approaches was done in an effort to achieve a more complete understanding of ethics in administration.

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Protection of Human Subjects

The respondents were guaranteed confidentiality and anonymity; no identifying information was collected that linked an individual to a questionnaire. Completing and returning the questionnaire was considered consent to participate in the study.

Procedure

The questionnaire was sent to the nurse executives the first week of January, 1991. Recipients self-administered the questionnaire and returned it in the enclosed envelope. When the completed questionnaires were received, data analysis was done by the investigator.

Data Analysis

To organize the data after collection, it was coded and entered into a data base. All entries were checked for clerical errors. The Statistical Package for the Social Sciences (SPSS) program was used for statistical analysis. Descriptive statistics were used for the initial analysis of the quantitative data. Because this initial statistical analysis yielded no significant findings, more sophisticated analysis was not done. The data were presented in table and narrative form. Content analysis was done on the open ended questions and was presented in a narrative description.

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Chapter IV

RESULTS

This chapter describes and analyzes the research data. Of the 500 questionnaires that were mailed to the nationwide random sample of nurse executives, 324 (64.8%) were returned and 315 (63%) were usable.

First, basic information about the hospitals in which the nurse executives worked is given. This information includes size, setting, governing affiliation, and whether or not the hospital has an ethics committee. Then, characteristics of the nurse executive respondents are described. Characteristics of the respondents include sex, age, years in patient care administration, annual salary, position, basic nursing education, highest degree held, and membership in professional organizations.

Next, beliefs in relation to the ethical issues of administrative practice of the nurse executive respondents are explored. Then, opinions about ethics in general and codes of ethics are presented. Finally, specific dilemmas encountered by the respondents are described as well as the resources used to resolve each one, and whether or not the respondent was satisfied with the solution. Other areas in which dilemmas were encountered are also discussed.

Characteristics of the Hospitals

The information about hospitals is given in Table 2. Three-fourths (76%) of the hospitals where the respondents were employed were divided evenly between 50-250 and 250-500 beds, 18% had over 500 beds,

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Table 2. Information About Hospitals

Characteristic		Frequency N=305*	Percent %=100
Size:			
under 50 beds		19	6.3
50-250 beds		114	37.7
251-500 beds		115	38.1
over 500 beds		54	17.9
Location:			
large city	(>100,000)	148	48.5
small city	(25,000-100,000)	93	30.5
town	(10,000-24,900)	37	12.1
small town	(<10,000)	14	4.6
rural area		13	4 3
Governing affiliation:			
government		56	18.4
church/religious		62	20.3
private nonprofit		160	52.5
for-profit		19	6.2
other		8	2.6
Ethics committee:			
have		220	72.1
do not have		85	27.9

*Except for hospital size, where N=302

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and 6% had fewer than 50 beds. Forty-nine percent of the hospitals were located in large cities, 31% in small cities, 12% in towns, and 9% in small towns and rural areas. Slightly over half (53%) were private nonprofit institutions, 20% were church affiliated, 18% were government and 6% were for-profit institutions. Seventy-two percent of these hospitals had ethics committees.

Characteristics of Nurse Executives

Demographic information about nurse executives is given in Table 3. Ninety-five percent of the respondents were women. The largest number of respondents were 40-49 years old. Fifty-two percent were distributed almost equally between the age groups 50-59 and 30-39. Four percent were 60 years of age or older and three-fourths of these were top managers. Only two were under 30 years of age; both were middle managers.

Sixty-two percent of these nurse executives had worked in patient care administration for more than 10 years. Twenty-seven percent worked 5-10 years in administration and 11% worked less than five years.

Sixty percent of respondents earned an annual salary of $35-65,000, 25% earned $65-85,000, and 11% earned $85-100,000. Ten (3.2%) were top managers and earned over $100,000. Only 3 (1%) earned an annual salary of $25-35,000; these three were also top managers.

Nineteen percent of the respondents were middle managers and 81% were top managers. The titles were varied and had little consistency. One respondent was the Chief Operating Officer (COO) for her hospital.

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Table 3. Demographic Information About Nurse Executives

Characteristic	Frequency N=*	Percent %=100
Age group:		
under 30	2	0.6
30-39	78	25.0
40-49	135	43.3
50-59	84	26.9
60 or over	13	4.2
Years in administration:		
less than 5 years	33	10.6
5-10 years	84	27.0
over 10 years	194	62.4
Annual salary:		
$25-35,000	3	1.0
$35-65,000	186	60.4
$65-85,000	76	24.7
$85-100,000	33	10.7
over $100,000	10	3.2
Management level:		
middle management	57	18.7
top management	248	81.3
Membership in organizations:		
ANA	112	59.3
Sigma Theta Tau	44	23.3
NLN	42	22.2
AHA	16	8.5
other	64	33.9

*Age N=302; Experience N=311; Salary N= 308; Management level N=305; Membership N=278

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Table 4 gives the entry level and highest level of education for the respondents. Of 288 respondents who gave their basic level of nursing education, 46% obtained a diploma. A masters degree was the highest level for 216 (71%) of the 304 respondents to this question. Included in the 216 masters degrees are 26 MBAs; nine (2.9%) had a masters degree in nursing as well as in business. All of those with doctorates had positions in top management. Two (0.6%) of the respondents had a law degree (JD).

Table 4. Levels of Education of Nurse Executives

Level	Entry level		Highest level	
	N=288	%=100	N=304	%=100
Diploma	133	46.2	13	4.3
Associate	30	10.4	1	0.3
Baccalaureate	120	41.7	61	20.1
Master's	4	1.4	216	71.0
Doctorate	1	0.3	13	4.3

While all of the respondents belonged to the American Organization of Nurse Executives (AONE), 59% belonged to the American Nurses Association (ANA), 22% to the National League for Nursing (NLN), 23% to Sigma Theta Tau, and 9% to the American Hospital Association (AHA).

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Only 64 (34%) respondents listed other associations to which they belonged.

Ethical Issues in Administrative Practice

Essentially all (99.7%) of the respondents said that they believed they had a responsibility as a patient care administrator to identify ethical issues related to their administrative practice. The majority (94%) reported that they encountered ethical dilemmas when making daily administrative decisions. Only 6% said that they did not encounter such dilemmas.

Respondents were asked to select three of 14 issues that most frequently presented dilemmas for them (Table 5). The issues selected most were those related to the use of resources and the quality of care. A large number of respondents chose more than three issues; a few checked all 14 of the issues.

These nurse executives were also asked to identify three of the resources they used most frequently when resolving ethical dilemmas (Table 6). Personal values, administrative colleagues, and nursing colleagues were named most often. The Patient's Bill of Rights was chosen by 54 respondents and 47 chose the ANA Code for Nurses. A personal spiritual counselor was not chosen by any of the respondents.

Seventy-one percent of the respondents said that they did not experience a conflict between the moral obligations of their administrative practice and their moral obligations as a professional nurse.

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Table 5. Issues that Present Ethical Dilemmas

Issue	Frequency N=568	Percent %=100
Allocation & rationing of scarce resources	134	23.6
Staffing level and mix decisions	96	16.9
Developing/maintaining standards of care	74	13.0
Treatment vs nontreatment	51	9.0
Incompetent physicians	47	8.3
Access to care for indigent	42	7.4
Employee relations	36	6.3
Downsizing services	25	4.4
Incompetent nurses	20	3.5
Promotion/demotion of employees	14	2.5
Selection/hiring of employees	8	1.4
Diversification of services	8	1.4
Labor negotiations with professional nurses	8	1.4
Marketing/advertising services	5	0.9

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Table 6. Resources Used to Resolve Ethical Dilemmas

Resource	Frequency N=630	Percent %=100
Personal values	148	23.5
Administrative colleagues	144	22.9
Nursing colleagues	94	14.9
Institutional ethics committee	68	10.8
Patients' Bill of Right	54	8.6
ANA Code for Nurses	47	7.5
CEO/Board of Trustees	30	4.8
Other	16	2.5
AHA Code of Ethics	14	2.2
AMA Code of Ethics	5	0.8
Hospital Chaplain	5	0.8
Friends/family	5	0.8
Personal spiritual counselor	0	0

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Ethics in Society

Several questions were asked as an indication of how respondents perceived ethical issues in society (Table 7). They were about evenly split (45% to 43%) as to whether or not society suffers from a "moral numbness" after a decade of scandals involving business and government. Almost half (49%) agreed that outright criminality in society distracts from more subtle dilemmas of everyday life. Thirteen percent were undecided and 39% disagreed. Eighty-six percent of the respondents agreed that concern about ethics is growing. Three-fourths disagreed that nothing is done about ethics; only 18% agreed. Sixty-three percent said that such issues as toxic waste disposal, trade with South Africa, racial discrimination, and making weapons were ethical concerns for administrators. The remainder were almost evenly divided between disagreement and indecision: 20% disagreed and 17% were undecided.

Ethics in Organizations

Questions were asked as an indication of how respondents perceived ethical issues in organizations (Table 8). Almost all (96%) of the respondents agreed that all people, especially managers, encounter ethical dilemmas at work. Seventy-six percent agreed that ethical concern can be empowering; 18% were undecided. Eighty-five percent disagreed that expressions of ethical concern evoke responses of cynicism, self-righteousness, and/or laughter. The same percent disagree that managers are concerned with appearing too idealistic: the remaining 15% were equally divided between agreement and indecision. A little over three-fourths (77%) rejected the idea that current management practices make ethics meaningless, the result of

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Table 7. Perceptions of Ethics in Society

Questions*	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
(1) Society suffers from a "moral numbness"	8.4	36.0	13.0	39.3	3.2
(2) Concern about ethics seems to be steadily growing	17.8	68.3	7.4	6.1	0.3
(4) Ethics is similar to weather; all talk, no one does anything	2.3	15.5	7.7	64.8	9.7
(5) Toxic waste, discrimination, are ethical concerns	8.1	54.7	17.2	17.5	2.6
(14) Criminality distinct from subtle ethical dilemmas	3.3	45.2	12.5	36.1	3.0

*The number in parentheses refers to the survey question number.

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Table 8. Perceptions of Ethics in Organizations

Question*	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
(3) Managers concerned with appearing too idealistic	0.3	7.1	7.4	66.7	18.4
(6) All people encounter dilemmas at work	44.0	52.4	1.9	1.3	0.3
(8) Administrator must rely on document, law	5.8	29.9	7.8	51.6	4.9
(9) Administrator must rely on greatest good for greatest number	3.2	35.9	17.2	39.5	4.2
(10) Standards harder to enforce in large organizations	1.0	30.3	16.9	46.9	4.9
(11) Ethical concern at work evokes cynicism	0.3	9.4	3.9	65.4	21.0
(12) Ethical concern can be empowering	12.9	62.8	17.5	5.8	1.0
(13) Management practices render ethics meaningless	0.3	10.4	12.7	55.0	21.5
(15) Not to question ethical concerns at work	0	1.3	2.6	47.1	49.0

(table continues)

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Question*	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
(16) Ethics covered in management training courses	1.0	5.5	2.9	54.4	36.2
(17) Organizations define and control decision-making	3.9	66.0	9.1	18.8	2.3
(18) Some indulge in "dirty" tactics	9.4	67.3	6.8	11.0	5.5
(19) Personal business on agency time unethical	12.7	64.2	13.4	9.4	0.3
(20) Passing blame, falsifying reports unethical	51.5	45.6	1.0	1.3	0.6
(21) Authorizing subordinates to violate rules unethical	36.0	54.9	3.6	4.5	1.0
(22) Peers have a looser set of standards than I do	1.9	7.5	21.8	61.0	7.8
(23) Superiors have stronger ethical standards than I do	0.3	1.3	15.9	70.2	12.3
(24) Administrators feel pressure to compromise standards	2.3	33.6	16.3	44.6	3.3

*The number in parentheses refers to the survey question number.

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organizational cultures which encourage a Machiavellian philosophy of power, survival, and expediency. Almost half (48%) said there was pressure to compromise personal standards to achieve organizational goals; 36% disagreed and 16% were undecided. Fifty-two percent disagreed that standards are harder to enforce in large agencies than in small agencies; 31% agreed and 17% were undecided.

Respondents were asked to choose the statement that best describes the approach that organizations take in addressing ethical concerns (Table 9). Almost 60% said that most organizations have no consistent approach. Nearly a quarter (23%) said that most organizations take a proactive approach; 16% said most organizations take a reactive, legalistic, blame-punishment approach. Only three percent chose other. When they specified, it was usually a blend of two of the three given approaches.

Table 9. Perceptions of Organizational Approaches to Ethics

Approach	Frequency N=301	Percent %=100
Reactive, legalistic	47	15.6
Proactive	70	23.3
No consistent	176	58.5
Other	8	2.7

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Seventy percent agreed that while individuals are responsible for their own actions, organizations define and control situations in which decisions are made; 21% disagreed. About three-fourths (77%) agreed that some indulge in "dirty" tactics to get ahead in their careers, 17% disagreed and 7% were undecided. Seventy-seven percent agreed that doing personal business on agency time, taking extra personal time, and not reporting violations of policy are unethical. The remaining 23% were about evenly divided between disagreement and indecision on this question. Virtually all (97%) respondents agreed that passing blame, falsification of reports, claiming credit for someone else's work, padding expenses, divulging confidential information, and accepting favors for preferential treatment are unethical. Ninety-one percent of respondents agreed that authorizing subordinates to violate rules,calling in sick to take the day off, concealing errors, and taking longer than necessary to do a job are also unethical.

Sixty-nine percent of respondents disagreed that their peers had a looser set of ethical standards then they had; 9% agreed and 22% were undecided. Eighty-three percent disagreed that their superiors had a stronger set of ethical standards than they did; 16% were undecided.

More than half (57%) of the respondents disagreed that when making a decision, an administrator must ultimately rely on some document, law or rule; 36% agreed and 8% were undecided. Forty-four percent disagreed that an administrator must ultimately rely upon "the greatest good for the greatest number;" 39% agreed and 17% were undecided. Almost all (96%) respondents disagreed that they were not to question ethical concerns at work.

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Of the 278 nurse executives who disagreed with the statement that ethical issues are adequately covered in management training courses, 54% disagreed and 36% strongly disagreed. Clearly these executives believe that ethics should be included in more educational programs.

Questions were asked to determine how respondents perceived codes of ethics (Table 10). Slightly less than half (46%) of respondents agreed that the role of professional associations such as ANA in affecting the ethical behavior of its members is very limited; 32% disagreed and 22% were undecided. Over half (57%) disagreed that organizations with codes of ethics were indistinguishable from organizations that do not have them; 11% agreed and 43% were undecided. Sixty-one percent said that there was an on-going effort to enforce an ethics code in their organization; 28% said there was not an on-going effort and 11% were undecided. Almost three-fourths (71%) disagreed that codes of ethics have limitations that make them ineffective; 29% were undecided. Ninety-three percent said that there was a need for codes of ethics in organizations and 88% said that the greater the congruence of a code with pre-existing values of employees, the greater the effectiveness of the code. Eighty-nine percent agreed that strong management commitment to enforce a code will encourage attitudes supportive of ethical behavior.

Ten percent of the respondents were not familiar with the ANA Code for Nurses. Of the 90% who were familiar with it, 14% had heard of it, 56% had a general familiarity with it, and 30% were quite familiar with it. Membership in ANA was not related to the response.

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Table 10. Perceptions of Codes of Ethics and Role of Professional Organization

Question*	Strongly Agree %	Agree %	Undecided %	Disagree %	Strongly Disagree %
(7) Role of professional organization in ethics is limited	4.8	41.3	22.3	27.7	3.9
(25) Performance of organizations with or without codes is the same	1.0	10.1	32.2	47.6	9.1
(26) There is an on-going effort to enforce a code in my organization	7.4	53.4	11.3	25.6	2.3
(27) Codes have limits that render them ineffective	0	6.5	22.1	64.8	6.5
(28) No real need for ethical codes in organizations	1.0	1.3	4.9	57.7	35.2
(29) Greater congruence between codes and values	25.4	62.2	8.1	3.6	0.7
(30) Management commitment will encourage ethical behavior	29.6	59.6	6.2	3.3	1.3

*The number in parentheses refers to the survey question number.

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Ethical Conflict Between Role Obligations

In response to the question whether respondents experienced ethical conflict between the moral obligations of their administrative practice and their moral obligations as a professional nurse, 88 said that they did experience such conflict. Of the 76 respondents who described the conflict, 42 described one concerning financial issues. The majority of respondents had the greatest ethical conflict in making decisions about staffing. These decisions involved skill, experience, and education levels as well as numbers of nurses. Because patients are sicker in today's hospitals there is an increased need for highly skilled or expert nursing care. Yet, due to budget constraints, there may be restrictions on using more skilled, educated, and experienced nurses as well how many nurses. Indeed, these restrictions may be so severe as to cause some nurse administrators to worry about patient safety and the institution's ability to provide the minimal level of safe care.

Nurse executives experienced conflicts between their professional values of providing high quality care to all patients and the fiduciary responsibilities of their administrative position. The economic constraints of cost containment and reduction lead to the need to decrease staff costs and maximize earnings and profit. One nurse executive stated that she found it "increasingly difficult to maintain the standards I feel are a patient's right while continually being forced to do more with fewer resources. As an administrator you must make the sound business decisions but often end up not feeling very good about it." Another nurse executive wrote that "Scarce resources

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sometimes affect decisions that would have otherwise been made differently."

Third-party reimbursement policies also cause conflicts for nurse executives. While many of these are about the above-mentioned staffing issues, some are caused by the institution's capital budget. Investment in equipment for diagnostic purposes or for surgical treatments, as one respondent said, may be "in reality based on whether the institution can afford it and will it be reimbursed, not on patient benefit."

Financial issues are also seen in role conflicts concerning access to care for the medically indigent. At times, putting the patient first is not always in the best interest of the institution. The difficulty comes in maintaining the financial integrity of the hospital versus providing expensive care for patients who have no means to pay. Nurse executives encounter this dilemma when they are the administrator on call and have to make the decision whether to permit or deny admission for these patients. It also arises after indigent patients are admitted and have special needs that require increased or extended use of resources.

The politics within the organization are a source of role conflict for nurse executives. Physicians often play a role in these conflicts. Some arise from every day physician-nurse contacts regarding patient care. One nurse executive stated, "Physicians here interfere with nursing practice beyond imagination." Another executive told of a surgeon giving poor care and the medical executive committee taking no action. She went on to say that "The board doesn't know and I don't feel I can tell them."

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A middle manager felt a conflict about disciplinary actions against physicians. In this case the conflict involved the physician's right to confidentiality versus the nurse's and administrator's need to know because the physician's incompetence put them and their patients at risk.

Another source of political conflict was the Chief Executive Officer (CEO). Here the conflicts involved trying to please the CEO versus respondents' professional values as a nurse and administrator. A nurse executive stated, "I am taking a big risk as my COO and CEO may not want to hear what I have to say. I have to be true to what my position calls for, not what would make me look good and not what others want to hear. I put my job on the line almost every day." Another wrote, "The politics in health care abound. A good political decision is frequently not an ethical decision." Yet another executive said, "Administrators, pressured by finances, often forget the purpose of the health care system." It appears that nurse executives often act as the conscience of the institution.

Thirteen nurse executives cited patient care bioethical issues as a source of role conflict. These issues revolved around "do not resuscitate" (DNR) orders, the right to die, and issues relating to quality of life and appropriate care. Unfortunately the respondents did not write anything more than the name of the issue. It was unclear if the conflict was one between personal beliefs and professional role obligations or society standards, rather than between professional nurse obligations and administrative obligations. There is also some tension and ambiguity between what society values and expects and what is possible. This was reflected in one executive's statement that "as

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technology advances care from state of the art to ordinary and usual care, criteria must be developed and refined." Another said that "evaluators still have a negative attitude on dying, which reflects the attitude of society in general that tends to deny death and makes technology an answer to the inevitability of death."

Several executives centered their role conflict on staff, rather than on patients. This had to do with the allocation of resources to patient care needs at the expense of staff needs. One nurse executive said "Sometimes my administrative responsibilities are in conflict with my personal beliefs regarding optimal decisions for a given nurse or staff." Another felt that achieving organizational goals "may result in staff/patient consequences incongruent with my obligations as a professional nurse."

Ethical Dilemmas Concerned with Allocation of Funds

The questionnaire asked respondents to describe a dilemma involving the allocation of resources. Eight of the 74 nurse executives who responded to this question said that they did not have any problems or could not remember one regarding the allocation of funds.

As could be expected, many of the dilemmas encountered had to do with staffing mix and numbers decisions. These descriptions had the same content and flavor as those discussed above regarding role obligation conflicts. One vice president for nursing described an extended period of working with an insufficient number of RNs to meet census/acuity demands. The staff had been working a lot of overtime and were very fatigued, which led to an increased number of incidents such as decubiti and medication errors. Hospital administration was not

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willing to close beds nor were they willing to pay for the use of agency nurses. The CEO was not willing to close beds because he felt that doing so would reflect negatively on his skills as a manager. Finally, after six months, the CEO acquiesced and agreed to close beds but threatened to fire the nurse executive. She ultimately resigned. The majority of citations of conflicts concerning funds for staffing were not as severe as this one only because the CEOs in those institutions were more concerned about their moral obligation to provide safe care than about personal benefits such as their own image. However, four other top nurse executives resigned over this issue.

A variation of the insufficient staffing problem was the need to reduce staff because of financial constraints. At least 20 nurse executives wrote of encountering conflicts over staff reduction decisions. These decisions involved staffing levels, skill mix, hours per patient day, and patient acuity. Recent budgets have required severe cutbacks in nursing. Some have caused the replacement of RNs with nursing assistants and technicians. Layoffs were the only possibility for a few. One nurse executive said that at the end of the year her hospital had sustained a 75% cutback in Medicare and Medicaid reimbursement. Financial realities have left room for few choices. In one case in the midwest the nurse executive resigned when she was asked to cut nursing FTEs (full-time equivalents) by 10%. The hospital was governed by a religious organization and was financially solvent.

Special care units have been affected by these budget constraints and decisions as well as general care units. The staff of one surgical intensive care unit with consistently high patient acuity had to "double up" patients as normal operating procedure. Unsafe care was being

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provided. Eventually the nurse executive resigned. In a pediatric cancer unit the acuity levels were high and staffing so low that the nurse executive was granted the money to hire three additional nurses. Needs were so great that even that was not an adequate solution.

Several respondents wrote of their agency's deliberately not meeting regulation requirements because of the costs that would be incurred by doing so. Reorganization to correct these problems brought with it the dilemma of finding the money to provide patient care while freeing staff to spend the time to develop the reorganization plan.

The capital budget was also a source of dilemmas for nurse executives. Prioritizing capital expense needs of all units was a problem for a few. More frequent difficulties were dealing with insufficient funds or lack of funds for specific needs such as equipment that prevented negative surgical outcomes, for surgical instruments for the operating room (OR) that would raise supply and other incidental costs but would decrease OR time and length of patient stay, and for new technology such as a lithotripser, intravenous pumps, monitoring systems for intensive care units, and computerized patient classification systems. Capital budget requests were at times expensive - $350,000 or more. Sometimes the conflict was between the purchase of a capital item or using the money for staff education, or between two or more capital budget needs. One nurse executive had the dilemma of having to decide between using money to staff overtime for patient care or to purchase an ECG monitor/defibrillator for emergency use.

Inadequate staffing brought with it the problem of compromised patient care. The psychosocial and education needs of patients had to be overlooked in order to provide their immediate physical care. Long-

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term needs versus short-term needs caused dilemmas for nurse executives with regard to both patient care and providing staff with sufficient resources to do their job.

Nine respondents answered this question with problems concerning individual patients. These patients were medically indigent and had long-term care needs such as head injuries, chronic vegetative states, or other conditions requiring extended care. Two were children who could not be discharged. The hospitals had to absorb the cost of caring for them.

Long-term intravenous antibiotic therapy caused problems for several executives. One indigent patient was receiving antibiotics for endocarditis secondary to intravenous drug abuse. If the patient had not been a drug abuser, the treatment would have been given on an out-patient basis. The providers were concerned that the patient would use the heparin lock to administer illicit drugs. The hospital provided 42 days of free care. In another case, an AIDS patient was covered by an HMO which would not provide intravenous services at home. The patient did not require hospital admission. In another, a chronic respirator-dependent patient was to be admitted but did not need intensive care. Hospital policy did not allow respirators on the general medical-surgical units.

Funding programs for groups of patients raised dilemmas also. Additional funding to expand services for an obstetrical/prenatal clinic was denied because it was for non-paying patients. Patients waited 12-16 weeks for an initial appointment. Another hospital reduced funds and positions for a chronic mental health clinic. Other services were not available in the community for these patients. A nurse executive in the

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southwest encountered a dilemma when her hospital, which was going out of business because it was insolvent, spent a large sum to obtain a certificate of need for an open heart surgery program.

One middle manager had a problem that was the result of an error her superiors made in allocating merit raises. She did not become aware that a nurse who was entitled to a merit raise was not given one until she had told half her staff what their raises were. Another middle manager had a conflict when her superiors made budget cuts without consulting her.

Three respondents told of difficulties because subordinates and a physician were not telling the truth. One heard a nurse administrator tell a staff nurse that reimbursement for a continuing education program would be granted. When the nurse submitted her reimbursement request, the administrator denied payment. The second had a department director who wanted to beat the system by costing out some equipment that should have been capitalized. In the third case, patient service employees did not want to do work for a physician because he was billing for their services.

Several respondents cited downsizing, closing a 26-bed unit because of low census, increasing the number of clerks to decrease waiting time in the emergency room, discrepancies in figures from the finance department and nursing service, and the hospital's receiving continuing education funds from infant formula companies. Unfortunately, these respondents did not elaborate on their dilemmas about these issues. It is not clear that the first four situations involved a moral issue; not all difficult problems are ethical problems.

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In the fifth case, it is possible that the companies were vying for preferential treatment in exchange for the funds.

While one nurse executive from the midwest did not tell of a specific situation, she did write with deep concern about the emerging two-tier health care system and the care of the elderly, especially those with mental disorders ("Heaven help the elderly mentally ill patient."). Because of cost-containment policies, third-party payers have developed strict admission criteria which make it difficult for many elderly patients to receive care.

Ethical Dilemmas Concerned with Access to Care

The question asked respondents to describe a situation concerning access to care for the medically indigent. Of the 73 who answered it, 19 said that they did not have problems in this area. Of those 19, four respondents qualified their statement. One said, "Our mission is to care for this group of patients." Another respondent said, "This hospital does not accept indigent patients." "Chief financial officer refuses to provide charity care" was another response. "Have not had problem - all patients accepted" was still another. The fourth respondent said that her hospital was "committed to spending millions a year in this area."

The respondents encountered dilemmas in relation to access to care by groups of patients. These groups were obstetrical/prenatal women, psychiatric patients, substance abuse patients, and the homeless. Seven respondents wrote about their dilemmas regarding pregnant women. One wrote that the "OB clinic has become unmanageable in terms of demand for services being far greater than our ability and capacity to respond."

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Two said that there was no facility in their communities for indigent and welfare pregnant women. Two more wrote that access to obstetricians was a problem. One wrote of the inappropriate transfer of a woman in labor because she did not have insurance. Another described a woman in the emergency room needing hospitalization because of abnormal laboratory results. Because she did not have the $3500 that was required for admission and because she was not in active labor, admission was denied. One respondent wrote of quite a different obstetrical-gynecological problem: the children of wealthy parents receiving welfare funds for abortion.

Four nurse executives cited problems related to access to care for psychiatric patients. One described the care of a young girl. She was admitted, stabilized, and discharged. Because there was no appropriate help or follow-up in the community, she required readmission eight days after discharge. In another case, a homeless psychiatric patient arrived in the emergency room. The patient was violent because of lack of medication control, but did not meet admission criteria. Again, there were no community resources available. A third case concerned a patient who needed in-patient psychiatric care. The physician was reluctant to admit the patient because of lack of insurance. The fourth nurse executive, at a for-profit psychiatric hospital, said that care of the indigent was frequently denied and is an ongoing dilemma.

Eight nurse executives wrote of difficulties with physicians and indigent patients. They wrote of physicians not wanting to give care, giving a lower quality of care or complaining that these patients returned to the emergency room for follow-up care rather than going to the private office. The medical staff at a nonprofit institution in the

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west wanted to separate the indigent population from the insured. These physicians went as far as conducting a $250,000 study to accomplish their objective.

One nurse executive wrote that her hospital's substance abuse program was cancelled due to the lack of funds. In another case, the local state hospital recently dissolved their pediatric services; those patients must now be dispersed to private facilities. A third respondent said, "My institution is financially compromised as a result of continued provision of free care." Another said that her dilemmas revolved around supplying adequate personnel to give care to all patients and to open needed new units.

Ensuring that all patients receive needed care is an on-going problem for financially strapped hospitals; this was apparent in several answers. An executive was disturbed about the care, or lack of care, for the homeless. Pressure to discharge homeless patients without adequate discharge plans was a frequent problem in a nonprofit hospital in a small New England city. The discharging of patients who were not ready to be discharged to their homes extended to elderly patients, and to head injury patients requiring long-term care.

When the indigent patient requires special care units there is additional strain on the hospitals and additional dilemmas for nurse executives. At a hospital that accepts all patients, the nurse executive told of loosing $70,000 in one month on an intensive care unit patient who was unable to pay but required a great deal of care. Another executive told about a terminally ill indigent cancer patient in an intensive care unit. The family insisted on full treatment; the patient lived longer than anticipated, draining the hospital's

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resources. Others told of long-term ventilator patients in the intensive care unit, and of a patient needing surgery but denied access to the operating room because of lack of money or insurance. The patient's condition deteriorated until emergency surgery was required.

Conflicts were also reported concerning the decision to admit indigent patients. Nurse executives made these decisions when they were the administrator on call. A respondent told of two patients, both of whom needed the only available intensive care unit bed; one patient was insured, the other was not. Another patient, a child from out-of-state, needed a costly life saving emergency procedure. None of the required payer information had been obtained; reimbursement was uncertain.

Two respondents told of having to turn indigent patients away from emergency rooms. The first respondent worked in a for-profit organization and had to refuse care to a patient because she could not pay and because her presenting complaint was not urgent. The situation ended with the nurse executive's giving the patient $5 so that she could go elsewhere. The executive resigned after this experience. In the second case, an increase in the number of non-paying patients with sexually transmitted diseases became a problem in the emergency room of a church-governed organization. These patients were to be referred to free city clinics. The difficulty arose because some of the patients could not afford the transportation to get to the free clinics.

One nurse executive did volunteer work and described a dilemma associated with access to care which she experienced in relation to that work. She had to help make the decision between allocating $800 on care for one child with a terrible disease or using it to buy over-the-counter drugs for a settlement (Colonia) of people.

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A respondent said that she had difficulty with "Medicare patients that don't want to or can't go home with the 'right' amount of time, and patients using the emergency room as family physician and never intending to pay the bill."

Ethical Dilemmas Concerned with Standards of Care

The question asked the respondents to describe a dilemma they encountered that involved setting or maintaining standards of care. Four of the 70 nurse executives who answered this question said that they did not have any problems in this area.

Remaining answers to this question were very varied. They ranged from substance abuse, incompetence, substandard care, lack of appropriate equipment, and admission to intensive care units to outright criminality and punishment. Three respondents had problems with nurses' diverting narcotics from patients for their own use or someone else's use. A fourth respondent had difficulty with the pharmacy's very loose accounting mechanisms for controlled substances. In another hospital, samples for drug screening were obtained without telling the patient. The results were being used to identify potential numbers of addicted newborns.

Errors, poor judgment, and incompetence were problems encountered by nine nurse executives. Errors involved medications. In one case the incorrect administration of total parenteral nutrition (TPN) was ordered by the physician and the error compounded by the pharmacy and the nursing staff. Patients received multiple "sticks" from nurses trying to start IVs even though a skilled IV nurse was available. A department manager was friends with an employee; the manager allowed the friendship

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to have an impact on the way she made the unit assignments. She favored her friend and increased the workload of the rest of the staff. Another example of poor judgment was seen when a patient and family wanted to see the patient's record; the physician and administrator on call refused to permit it. Emergency surgery patients received recovery room care that was of questionable quality and safety. A physician demonstrated poor moral judgment in relation to standards of care; he wanted to discontinue hydration of a sick neonate without consulting its native American parents. A nurse anesthetist gave a patient unnecessary anesthesia when the surgeon was not present.

One nurse executive had a dilemma with the incomplete education as well as supervision of physician's assistants and nurses. After trying to remedy the problem for a year, the executive left the institution. Physician incompetence was a problem for three respondents. Another respondent was told by the president and COO that "we must do everything to comply with and please the doctors because they supply us with the patients we need." The nurse executive resigned. An incompetent program director for psychiatry had been hired by a management company with a three-year contract to provide service. A nurse executive wrote about conducting the performance appraisal conference for a nurse manager; the manager reacted badly and her husband, a physician, went to the CEO and threatened to sue the hospital.

A respondent was faced with a "strong push" to hire a nurse who did not have the necessary clinical experience for the position. Another said she had a shortage of trained staff; they were insufficient in numbers and inappropriately prepared for caring for acutely ill patients. Four respondents said that the mix of staff for patient

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acuity versus budgeted hours per patient day was a problem in maintaining standards of care. A middle manager was concerned about compromising standards of care when a consultant was called in to redistribute the work load and probably to cut RN staff in order to reduce labor costs. One respondent said that the increased work load due to a sudden one-day influx of patients created a problem in maintaining standards of care. Another wrote of an ongoing conflict between two nurses over standards of care.

Three nurse executives cited problems with the way others were setting written standards. In one institution, managers were making literal interpretations of specialty standards without considering the appropriateness and need for such an interpretation; they were losing the intent in the absolute. The second institution had a nurse manager and staff who decided no longer to include a basic minimal level of care in their revision of standards. A physician in a multidisciplinary group in the third hospital convinced the group to eliminate the clinical pathway for the medical care of the patient with a stab wound. The clinical pathway is used as a standard upon which patient care, quality assurance, physician reimbursement, and trauma surveyors assessments are based.

Two nurse executives encountered dilemmas concerning standards of care in relation to obstetrical patients who were medically indigent. One of the executives did not give the details of her situation, the other did. When indigent patients in labor presented themselves in the emergency room they were taken directly to the obstetrics unit where qualified nurses assessed them. Sometimes the obstetrician on call

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refused to come in to see the patients, gave telephone orders for care and for transfer out to another facility.

These dilemmas revolved around providing an acceptable standard of care to pregnant women and their unborn children. The issue took on a somewhat different focus when the pregnant woman was a drug user, was carrying a viable fetus, and wanted to sign herself out of the hospital against medical advice in order to obtain drugs. Here the dilemma was whether the fetus had any rights.

The nurse executive in a community hospital in the south which provides general care had a problem with maintaining standards of care for premature, high-risk infants. Since there was a shortage of neonate intensive care unit beds in the state, the infants often could not be transferred to another institution for appropriate care. They had to be kept in the community hospital and the staff had to do the best they could.

The clinic for HIV positive patients in a large midwestern city had to be moved in order "to keep 'them' out of 'the public eye' of the hospital." This was a case of treating one group of patients differently from the rest, and presented the nurse executive with a conflict concerning standards of care. Another executive had to eliminate a program but did not describe the problem further. Denying transfer patients admission to the intensive care unit when the patients who occupied the beds did not have any chance of survival was the source of conflict for another executive. A variation of the problem of how best to use skilled care beds was another decision whether to admit an indigent patient or a paying patient, both of whom needed the one available bed.

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Two nurse executives described conflicts over standards of care in relation to money. One hospital did not have the equipment needed to monitor patients after they received medications via epidural catheters. Nocardia species were found in air samples in the operating rooms in the second hospital; there had been some nocardia sternal wound infections. The problem was whether to tell the surgeons and shut down the rooms at a great financial loss to the hospital or to wait for more information

One nurse executive described a conflict over maintaining standards of care because physicians were inconsistently applying brain death criteria for determining organ donation. Another wrote of a patient who was the wife of an anesthesiologist; the patient wanted her husband to administer the anesthesia for her surgery. A third executive wrote of a cancer patient who was a nurse and no longer needed skilled nursing care, but did not want to go home. Her husband felt that the hospital owed his wife the best nursing care available. The insurance company denied further coverage of the hospitalization.

Two nurse executives encountered dilemmas because of policies that did not permit appropriate solutions to problems. One recruited an operating room specialty nurse at a higher rate than others in the same pay grade; had she not done so, the nurse would have gone to another institution. The second executive worked with a county policy that resulted in poor treatment of employees.

Four respondents wrote about dilemmas in maintaining and setting standards and DNR orders. Two said that this issue most frequently arises from the failure of physicians to write DNR orders. Two wrote of the difficulty with DNR orders on a patient in the operating room. One of these respondents described an incident where the DNR patient was off

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the unit for a procedure during which the patient "coded." The physician felt the need to do everything possible and resuscitated the patient, much to the family's anger. A fifth respondent wrote of experiencing difficulty when moribund patients were taken to surgery. Another encountered conflict when patients with living wills were transferred to intensive care units and put on ventilators. Another respondent encountered a dilemma when a pediatric cerebral palsy patient was transferred to the hospice. The situation involved giving the child supplemental feedings and antibiotics and included the physician, family, and hospice policy.

Another aspect of the DNR issue arose when health care professionals cared for a terminally ill patient. The family wanted everything possible done, including resuscitation if the patient had a cardiac or respiratory arrest. Professional opinion was that only minimal efforts should be made.

Truth can affect standards of care. Falsification of information was a problem cited by two nurse executives in answer to this question. One did not elaborate further on the problem. The other told how a nurse forged the signatures of a nurse and a doctor on a work excuse form that said the employee had been seen and treated in the emergency room. Making the situation worse was the fact that the nurse was on education assistance payback and was a single parent.

Patient abuse was a problem cited by four executives. One was concerned about an RN's verbal interaction with a patient. The remaining three executives told of physical abuse of patients. In one case, a 12 year old girl was "mishandled and sexually approached" during the night by a male housekeeping employee. A nurse's aide in one and an

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employee in the other abused patients in the remaining two cases. No other details were given.

Theft of hospital property by a manager was the cause of one nurse executive's dilemma. The problem for her was both the reduction in standards of care and whether or not to involve the police.

In two answers to this question respondents wrote of situations where it was difficult for the researcher to see the moral issue. The first executive wanted a supervisor to attend a job fair in another part of the state in order to hire on the spot for the emergency department; funds were denied. For the second executive, the issue was of standardizing patient charges across patient units. No further information was given to link the problems with a moral conflict and standards of care.

Other Dilemmas

Respondents were asked in what other areas they encountered dilemmas. In answer, they wrote of many varied situations including allocation of resources, access to care for the indigent, and standards of care; performance appraisal, promotion, demotion, and termination; civil rights; substance abuse in patients, staff, and physicians; medical and nursing practice issues; truth and honesty on the part of patients, staff, and physicians; reporting nurses to the state board; Medicare and Medicaid utilization and benefits; medical research; closure of health care facilities; and confidentiality.

Many respondents wrote of patient care issues without relating the issues to administrative practice. It was impossible to say if the dilemma was about a personal moral obligation or a role obligation.

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Twenty-four respondents cited "do not resuscitate" orders, 29 cited discontinuation of life support, 6 cited feeding tubes, 10 cited right to die/living wills, and 2 cited right to life. While it is not clear how these issues caused nurse executive dilemmas, it is apparent that, as in society, these are important ones. Other bioethical issues such as abortion, organ transplant, quality of life, in-vitro fertilization, and AIDS were raised by at least one respondent.

Another important issue, which the respondents did link to their administrative practice, was substance abuse by patients as well as by health care providers; 19 respondents cited this problem. Other respondents said they had encountered ethical dilemmas in work relationships. For example, people using other individuals and situations for personal gain, people who said one thing and did another, and people who shared (or did not share) information that conflicted with desires of staff. Veracity was an issue with regard to staff, physicians, and patients. Twenty-two said that they encountered situations where truth/lying was an issue. Seven respondents said that they had met dilemmas regarding superiors or subordinates. No one wrote about diversification of services or labor negotiations with professional nurses as being ethically problematic.

How the Dilemma Was Solved

The responses to the question "How did you resolve this dilemma?" were diverse in process and content. Some were creative or innovative. Others were ordinary but effective and got the job done. Thirty-six were unresolved; two respondents did not know the resolution of the problem they had cited.

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Many of the dilemmas concerned with allocation of funds were associated with staff mix and level decisions. These dilemmas were resolved by working closely with nursing personnel including middle and first line managers, and nursing staff. Reorganization was sometimes done. At other times, reallocation was done, priorities set, and other adjustments made. In those situations where the nurse executives had to make difficult decisions, they made them.

In relation to dilemmas and the capital budget, they also used a wide range of strategies. They effectively balanced short-term needs and long-term goals to bring about as effective a solution as possible. Again they did not shirk from their responsibility of making the hard choices.

Thirteen of the dilemmas cited involved physicians. If the dilemma could not be directly resolved, the nurse executives directed the problem to those who could work out a resolution.

In working out resolutions of conflicts over staff wrongdoing, discipline, and punishment, the executive wanted justice for the employee and for the victim, if any. They seemed to want to do the right and the just thing.

In the resolution of dilemmas concerned with access to care for the medically indigent, the executives showed deep concern for the patients currently in their institutions, for those in the surrounding community, and for those in society in general who might need care at some future time. While taking their responsibility for the financial health of the hospital seriously, they also took their responsibility to patients seriously. In finding the best way to provide care to the indigent, they chose to "opt for the patient in most cases." They

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placed the patient in the unit that would be the best for that patient. In the case described of an indigent patient and a paying patient both needing the one available intensive care unit bed, it was the indigent patient who was given the bed.

A nurse executive developed a package to assist indigent, pregnant women in obtaining needed obstetrical care. The program provided for a one day stay, took medicaid as payment, assisted mothers in obtaining Medicaid, had an RN consultant program for screening, educating, and counseling patients, and found obstetricians to accept these patients. Participants in this program average 150 births a year out of 2000 total for the hospital. Another nurse executive was trying to assist the county to open a clinic that would provide comprehensive care. Others set up systems to provide for care for indigent pregnant patients whether they were to be cared for in their hospital or, when necessary, to be transferred to another agency.

A respondent was concerned about the lack of availability of healthcare for the homeless. She assisted the community in developing a program. When the request to transfer a patient to a state hospital for special care was refused because of lack of adequate reimbursement, the nurse executive went to the CEO of the institution that was refusing the transfer and lobbied for the patient's rights.

Repeatedly, the nurse executives wrote convincingly of dilemmas and the genuine desire to resolve the problems in the best way possible. To find solutions they seemed easy about going to multiple and varied resources. They appeared to be flexible in their implementation of the solutions.

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Satisfaction with Solution

Respondents were asked how satisfied were they with the solution to the ethical dilemma they described (Table 11). A total of 127 (72%) respondents indicated some degree of satisfaction with the solution. Fifty (28%) respondents were moderately dissatisfied or not at all satisfied with the solution.

Table 11. Satisfaction with solution of Dilemma

Level of Satisfaction	Frequency N=117	Percent %=100
Very satisfied	53	29.9
Moderately satisfied	36	20.3
Satisfied	38	21.5
Moderately dissatisfied	27	15.3
Not at all satisfied	23	13.0

Resources Used to Resolve Dilemmas

As indicated in the earlier question about most frequently used resources in resolving ethical dilemmas, most frequently the respondents relied on personal values, both their own and others'. The people to whom they turned were their administrative and nursing colleagues. Frequently, and appropriately, the nurse executives turned to their

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bosses: the CEO, president, or administrator, if not the top nurse or the vice president for nursing.

Other common resources were physicians, chiefs-of-service or department heads, social service colleagues, lawyers, first line managers, middle managers, nursing staff, nursing specialists, risk management, quality assurance, boards of trustees, committees, and community, county, state, and federal agencies. Four respondents used the Hospital Mission Statement, the ANA standards of practice, or the Patient's Bill of Rights. Six said they went to the literature. Nowhere was there any indication that their resources were insufficient.

Summary

The respondents to a nation wide survey of ethical dilemmas in nursing administration were a well-educated, mature group. The overwhelming majority were women. They encountered ethical dilemmas in their administrative practice in a wide range of situations. Among the most prevalent situations were the allocation of resources, including staff level and mix, care of the indigent, the developing and maintaining of standards of care, the competence of health care providers, employee relations, and hiring, promoting, demoting, and terminating employees.

Resources used to resolve the dilemmas were also varied and diverse. The most frequently cited were personal values of self, nursing and administrative colleagues, and superiors. The respondents used as many resources as necessary to resolve their dilemmas. Many respondents said they were satisfied with the results. There was no indication that the respondents lacked, or found insufficient, the

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resources to resolve their dilemmas. They were willing to jeopardize their positions for the good of patients and staff.

The dilemmas were experienced in many situations. These included making decisions about care for individual patients, policy interpretations for individual staff members, short-term and long-term planning, as well as strategic planning for groups of patients and staffs. In order to resolve the dilemmas they went to the appropriate people including subordinates, colleagues, superiors, their CEOs, boards of directors, and, when necessary, to outside local and government agencies.

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Chapter V

DISCUSSION

The purpose of this study was to describe the ethical issues nurse executives encounter in their work and to identify the facilitating and inhibiting factors perceived by nurse executives when making decisions that have ethical implications. There were three major findings in this research study: (1) nurse executives experience ethical dilemmas about a wide range of topics; (2) resources used to resolve dilemmas are varied and diverse; (3) dilemmas are experienced in many situations. In addition, it was found that the most important factors influencing decisions that have ethical implications were the superiors of the nurse executives and the politics within the institution. This chapter contains a discussion of these findings.

Demographic Characteristics

Analysis of the data yielded no statistically significant findings. Among the demographic features that might have had an impact on the present study were age, sex, years in administrative practice, and education. Only five percent of the respondents were men. While this is the approximate number of men who are employed as nurse executives nationwide, it is too small a number for comparative analysis. The other characteristics did not identify statistically significant relationships because this was a homogeneous group; 70% of the respondents had the same level of education - a masters degree. Most of the respondents were in the same age groups and had about the

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same amount of administrative experience. This left too few members in some cells on the crosstabulation tables.

Demographic data for nurse executives nationwide is not readily available. Two recent studies (Patz, Biordi, & Holm, 1991; Sabatino, 1991) produced results similar to those found in this study. Generalizability of the data was limited because of the populations studied. The study reported by Sabatino was conducted by Witt Associates, Inc. and AONE. Only chief nurse executives were included. How membership in AONE affects other demographic characteristics is unknown. Patz, Biordi, and Holm conducted a survey of academic health center chief nurse executives. There is a strong likelihood that there are differences when compared with nurse executives in community and other types of hospitals. Both of the above studies were nationwide. Neither of the studies gathered data on all of the characteristics solicited by this one. Taking this into consideration, the demographic data about nurse executives nationwide seems to be on target.

The demographic data in this study was compared with that in the Sietsema and Spradley (1987) nurse executive study. There were many differences in the demographic data of the nurse executives in the two studies. The majority of respondents in the 1987 study worked in hospitals of less than 50 beds and their years of experience in nursing administration was divided equally among the three categories of years of experience. This is different from the current study where three-fourths of the hospitals had 50 to 500 beds; only 6% had fewer than 50 beds. Instead of being evenly divided over the three categories for years of administrative practice, 64% of the respondents in the current study had more than 10 years and 11% had less than five years

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experience. Diploma graduates were in the majority in the 1987 study; 33% held baccalaureate degrees and 19% had masters degrees. In contrast, the current study showed a very different picture of education. Only 4% had a diploma and 20% had a baccalaureate degree; the majority (71%) held masters degrees. Despite these differences, the results were strikingly similar. The same issues were chosen as presenting ethical dilemmas most frequently in both groups: 90% in the 1987 study versus 97% in the current study chose issues related to the use of resources and the quality of care. The three most commonly used resources were the same in both studies, as was the percent of respondents reporting role conflict (30%).

In Sietsema and Spradley's study, 32% of the hospitals had ethics committees, while 72% of the hospitals in the current study had one. It is evident that organizations feel the need for this kind of resource.

It is interesting to note that about 30% (92) of the respondents made more than three choices of frequently encountered dilemmas, while 15% in the Sietsema and Spradley study also chose more than three. Sietsema and Spradley suggested that the respondents were not willing to limit themselves to only three choices. This may still be the case, but does not explain the doubling of the incidence from 15% to 30%. It may be that nurse executives have experienced an increase in ethical dilemmas during the intervening four years.

Ethics in Society

The nurse executives' perceptions of ethical concerns in society and in organizations were more optimistic than those of the public administrators in Bowman's (1990) study (Table 12). The respondents in

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Table 12. Comparison of Answers to Selected Questions for Nurse Executives and Public Administrators

Topic	Response	Nurse Executives % of response	Public Administrators % of response
Concern about ethics growing	agree	86	70
Moral numbness after decade of scandals	agree	45	60
	disagree	43	28
	undecided	12	12
Ethics like weather: all talk and no action	agree	18	39
	disagree	75	51
	undecided	7	12
Management practices render ethics meaningless	agree	11	29
	disagree	77	60
	undecided	13	11
Organizational approaches to ethics	reactive	16	22
	proactive	23	7
	inconsistent	60	64
	other	3	7

Source for Public Administrators data: Bowman, J.S. (1990). Ethics in Government: A national survey of public administrators. Public Administration Review, 50, 345-353.

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both groups were well-educated, experienced, middle or senior level managers with relatively high incomes. Sex was the major difference; the nurse executives were women and the public administrators were men.

The data in the current study indicated that most of the respondents did not believe that the current interest in ethics was only temporary. Eighty-six percent agreed that concern about ethics was growing. About 75% disagreed that nothing was done about ethics; only 18% agreed. Almost half (49%) agreed that outright criminality in society distracted from more subtle, genuine ethical dilemmas. The survey respondents, like the respondents in Bowman's (1990) study, saw a growing interest in ethics, but they also seemed somewhat more positive that something would come out of it than did the public administrators.

In response to the question whether such issues as toxic waste disposal, trade with South Africa, racial discrimination, and making weapons were ethical concerns of administrators, 63% agreed. From comments and remarks written on the questionnaires, it seemed that some had difficulty seeing their relationship to this question. While some respondents wrote comments that these were issues about which everyone should be concerned, others apparently thought that not all of these issues concerned them. The Persian Gulf war was fought during the time that the respondents answered the questionnaire. Its effect on the respondents answers is unknown, but the war could have highlighted the need for concern.

Ethics in Organizations

Respondents in both studies had similar beliefs about ethical concerns inside organizations although, again, the nurse executives were

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somewhat more positive. About half of each group felt that there was pressure to compromise personal standards to achieve organizational goals. Eighty-three percent of the nurse executives disagreed that their superiors had a stronger set of ethical standards than they did; only 1% agreed. Nearly 75% of the public administrators disagreed and 3% agreed that the standards of superiors were stronger. The reason for this was unclear. It did seem to indicate that nurse executives had at least some wariness about the ethical conduct of their superiors.

Factors that affect ethical behavior include one's own values and those of peers, subordinates, and superiors, along with the values inherent and expressed in the written policies and statements of the organization plus their implicit expectations. Seventy percent of the nurse executives agreed that while individuals were responsible for their own actions, and American nursing encourages autonomy of decision-making, organizations defined and controlled situations in which decisions were made. This seems to reinforce the idea that organizations are a source of social control. It also helps to explain why young nurses with little experience seem to make decisions that are more in the interest of the institutions than in the interest of the patient. And it underscores the imperative that nurse executives and other top administrators must develop and maintain an organizational climate that supports ethical decision-making.

Almost a quarter (23%) of nurse executives said that organizations took a proactive approach in addressing ethical issues, about 60% said that most organizations had no consistent approach, and 16% said that most took a reactive, legalistic, blame-punishment approach. If a key function of nursing administration is to develop, maintain, and

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implement the nursing division philosophy which states and supports the values and beliefs that influence the practice of nursing in a particular institution, then nurse executives must work to make their institutions' policies consistently conducive to ethical behavior. This means that the everyday moral issues and work ethic issues are deemed important even as the life and death issues of bioethics are important. (According to this survey, there is some consensus regarding work ethics.) A moral climate throughout the organization will benefit staff, employees, physicians, patients, and families as well as administrators.

Over half (57%) of the respondents believed that they did not need to rely on some document, law, or rules; 44% felt that as an administrator they did not need to ultimately make decisions based on "the greatest good for the greatest number." This seems to say that nurse executives are confident that they will make just and responsible decisions in most situations. Almost all respondents indicated that they were to raise ethical questions at work.

The nurse executives were generally more positive about the Code for Nurses than the public administrators were about the American Society for Public Administration (ASPA) Code. More nurses were familiar with the Code for Nurses than ASPA members were with their code. This may be explained by the fact that nurses have had their code for a longer time than have the public administrators. The first nursing code was the Nightingale Pledge, which was written in the United States in 1893. The American Nurses' Association first discussed the need for a code in 1897 bud did not develop one until 1950. In contrast, the ASPA code was adopted in 1984 (Bowman, 1990). Nursing's

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long history of having a code may account for the overall positive view nurse executives have about codes and their effectiveness.

Questions about membership in organizations and use of the organization's code of ethics in resolving ethical dilemmas were asked to see if there was a relationship between such membership and use of the code. Membership in an organization was not related to the use of its code. Membership in the ANA was not related to whether or not the respondent was familiar with the code.

Sietsema and Spradley (1987) found that 75% of nurse executives belonged to at least one organization. While all of the respondents in this study were members of AONE, other membership behavior of other nurse executives in general cannot be assumed. In a marketing survey of membership in state and district nurses' associations, it was found that those nurses who belonged to the state/district association tended to belong to other professional organizations; those who tended not to belong to the state/district association did not belong to other organizations (Camuñas, Alward, & Vecchione, 1988). The marketing survey also found that as education increased membership in organizations increased.

Ethical Issues in Administrative Practice

As has been described previously, 94% of the nurse executives reported that they encountered ethical dilemmas when making daily administrative decisions. Of the 6% who said that they did not encounter such dilemmas, it is unknown how many did not recognize or label a situation as having a moral component.

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Ethical Conflict Between Role Obligations

Approximately 30% of the respondents said that they had experienced ethical conflict between the moral obligations of their administrative practice and the moral obligations as a professional nurse. For almost half of these respondents the dilemma centered around their professional values of providing high quality care to all patients and their administrative responsibilities of conducting sound financial transactions. The remaining respondents cited the organizational politics, involving physicians or the CEO, and bioethical issues as sources of role conflict. Several respondents centered their role conflict on staff rather than on patients. It is unclear how the bioethical issues resulted in conflict between the role of professional nurse and the role of administrator.

Sietsema and Spradley (1987) found a statistically significant association between the absence of an institutional ethics committee and the executives' report of experiencing ethical conflict between the administrative and professional nursing role obligations. No such association was found in the current study.

It is unclear why 30% of nurse executives experienced conflict while the majority apparently were able to handle their positions and conflicts in such a way that they did not encounter dilemmas between roles. It is possible that some do experience moral conflict over role obligations and do not identify or label the conflicts as such. Still another possibility is that the nurse executives are uncomfortable sharing their personal ethical dilemmas. Nurses are used to and are comfortable discussing ethical dilemmas that are not their own. Nurses

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advocate for patients' rights and for all of the ethical issues important to and for patients, and nurses fight for ethical issues concerned with professional nursing. Rarely do nurses talk about personal feelings and dilemmas related to themselves and not to others; to do so is to take a risk. It may be that respondents did not feel that it was safe or acceptable to tell the researcher about their personal ethical dilemmas. They knew little about this researcher, which may have contributed to a reluctance to expose themselves.

Descriptions of Dilemmas

By their response rate to this study and by their responses to the questions related to ethical dilemmas encountered when making administrative decisions, it seemed apparent that nurse executives considered this topic important. However, approximately one third of the respondents failed to provide a description of the last dilemma they encountered. This may have been because they did not want to take the time to write, or it may have been because of inexperience in discussing personal ethical dilemmas as described above.

The nurse executives did indicate that they experienced ethical dilemmas in a wide range of situations. When content analysis of the descriptions regarding the moral issues inherent in the described dilemmas was done, all ten of the universal moral issues identified by Kohlberg (1976) were uncovered. (These universal issues were: (1) laws and rules, (2) conscience, (3) personal roles of affection, (4) authority, (5) civil rights, (6) contract, trust, and justice in exchange, (7) punishment, (8) the value of life, (9) property rights, and (10) truth.) The issue of contract, trust, and justice was the one

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most frequently found in the descriptions. This was, perhaps, predictable. Health care professionals have an unwritten, assumed contract with patients that the patient will receive the appropriate care required and will certainly not be harmed. Patients trust professionals to fulfill their part of the contract in a just manner. In exchange, society pays professionals for their service and accords them social status and respect.

The dilemma about giving merit raises, cited by a middle manager, was initially a difficult problem. It became an ethical issue when the decision was made to be less than honest with the staff. The moral issue of contract, trust, and justice in exchange and the issue of truth were both violated when the manager chose to decrease the raise of the nurses not yet informed of their raises in order to grant one more nurse the raise to which she was entitled. This middle manager used the vice president of nursing and a peer as resources to solve the dilemma. The fact that she indicated on the questionnaire that she was moderately dissatisfied may reflect her discomfort with the solution; mature individuals have learned to associate anxiety with their own deviance (Simpson, 1976).

The moral issues that were found least frequently were personal roles of affection and conscience. However, the nurse executives seemed to function as the consciences of the institutions. Truth was an implicit component of the dilemma in 50 of the cited dilemmas. The value of life was an issue in 58 of the examples, most of which focused on bioethics and patient care and were not related to administrative practice by the respondents.

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Undoubtedly, bioethical issues are important and are encountered frequently. The frequency of the respondents' citing these issues without relating them to their administrative practice may indicate a greater ease in discussing them or even thinking about them. These patient-centered ethical issues are discussed frequently in the literature, at meetings, and in the lay media. Professionals have developed a kind of fluency in discussing them.

Resolution of Dilemmas

The respondents resolved their dilemmas in many appropriately different ways. They were willing and able to go to a wide variety of resources to find a solution. Since the choices of dilemmas and the solutions described were those of the respondents, one must be careful about interpreting these results. The nurse executives may have chosen the dilemmas they wrote about because they were comfortable with how they dealt with and resolved them. They may have avoided mentioning other dilemmas or resolutions that made them uncomfortable.

Sietsema and Spradley (1987) raised the question as to whether the prominent use of personal values (their own and those of administrators and nursing colleagues) was an acceptable mode of practice for nurse executives. They also questioned the efficacy of the use of deontological or duty focused codes of ethics such as the Patients Bill of Rights, when nursing administration has a more utilitarian focus. The use of these resources did not seem to present a conflict to the respondents in the current study.

In their responses to the multiple choice questions, the respondents indicated that they did not need written rules and

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guidelines for their decisions, nor did they need to follow the utilitarian concept of "the greatest good for the greatest number." By their responses to the open-ended questions, the respondents seemed to be comfortable making decisions based upon a particular situation. They did not seem to require a formula.

While it was beyond the scope of this study to measure levels of moral development, it seems likely that many of the respondents had a high level of moral development. The respondents seemed to consider both the moral and legal points of view for individuals and for groups; they seemed to feel that the basic moral premise of respect for other people was an end not a means.

When looking at solutions to ethical problems, it must be remembered that there are no simple answers. The choice often is not between good and bad or right and wrong. The choice may involve two goods or doing the least harm. For example, some of the dilemmas regarding allocation of funds involved using money to pay overtime for patient care or using it to buy emergency equipment. In a dilemma about access to care for the medically indigent, one good could be treating patients who could not pay. However, to keep an institution economically solvent and able to continue to provide care would be another good.

Because institutional finance has become such a driving force in decision-making, nurse executives have encountered more ethical dilemmas. Many of the choices have been difficult ones and many have not been entirely satisfactory. The nurse executives were able to identify their own position and seemed to be able to interpret such difficult issues to their staffs. On this basis it appeared that the

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respondents made good use of, and found adequate, their resources for resolving their ethical dilemmas concerning administrative decisions.

An area about which the respondents did not talk was the unethical behavior of business administrators. None of the respondents discussed fraudulent misappropriation of funds that led to a decrease of funds in needed patient care programs, or for staff or equipment. While this kind of behavior does not often reach the mass media, it does occur and employees generally know about it.

Seven nurse executives resigned from their positions. From their descriptions of their situations, resignation was a reasonable decision. Four resigned after a year of trying to resolve the dilemma. One of these resigned after finding a workable solution. Three resigned after a shorter period of time when it seemed that a fundamental difference of values was at the root of the conflict; there would not be a better resolution for them than removing themselves from the situation. These three stated that resignation was a very satisfactory solution.

Sietsema and Spradley (1987) questioned the effectiveness of nurse executives' use of administrative colleagues as a resource more frequently than nursing colleagues. However, the higher the nurse executives are in the hospital hierarchy, the more likely it is that they will have administrators who are not nurses as peers and as the person to whom they report (such as the CEO). Discussing ethical issues with these people is a rational and reasonable decision.

Among the most important factors perceived by nurse executives when making decisions that have ethical implications were their superiors and the politics of the institutions. These two factors were

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either facilitating or inhibiting, depending on the attitudes and behaviors of the people involved.

Implications

The findings of this study shed some light on the ethical issues surrounding administrative decision-making, an area in which little research has been done. These findings therefore hold many implications for nursing.

Nurse Administrators

Study findings have implications particularly for nursing administrators. Because of the need for cost containment, finances will continue to be a controlling force in the health care system in the foreseeable future. As a result, funding will continue to be problematic. Nurse executives will continue to encounter complex situations in their administrative decision-making. The decisions they make will have important ramifications on the efficient and effective running of any hospital. Therefore, nurse executives need to know and demonstrate their own and their hospital's position on ethical issues in order to provide the required leadership. Nurse executives need to look at the ethical implication of nursing practice and of institutional policies and strategies. They also need to examine moral issues related to business decisions.

As mentioned earlier, the single most important factor in the ethical climate of an organization is the attitude and behavior of top management (Baumhart, 1961). Subsequent research supports this finding. In fact, it is one of the few undisputed findings of business ethics

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research (Laczniak & Murphy, 1985). Top nursing management have to be ever-mindful of their influence on other managers and staff. There is a need to focus attention on ethics in the everyday life of the organization.

Nurse Educators

Findings from this study have implications for undergraduate and graduate educators also. Educational programs with clearly defined instruction in general ethics and ethical decision-making skills as well as in bioethics need to be developed to prepare nurses for positions at all levels. This was a clearly stated need by the respondents of this study.

An important area for change in the curriculum is the ideology on which we base nursing care: "total patient care" or "comprehensive care." Traditionally nurses have been guided by a goal driven-model. That is, first we identify our goals and then we find the resources needed to achieve those goals. This may have been adequate during times of abundant resources. It is ineffective in times of resource restriction. With the goal-driven model nurses often do a superb job with limited resources but end up not feeling very good about it because they have not provided idealized comprehensive care.

As resources of all types become more scarce, nurses must learn to use resources in the most effective way and to feel good doing so, or at least not encounter a severe disjuncture between ideology and practice. Again, this is true for all levels of nurses, from staff to executive. For nurses to base their practice on the resource-driven model discussed and advocated by Stevens (1985) rather than on the idealized goal-driven

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model traditionally used would help nurses avoid conflicts between reality and an impossible ideal. The goal-driven model is not compatible with the continuing constraints of cost-containment and scarce resources which dominate the current health care environment. Changing the dominate ethos of the profession would help to reduce conflict for all nurses. It would also assist in developing the ethical basis of nursing practice.

Staff Development

In addition, there are implications for staff development programs for both nursing staff and management. Programs that teach the process of ethical decision-making for all levels of nurses would enhance the ethical climate. Providing education for managers on ways to enhance and facilitate support for those encountering ethical dilemmas would also assist in developing an ethical climate.

Suggestions for Further Research

Some questions have been answered by this study and, as often occurs in the research process, new questions are raised by those answers. Several questions may be asked as a result of the findings of this research.

What is the level of moral development of nurse executives? Is there a relationship between moral reasoning and moral behavior? Nurse executives deal with issues of moral complexity in their everyday administrative decision-making. Since we know that moral development is learned and that moral reasoning can be enhanced through education and

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critical thinking, the education and experience a nurse executive brings to a situation may affect the quality of moral reasoning and decision-making.

Are ethical values consistent throughout the organizational hierarchy? Because the attitudes and behavior of top management is shown to be so important a factor in an organization those of the CEO and chiefs-of-staff would be important to understanding, developing, and maintaining an ethical environment.

Are the ethical dilemmas and resolutions of those dilemmas of male nurse executives different from those of female nurse executives? While there is much debate in the literature relating sex to moral reasoning, there are no studies looking at differences of sex in nursing. This is probably because the number of male nurses is small (3% of general nurse population and about 6-8% of nurse executives).

In short, many questions arise out of the findings of this research. These relate to understanding levels of moral reasoning, the effects of moral issues and the decisions regarding those issues throughout the institution, and how an ethical climate can be developed, enhanced, and maintained in an institution. Potential areas for future research are, in fact, unlimited.

Summary

This research was designed to describe the ethical dilemmas encountered in nursing administration. The need for the study was based on: (1) the overall interest in and concern of society and nursing about ethics, (2) the lack of research on ethical decision-making and moral reasoning related to nursing administration, (3) the need for ethical

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climates in health care organizations. The results of this research were intended to benefit all levels of nursing management by providing ground work for understanding ethical dilemmas in administration.

The rationale for the study was based on the work of Kohlberg (1976) and Gilligan (1982) and their concern for the principled resolution of ethical dilemmas. Nurse researchers have begun to validate aspects of moral reasoning using Kohlberg's model (Crisham, 1981; Ketefian, 1981a, 1981b).

A questionnaire was developed using two instruments that had been used, one in a study of public administrators (Bowman, 1990), and the other in a study of nurse executives (Sietsema & Spradley, 1987). Four open-ended questions were developed for this research. The questionnaire was mailed to a random sample of 500 nurse executives who were members of AONE.

The response rate was 63%. The respondents were a homogeneous group. Statistical analysis yielded no significant differences. Content analysis was done on the open-ended questions and was presented in narrative form. The major findings of this research were: (1) nurse executives experience dilemmas about a wide range of topics, (2) resources used to resolve dilemmas are varied and diverse, (3) dilemmas are experienced in many situations. It was also found that the attitudes and behaviors of superiors and the politics of the institution were perceived as either facilitating or inhibiting by nurse executives when making decisions with ethical implications.

The most frequently encountered ethical dilemmas involved allocation of resources and quality of care issues. These dilemmas were encountered in such different situations as short-term, long-term and

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strategic planning, performance appraisal, and other management functions. Nurse executives most frequently relied on their own personal values and those of administrative and nursing colleagues to resolve their dilemmas. They did turn to other resources as was appropriate to the specific dilemma. Available resources for resolving ethical dilemmas seemed to be sufficient.

The results have implications for nursing administration, nursing education, and staff development. They underscore the need to know more about ethical decision-making as it relates to administration and organizational climate. They confirm that ethics needs to be taught at the undergraduate and graduate levels, and that staff development should incorporate ethical management into its programs.

Although a limitation was cited, it does not detract from the importance of these findings. The generalizability of the study is limited because all the participants were members of AONE.

Several potential areas for research were identified. These include an investigation of the levels of moral reasoning, the relationship between moral reasoning and moral behavior, the consistency of ethical values throughout the organizational hierarchy, and the difference between or similarity of ethical dilemmas and the resolution of those dilemmas encountered by female and male nurses. These topics would provide useful data for nurse executives concerned with the multi-faceted bottom line that includes quality and ethics as well as finance.

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Appendix A

INSTRUMENT

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Ethics in Nursing Administration

Please indicate your answers by placing a check on the line corresponding to the appropriate response.

I. Demographic Data

A. Sex:
1. __female
2. __male

B. Age:
1. __under 30
2. __30-39
3. __40-49
4. __50-59
5. __over 60

C. Number of years in patient care administration:
1. __less than 5 years
2. __5 to 10 years
3. __more than 10 years

D. Size of hospital where you are employed:
1. __under 50 beds
2. __50 to 250 beds
3. __251 to 500 beds
4. __over 500 beds

E. Geographic setting of your hospital:
1. __large city (population over 100,000)
2. __small city (25,000-100,000)
3. __town (10,000-24,900)
4. __small town (less than 10,000)
5. __rural area

F. Governing affiliation of your hospital:
1. __government (federal, state, city, county, community)
2. __church or religious organization
3. __private nonprofit
4. __for profit
5. __other

G. Annual salary:
1. __ $25-35,000
2. __ $35-65,000
3. __ $65-85,000
4. __ $85-100,000
5. __ over $100,000

H. Position: _____
1. __middle management
2. __top management

I. Does your hospital have an ethics committee?
1. __yes
2. __no

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J. Basic nursing preparation (entry into nursing):
1. __diploma
2. __associate degree
3. __baccalaureate
4. __masters
5. __doctorate

K. Highest degree held: _____ Field: _____

L. Are you a member of a professional (health or nursing related) organization?
1. __yes
2. __no
If yes, please specify: _____

Ethical issues and dilemmas involve situations when alternatives are equally satisfactory, or when a difficult problem seems to have no satisfactory solution, or when alternatives are equally unsatisfactory.

II. Ethical Data

A. Do you believe that you have a moral responsibility as a practicing patient care administrator to identify ethical issues related to your administrative practice?
1. __yes
2. __no

B. Do you feel that you encounter ethical dilemmas when making daily administrative decisions?
1. __yes
2. __no
If no, proceed to Question F.

C. What types of decisions do you believe most frequently present ethical dilemmas for you? (Please select three.)
1. __allocation and rationing of scarce resources
2. __access to care for the indigent
3. __staffing level and mix decisions
4. __promotion/demotion of employees
5. __selection/hiring of employees
6. __treatment vs. non-treatment
7. __downsizing services
8. __diversification of services
9. __marketing/advertising services
10. __developing/maintaining standards of care
11. __incompetent physicians
12. __incompetent nurses
13. __employee relations
14. __labor negotiations with professional nurses

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D. What resources do you most frequently use when resolving ethical dilemmas? (Please select three.)

1. __ANA *Code for Nurses*
2. __AMA *Medical Ethics Code*
3. __*Patient's Bill of Rights*
4. __AHA *Ethical Conduct and Relationships for Health Care Institutions*
5. __hospital chaplain
6. __personal spiritual counselor
7. __friends/family
8. __institutional ethics committee
9. __administrative colleagues
10. __CEO/Board of Trustees
11. __personal values
12. __nursing colleagues
13. __other _____

E. Ethical conflicts exist when ethical beliefs are at variance or in opposition to each other. Do you believe you experience ethical conflict between the moral obligations of your administrative practice and your moral obligations as a professional nurse?

1. __yes
2. __no

If yes, please describe:

Using the key below, please circle the number that best represents the extent to which you agree or disagree with the statements below. No answer is "right" or "wrong"; it is your opinion that is important.

Strongly Agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

1. Society today suffers from a "moral numbness" following a decade of scandals involving Wall Street, religious organizations, the Pentagon, Congress, and the White House.

1 2 3 4 5

2. Interest in ethics may vary, but concern seems to be steadily growing.

1 2 3 4 5

3. Discussing ethics with most managers is difficult because they are concerned with appearing too idealistic or "Sunday-schoolish."

1 2 3 4 5

4. Ethics is similar to the weather; everyone talks about it, but no one does anything about it.

1 2 3 4 5

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Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	2	3	4	5

5. Such issues as toxic waste disposal, trade with South Africa, racial discrimination, and making weapons are ethical concerns of administrators.
1 2 3 4 5

6. All people, especially managers, encounter ethical dilemmas at work.
1 2 3 4 5

7. The role of professional associations such as ANA in affecting the ethical behavior of its members is very limited.
1 2 3 4 5

8. When making a decision, an administrator must ultimately rely upon some authoritative document, law, or set of rules.
1 2 3 4 5

9. When making a decision, an administrator must ultimately rely upon "the greatest good for the greatest number."
1 2 3 4 5

10. Ethical standards are harder to enforce in large, multi-divisional agencies than in small agencies.
1 2 3 4 5

11. Expressions of ethical concern at work evoke cynicism, self-righteousness, and/or laughter.
1 2 3 4 5

12. Ethical concern can be empowering in organizational life.
1 2 3 4 5

13. Current management practices render ethics meaningless because organizational cultures encourage a Machiavellian philosophy of power, survival, and expediency.
1 2 3 4 5

14. Incidents of outright criminality in society distract attention from more subtle, genuine ethical dilemmas in our workaday lives.
1 2 3 4 5

15. When confronting ethical concerns at work, I take the view that, "Mine is not to question why, mine is but to do or die."
1 2 3 4 5

16. Ethical issues are adequately covered in management training courses.
1 2 3 4 5

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Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	2	3	4	5

17. While individuals are ultimately responsible for their own behavior, organizations define and control the situations in which decisions are made.

1 2 3 4 5

18. To make progress in a career, some will occasionally indulge in "dirty" tactics (e.g. taking credit for someone else's work, concealing mistakes, "stepping" on other people).

1 2 3 4 5

19. Actions such as doing personal business on agency time, taking extra personal time (e.g. frequent work breaks), and not reporting violations of policy are unethical.

1 2 3 4 5

20. Actions such as passing blame to others, falsification of reports, claiming credit for someone else's work, padding expenses, divulging confidential information, and accepting favors in exchange for preferential treatment are unethical.

1 2 3 4 5

21. Actions such as authorizing subordinates to violate rules, calling in sick to take the day off, concealing errors, and taking longer than necessary to do a job are unethical.

1 2 3 4 5

22. My peers have a looser set of ethical standards than I do.

1 2 3 4 5

23. My superiors have a stronger set of ethical standards than I do.

1 2 3 4 5

24. Administrators feel under pressure to compromise personal standards to achieve organizational goals.

1 2 3 4 5

25. The ethical behavior and overall performance of organizations with codes of ethics is indistinguishable from that of organizations that do not have them.

1 2 3 4 5

26. There is an on-going effort to reinforce an ethics code in my organization.

1 2 3 4 5

27. Codes of ethics have so many inherent limitations as to render them essentially ineffective.

1 2 3 4 5

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Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	2	3	4	5

28. There is no real need for codes of ethics in organizations.
1 2 3 4 5

29. The greater congruence of a code with pre-existing values of employees, the greater the effectiveness of the code.
1 2 3 4 5

30. A code with a clear management commitment to enforce it will encourage attitudes supportive of ethical behavior.
1 2 3 4 5

31. Are you familiar with the ANA *Code for Nurses*?
1. __yes
2. __no

32. If yes, please select the choice below that best describes your familiarity with the Code.
1. __I have heard of it.
2. __I have a general familiarity with it.
3. __I am quite familiar with it.

33. Please choose the statement that best describes the approach that organizations take in addressing ethical concerns.
1. __Most organizations have a reactive, legalistic, blame-punishment approach that focuses on discouraging and detecting unethical behavior.
2. __Most organizations have proactive, human-development, problem-solving approach that focuses on encouraging ethical behavior and deterring unethical behavior.
3. __Most organizations have no consistent approach.
4. __Other (please specify)
_____

Please describe your experience regarding the following issues (use additional paper as needed).

34. Describe the last situation concerned with developing/maintaining standards of care that you encountered that presented a dilemma for you.

35. How did you resolve this dilemma?

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How satisfied were you with the solution?

1. __very satisfied
2. __moderately satisfied
3. __satisfied
4. __moderately dissatisfied
5. __not at all satisfied

36. Please describe to what or to whom you turned for assistance in resolving the above dilemma.

37. In what other areas have you encountered dilemmas?

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Appendix B

COVER LETTER

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OFFICE OF DOCTORAL STUDIES

STUDENT WORKROOM

TEACHERS COLLEGE
COLUMBIA UNIVERSITY
NEW YORK, NEW YORK 10027

[redacted]
January 2, 1991

Dear Colleague:

I am a doctoral candidate in nursing administration at Teachers College and, for my dissertation, I am investigating the ethical dilemmas encountered by nurse executives. Because of technological advances and cost-containment policies, ethical problems and controversies are prevalent in health care and are bound to increase. Since little is known about the ethical dilemmas of managerial decision-making this is a descriptive study. Five hundred randomly selected nurse executives nationwide are being asked to participate. The mailing list was obtained from AONE. I am requesting that you take part in this study. Your experience is important. Please be assured than your responses will be anonymous and confidential. Your name will not be associated with any of the data.

Enclosed is a questionnaire and a stamped, addressed envelope. The survey takes approximately a half hour to answer. Please complete and return it to me as soon as possible. You will not receive any follow-up reminders. Thank you very much for your help.

Sincerely,

Caroline Camuñas, EdM, RN

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Appendix C

PERMISSIONS

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Margaret R. Sietsema, MPH, RN, CNA
Director of Nursing Services
Rice Memorial Hospital
[redacted]

Dear Ms Sietsema:

I am writing a doctoral dissertation at Teachers College, Columbia University. The title is Ethical Dilemmas of Nurse Executives: A Descriptive Study. It will be completed May, 1991. I request your permission to adapt and include your Patient Care Administration Ethics instrument in this dissertation.

Please indicate agreement by signing and returning this letter. In signing, you warrant that you are the sole owner of the rights granted and that your material does not infringe upon the copyright or other rights of anyone else. If you do not control these rights, I would appreciate your letting me know to whom I should apply. Thank you.

Sincerely,

[redacted]

Caroline Camuñas, EdM, RN
[redacted]
New York, NY 10025

Agreed to and accepted:

by [redacted] 3/8/91
signature *date*

Credit and/or copyright notice:

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James S. Bowman, PhD
Professor
Department of Public Administration
The Florida State University
Tallahassee, Florida 32306

Dear Professor Bowman:

I am writing a doctoral dissertation at Teachers College, Columbia University. The title is Ethical Dilemmas of Nurse Executives: A Descriptive Study. It will be completed May, 1991. I request your permission to adapt and include your Ethics in Government instrument in this dissertation.

Please indicate agreement by signing and returning this letter. In signing, you warrant that you are the sole owner of the rights granted and that your material does not infringe upon the copyright or other rights of anyone else. If you do not control these rights, I would appreciate your letting me know to whom I should apply. Thank you.

Sincerely,

[redacted]

Caroline Camunas, EdM, RN
[redacted]
New York, NY 10025

Agreed to and accepted:

by [redacted] 3/10/91

signature *date*

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