NURSES' NEGOTIATION PROCESSES IN FACILITATING ETHICAL DECISION-MAKING IN PATIENT CARE

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This thesis is dedicated to my husband, Arthur, who, as the passage from Gibran's The Prophet says, gave his heart, stood with me, and let me grow with him but not in his shadow, and to my parents, for their unwavering love and faith in me.

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LIST OF ABBREVIATIONS

AUL	Assistant Unit Leader
CABG	Coronary artery by-pass graft
CPR	Cardiopulmonary resuscitation
DNR	Do not resuscitate
ICD	Internal cardiac defibrillator
IV	Intravenous fluids
LPN	Licensed practical nurse
OSHA	Office of Safety and Health Administration
PIT	Pediatric Intensive Therapy
VTACH	Ventricular tachycardia

SUMMARY

Nursing practice involves assessing, planning, implementing, and evaluating a patient's plan of care. At each step in the process, the nurse makes judgments. Those judgments are not value-neutral. The judgments are ethical decisions and actions that follow are moral actions. This study was conducted to explore the processes nurses use in making these ethical decisions in patient care, and to learn how they facilitated ethical decision-making of their patients. Eighteen (18) nurses working in eleven different units of the same medical center were interviewed; half of them were interviewed two or more times. Employing a naturalistic inquiry methodology, ongoing data analysis was conducted to focus the line of inquiry and to direct sampling decisions.

The major findings were these: Every interaction the nurse has with a patient is a moral interaction; nurses are motivated by respect for the patient's autonomy and desire to prevent harm; nurses have internalized their sense of right and wrong and operate from their feelings; the "doctor-nurse" game first described by Stein in 1967 continues; nurses pass through a maturational phase, usually early in their career or in orientation to a new unit, in which they experience cognitive dissonance; nurses decide what they believe is the right course of action, then proceed in the manner in which they were socialized to bring about the outcomes they desire; the interactive style nurses use with physicians is characteristic of oppressed group behavior; nurses feel responsibility to safeguard patients and thereby monitor their medical management, but do not want the legal authority to write orders; nurses believe they provide information, clarification, and reflection for patients when they are making major health decision, but that the patients freely make their choices.

I. INTRODUCTION

> "The nature of nursing practice, which makes nursing ethics unique, derives from the constant, intensive, and direct relationship that nurses have with patients. They are the care givers present to witness their patient's loss of autonomy. They are there to question the competency, the invasions of privacy, the breaches of confidentiality, and the needs for patient advocacy. Their daily obligations expose them to a range of various dilemmas that require ethical responsiveness. Additionally, nurses often face conflicting allegiances by virtue of their varied obligations not only to patients and patients' families, but also to the other healthcare givers involved in their patients' care and to their employing institutions." (Hayne, Moore, and Osborne, 1990, p. 11)

Nurses have been dealing with ethical issues since the beginning of the profession. As nursing practice has changed, nurses' responsibilities in dealing with ethical issues have changed, as illustrated by the above quote. This study investigated a critical aspect of ethical decision-making by nurses in the clinical setting. The critical aspect was the process of negotiation a nurse undertakes in order to deliver what the nurse believes is ethically appropriate nursing care. Nurses are taught to assess their patients, identify their needs, and develop and implement a plan of care that will meet their patient's needs. In the current health care delivery system, nurses are required to interact with a number of individuals who have direct authority over the interventions the nurses wish to implement. The skills that the nurses must employ to obtain permission to implement specific interventions are described by the 18 nurses who engaged in this naturalistic study.

A. Research Question

What is the process by which nurses interact with others in order to deliver ethically appropriate care? Different ethical decision-making processes for nurses have been described in the literature. There is no detailed description of the interactive processes nurses undertake in the decision-making process, yet in the clinical experience of the author, the interaction is the critical aspect of the process that moves it toward resolution. The interaction represents many dimensions of the

nurse's role: the moral authority of the nurse, the nurse's autonomy, the relationships the nurse has with the patient, family and/or significant others, physician, other nurses, other health care professionals, administrators, and third party payors. The recognition of the need for interaction, the manner in which it is done, the emotional and psychological energy involved, and the sequelae are all aspects of the interactive process that have not been described.

For successful implementation of the nursing process, the patient's plan of care must be developed. In the nursing process, the plan for the delivery of care relies upon the nurse's ability to implement the plan. The medical plan and nursing plan should be compatible. If not, the onus for change is usually on the nurse, since nurses typically are aware of the medical plan, but the physician may not be aware of the nursing plan. While there is no literature to support the following assumption, it is the investigator's experience that the physician assumes nursing care will be planned according to the medical plan and the physician does not seek to learn the nursing plan of care unless a conflict arises. For example, the physician writes orders for chemotherapy to treat a patient's malignancy. The nurse discovers during her assessment that the patient does not wish to be treated. The nurse now experiences ethical conflict in not being able to satisfy the patient's wishes and follow the physician's orders. The nurse can develop a plan of care that reflects the physician's orders despite the patient's wishes to forgo treatment, or the nurse can begin the process to resolve the ethical conflict.

One particularly troubling situation was described to the investigator and served as a stimulus in identifying the research question. Mrs. A. was an elderly woman who had suffered a number of strokes and was now in a persistent vegetative state. Her nursing care consisted of routine vital signs, positioning, suctioning, intravenous fluids, administration of anticonvulsants, and prn antipyretics. Her daughter, who flew in from the West Coast, came to the hospital, saw her mother, and

spoke with the physician. At that point she closed the door to her mother's room and instructed the nurses to stay out of her mother's room, not to touch her mother, and to call her when her mother had died. The nurses expressed concern that they could not administer anticonvulsants or antipyretics although the patient was febrile and at risk for a seizure. They could not suction her although audible gurgling was heard. They believed that the daughter was the durable power of attorney; therefore, her requests had the weight of the patient's requests. Their attempts to explain their rationale for the care they wished to give were rebuffed by the daughter, who stated that their manipulation of her mother only prolonged the dying process and the withholding of their care would hasten the death of her mother. The nurses consulted with a clinical ethicist because of their discomfort in withholding what they thought was ethically appropriate care. The ethicist identified these questions: Who is the durable power of attorney, what life-sustaining measures should be withheld and who should decide, what is the distinction between routine nursing care and life-sustaining measures? Additionally, the ethicist observed a lack of communication between the physician and the nursing staff and between the daughter and the nursing staff, and the nursing staff's perceived powerlessness in giving care they feel to be appropriate and indicated for this patient.

This scenario illustrates two areas of focus for this study. The first area concerns application of ethics and ethical decision-making. According to the literature, ethical conflict in the health care setting can be resolved through the application of an ethical decision-making process (Thompson & Thompson, 1985). Like clinical reasoning, ethical decision-making is a step-wise process leading to the resolution of a problem. Values and ethical principles are identified and given as support or justification for adopting a course of action. Historical trends leading to current approaches in ethical decision-making in patient care will be reviewed. The second area of focus represented by the scenario is the nurse's role in the process of

ethical decision-making. The nurses described their feelings of discomfort when they were instructed by the daughter not to touch the patient, thereby preventing even comfort care. Applying an ethical decision-making model could have resulted in their conclusion that the daughter has absolute authority in decision-making and to challenge her authority shows a disregard for the autonomy of the patient, as exercised by her durable power of attorney. The nurses then are still left with the discomfort in feeling prohibited in giving what they believe is appropriate nursing care to this patient. In this case, the nurses chose to consult an ethicist to guide them in their ethical decision-making process. Nurses often need to interact with others--patients, family members, physicians, other health care team members--to deliver the kind of nursing care they feel is ethically appropriate. Yet, as the review of literature will reveal, there is little direction given in application of the prescriptive models of ethical decision-making, or little description between the steps of the process in normative models of ethical decision-making. To provide a background for the context in which nurses practice and face ethical issues currently, a historical perspective is offered.

B. Historical Perspective of Ethics in Patient Care

Medical care, since the beginning of the profession, relied on the unquestioned authority of the physician. Out of respect for his advanced knowledge and protected by the oath to "Primum non nocere" (above all, do no harm), patients put their lives in the hands of the physician. Treatment decisions were left to the physician who often had little technology to offer. Paternalism in medical care was expected and accepted. Medical ethics consisted of protecting the patient, often by withholding information from the patient, and making decisions unilaterally.

Nursing ethics pertained more to appropriate etiquette in a given situation and to the virtues of a good nurse (Fowler, 1992). The nurse's loyalty to the physician

over advocacy for the patient was stressed. Dock wrote in 1917, "In my estimation obedience is the first law and the very corner stone of good nursing. And here is the first stumbling block for the beginner. No matter how gifted she may be, she will never become a reliable nurse until she can obey without question." (Pence and Cantrall, 1990, p. 11). Dock continued to describe how military discipline, with the physician as the nurse's immediate superior, is necessary for the education of nurses and the acceptable behavior of nurses in health care settings.

The Somera case, however, challenged the nurse's obligation to follow physician's orders without questions. Ms. Somera was sentenced to a year in jail for preparing a syringe of 10% cocaine that was given to a 13 year old girl during a tonsillectomy. One of the physicians on the case had asked that the solution of 10% cocaine be prepared, and during the procedure, had given the patient three injections with the solution; the patient convulsed and died. The physicians were acquitted because the precise cause of death could not be determined. However, Ms. Somera was found guilty of reckless homicide. The Filipino Nurses' Association made an appeal to the Supreme Court for a pardon based on the argument that nurses were taught to verify medication orders, never to question the prudence of the physician's orders. Through a massive public relations effort by the nursing association and the International Council of Nurses, the Supreme Court of the Philippines granted Ms. Somera a conditional pardon. The nursing association interpreted the court's decision as "lift(ing) nursing from a subservient place to one of equality in responsibility and dignity with that of the doctor."(Pence & Cantrall, 1990, p. 190).

Patient's rights was not a concept embraced in the medical community. In the 1920s with the eugenics movement, individuals believed to be mentally retarded were involuntarily sterilized (Hatchett, 1991). Subjects were recruited for medical research without being fully informed of the availability for cure, the risks, or their option to withdraw from the study. The Nazi atrocities caused the world to scrutinize

the integrity of the medical profession. The nurses in Nazi Germany followed doctors' orders, perhaps out of fear for their lives if they resisted, but also perhaps because they believed a greater good would be served by their participation (Steppe, 1992). The Nuremberg Code defined the rights of individuals to informed consent before participating in medical research, and began a trend away from paternalism.

Technology and the application of technology pushed the boundaries of human mortality. Antibiotics, surgery, iron lungs, and intravenous fluids are a few examples of the increasing repertoire of interventions that became available to patients. Patients however still deferred to the judgment of the physician shrouded in the mystique of medicine. Prescriptions were written in Latin, continuing the paternalistic behaviors of the physician. Nurses were prohibited from discussing treatment options with patients, or even telling the patient what their vital signs were or what medication they were being given. The Tuma case was landmark in its representation of the power relationship between medicine and nursing.

Ms. Tuma was an instructor in a junior college nursing program. She had assigned a student to a 59 year old woman with a history of myelogenous leukemia. In the course of giving her care, the student learned that the patient, while having given informed consent for chemotherapy, was upset and crying over her decision. Ms. Tuma spoke with the patient who described her 12 year history with leukemia and her belief in healthy foods and a natural diet in battling cancer. She asked Ms. Tuma to speak with her children regarding options for treatment other than conventional chemotherapy.

The patient spoke to a daughter and told her she was rethinking her decision to accept chemotherapy. She asked her daughter to assemble the family and meet with Ms. Tuma that evening. The daughter phoned the physician to inform him that her mother was refusing the chemotherapy. The physician called the floor and ordered the chemotherapy infusion discontinued. He also asked the patient's

daughter to get the name of the nurse. Ms. Tuma met with the family, discussed options such as chemotherapy and its side effects and natural remedies and herbs not available in the United States. The patient decided to proceed with chemotherapy, the physician was notified, and the chemotherapy was given after an interruption of one hour and 15 minutes. The physician contacted the college that employed Ms. Tuma and demanded she be discharged from her position. The hospital notified the licensing board of the state and sought to revoke Ms. Tuma's license. Ms. Tuma was suspended from her position for causing the interruption in the treatment. She had her license suspended for six months for interfering with the physician-patient relationship, which was deemed unprofessional conduct.

After appealing to the state's Supreme Court, Ms. Tuma was found not guilty of unprofessional conduct because the nurse practice act did not define unprofessional conduct, nor did it specify actions by which a nurse would be cautioned that she was bordering on unprofessional conduct. This case was widely debated in nursing and medical circles. The patient's right to know was central in the case, yet the debate focused on who "owns" the patient. In the investigator's own nursing education in 1970, the case was used as a warning in overstepping the boundaries of the nursing role. The tension between advocating for the patient and remaining loyal to the physician placed nurses in the middle. Nurses who wished to advocate for the patient, especially in instances of providing information to the patient, or when the nurse believed the patient could be harmed were given a strong message to do so surreptitiously or not at all. Nurses were often characterized as whistleblowers if they brought attention to a situation. Again in the investigator's own experience, a nationally renowned physician ethicist, when asked to describe the nurse's role in ethical decision-making, responded by saying the nurse's role was as whistleblower (Fost, personal communication, 1983). He agreed with the investigator's observation that nurses may seek this route when no other forum for expression is available.

The Tuma case exemplifies the difficulty nurses had in meeting their ethical obligation to the patients and remaining within the boundaries of the loyal physician-helper. Ethical decision-making was in the purview of physicians and their patients, although many times physicians conferred with the families and made decisions without consulting the patient. Ethical decision-making continued to be the physician's judgment of what information to share, what options to pose, and what course to recommend. Nurses were ordered to refer questions to the physician, and sometimes nurses were specifically ordered not to discuss certain issues with the patient, such as resuscitation.

Another example of technological advances leading to ethical conflict is the adoption of cardiopulmonary resuscitation (CPR) as the standard of care for all deaths in a hospital (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983, p. 233). In teaching hospitals, an arrest was seen as an opportunity to learn resuscitation as well as to revive the patient. Physicians would give verbal orders not to resuscitate and the orders would be noted in pencil on the patient's kardex. In 1972, the investigator was given a telephone order not to resuscitate a 19 year old girl with advanced Hodgkin's disease. The order was written on the order sheet, as was and still is the custom when a telephone order is given. Upon reading his order in the chart, the resident became furious and raged at the investigator for jeopardizing his license. There was no acknowledgment of the jeopardy of the nurse's license in complying with the unwritten order to withhold resuscitation. As the investigator sought support from her colleagues and nursing supervisor, she learned that there was a reluctance to address the issue, and the plan each nurse had for dealing with the eventual arrest of the patient was to "go through the motions" of a resuscitative attempt, but not to actually resuscitate the patient, since all agreed it would be futile. The patient arrested on the investigator's day off; she was not resuscitated. The nurse on duty at

the time allowed the patient's mother to lay beside her and hold her at the time of her death.

Recognizing that CPR was not always appropriate or desirable, some institutions began to formulate "Do Not Resuscitate" policies. The consumer movement, demanding information from and regulation of certain industries, sparked an assertiveness in patients as consumers of health care. Competent patients demanded information and respect for their freedom to choose the option they believed was in their best interests. While physicians were held in high esteem in the community and patients often did not question the advice of their physicians, there was growing discontent with paternalism.

About the time CPR was becoming mandatory in all hospital deaths, other technology was being developed. In 1960, when hemodialysis was available on limited basis, hospitals struggled with fair allocation of this new and scarce resource. One hospital in Seattle assembled a committee of community leaders to review the cases of patients needing hemodialysis and decide who would receive dialysis. They based their decisions on the social utility of the patient--who are the upstanding citizens of the community, who are the "good" people and who are the "bad" people. Shana Alexander described this committee in her article in Life magazine and a public outcry followed. Medicare coverage for patients requiring dialysis (and later kidney transplantation) resulted from this public response. The concept of using a committee to aid in ethical decision-making was broached, but not well received. Only one percent of hospitals had ethics committees and these were primarily Catholic hospitals. Their committees dealt primarily with decisions involving termination of pregnancy when the mother's life was in jeopardy. The patient's role in ethical decision-making was given voice in terms of Congress' response to this issue by attempting to resolve the scarce resource allocation dilemma (Ross, 1986).

Ethical decision-making for the incompetent patient was the next major milestone in the history of clinical ethics. The Quinlan case presented the complexity of treatment decisions with incompetent patients. In 1976, the patient's right to consent or refuse treatment was accepted by the medical community. However, when the patient becomes incompetent, it was not clear who would exercise the patient's autonomy, or even if the patient still had autonomy. Karen Ann Quinlan, a teenager who was rendered unconscious and apneic for unknown reasons, was resuscitated after a prolonged period without oxygen. She never regained consciousness and continued to need intermittent mandatory ventilation. Her father, after seeking direction from his church, petitioned the court to allow Karen to be discontinued from the ventilator because he believed she would want it that way. New Jersey Supreme Court, in its decision granting his petition, expressed the need for a committee composed of physicians--a prognosis committee--to deliberate cases such as these before legal recourse is sought (Ross, 1986). Karen was removed from the ventilator, most probably weaned over time, and when the moment came to discontinue the ventilator, she was able to breathe unassisted. She continued to receive nourishment, most likely through a gastrostomy or nasogastric tube, and she lived ten more years in a persistent vegetative state. The resolution of the Quinlan case sent the message that committees were the mechanism for ethical decision-making and these committees should be composed of physicians who could debate the prognosis of the patient.

Obligatory CPR led to further ethical quandaries--do not resuscitate/do not intubate orders, the determination of death, and the withdrawal of nutrition and hydration as the means of death--for example. Massachusetts General Hospital adopted treatment options for the hopelessly ill. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) addressed the decisions in forgoing life-sustaining treatment. Nurses often

provided the stimulus for policy development and for conducting patient care conferences resulting in a decision on the resuscitation status of patients. Two pediatric cases occurred in the early 1980s that had far-reaching effects in influencing the use of ethics committees and the use of technology with incompetent patients.

In Bloomington, Indiana, Baby Doe was born with Down syndrome and duodenal atresia. The parents were given two options: consent to life-sustaining treatment or forgo surgery and allow the infant to die. They chose the latter and the hospital administration contacted the Indiana Child Welfare agency. The case went up to the Indiana Supreme Court; the Court ruled that parents, when given two opposing medical opinions on the merits of life-saving treatment, have the prerogative to chose. The hospital's attorney was on his way to the U.S. Supreme Court when the baby died of dehydration and pulmonary hemorrhage (Lyon, 1983).

President Reagan learned of this case and asked Secretary Heckler of the Department of Health and Human Services to ensure another baby like Baby Doe does not die from nontreatment. The Secretary invoked Section 504 of the Rehabilitation Act of 1973 which stipulated that health care facilities could lose federal funding if treatment is denied to patients on the basis of a handicapping condition. Large posters with a toll-free number to report suspected discrimination were hung in hospital nurseries.

Groups such as the American Hospital Association and the American Academy of Pediatrics opposed the regulations. The alternatives they recommended included the development of hospital ethics committees or infant care review committees. These regulations, later known as the Baby Doe regulations, were struck down as being invoked arbitrarily and capriciously. The large posters were replaced with smaller signs to be posted in nurses' lounges. The implication again was that the nurses' role in ethical decision-making is as the whistleblower as mandated by the

federal government. President Reagan directed that the state's child abuse and neglect acts be amended to include nontreatment of handicapped children. The quality of life of the child was not to be considered in the decision of whether or not to treat. If a nonhandicapped child would be treated, then a handicapped child should be treated.

Another case around the same time was the case of Baby Jane Doe. Born with myelomeningocele, hydrocephalus, and microcephaly, the parents initially consented to surgery, then changed their minds and opted to forgo surgery. Someone on the hospital staff secretly contacted a Vermont right-to-life attorney who brought suit to compel surgery. A hearing was held and surgery was ordered. The parents' lawyer appealed and that appeal was upheld by a higher court, but the court did not comment on the right of the child to surgery, as was the opposing side's argument. The court ruled that the right-to-life attorney had no standing in the case. The Federal Government sued to obtained her medical records, in attempt to learn if the baby was being discriminated against because she was handicapped. The court did not grant the government's request, and eventually the case was rendered moot because the parents consented to insertion of a ventriculo-peritoneal shunt. They believed the hydrocephalus was causing the baby discomfort. The baby was discharged home to the parents.

The public saw the Baby Does as the vulnerable, incompetent patients who needed protection from their parents and their doctors. Hospitals across the country were forming ethics committees as a way of preventing cases from going to court. Nurses were invited to sit on ethics committees. This gesture symbolized the first legitimate acknowledgment that nurses have standing in ethical deliberation. Another result from the Baby Doe cases was the trend toward over-treatment out of fear of investigation by the Baby Doe squads if treatment is withheld or withdrawn.

Some hospitals resisted forming ethics committees or had them in name only. Others identified persons in the institution who would provide ethics consultation. Those ethicists were philosophers, chaplains, or academicians with expertise in medical ethics. University of Chicago had a Clinical Ethics program in which they offered a fellowship in ethics consultation for physicians who wish to acquire those skill. Georgetown University had a similar program open to other health care professionals besides physicians. Private organizations, such as Hastings Center and Kennedy Institute of Ethics (at Georgetown) held intensive continuing education programs on developing, maintaining and operating hospital ethics committees and on specific ethical issues. These ethicists and ethics consultants then returned to their institutions as resources for ethical decision-making. Policies were revised to reflect mandatory or optional consultation to ethics committees or consultants in specific situations.

Another widely publicized case involving an incompetent patient led to the passing of the Patient Self-Determination Act. Nancy Cruzan was a 25 year old woman who was in a persistent vegetative state after sustaining irreversible brain damage in a motor vehicle accident. Five years after her accident, her parents sought a court order to remove her gastrostomy tube as they believe that Nancy would not have wanted to live in a vegetative condition. After losing in the state courts and on appeal to the United States Supreme Court, her parents finally were granted their order when additional witnesses came forward to attest to Nancy's wishes not to live this way. Nancy's tube was removed and she died 11 days later from dehydration. Congress passed the Patient Self- Determination Act that requires all health care facilities, agencies, and insurance companies to ask all patients or subscribers if they have an advanced directive, meaning living will or durable power of attorney for health care, or if they want information on advanced

directives. Institutions were also required to provide information on the patient's right to refuse treatment.

In many institutions, the responsibility for asking the questions fell to the clerk who gathered insurance and/or admitting information. If patients asked any questions, they were told to ask their doctor or nurse. Some institutions delegated the responsibility to social workers, who were also educated in the execution of the documents should patients wish to complete an advance directive. Often the questions were fielded by the nurses, who had a one hour, mandatory inservice on advance directives. Several years after the implementation of the Patient Self-Determination Act, most patients do not have advance directives and do not complete them during their hospitalization (Yellen, Elpern, & Burton, 1994). Anecdotally, nurses have told this investigator that conflict arises more often when patients have advance directives that are not honored by the medical staff. Nurses are again in the middle between advocating for the rights of their patients and being ordered by the physician to provide treatment.

Clinical ethics in the health care setting has been focused on resolution of ethical conflict and ethical dilemmas. Nurses have been socialized to defer to the physician's authority in ethical decision-making and not to interfere in the physician-patient relationship, but nursing care does not occur in a vacuum. Nurses are often placed in untenable positions of having a duty to the patient to prevent harm, but being ordered to give a treatment, e.g. chemotherapy, resuscitation when the nurse does not believe it is in the patient's best interests. Dilemmas aside, every interaction the nurse has with a patient is a moral interaction based on respect for the patient and with the patient's consent. Less dramatic than resuscitation or life-saving interventions are the everyday occurrences that pose ethical conflict for the nurse. Clinical ethics gives little attention to how nurses should manage these situations. Medical centers were compelled by Joint Commission on Accreditation of

Healthcare Organizations to have a mechanism for nurses to resolve ethical problems (JCAHO, 1995). Many institutions identified their ethics committee as that mechanism; those without ethics committees had ethics consultation services or ethicists identified as meeting this requirement. There is no data available to determine the use of ethics committees and consultation services by nurses. Often nurses are socialized to direct their ethical issues to their nurse manager, which may resolve in a resolution that is politically expedient but morally unsatisfying. Nurses still were left with little direction in resolving everyday ethical issues.

C. Review of Literature

The search in the nursing ethics literature on ethical decision-making yields articles related to decision-making models. Prescriptive models of ethical decision-making have been proposed (Aroskar, 1976; Bunting and Webb, 1988: Curtin, 1978: Murphy & Murphy, 1976; Thompson & Thompson, 1985) and descriptive models have been developed from research (DeWolf, 1989). In the prescriptive models, nurses are encouraged to follow specific steps to work through an ethical decision. There is no recommendation for how the nurse works through each step, such as how to identify the ethical question or how to apply bioethical principles. The clinical application of these models have not been studied. The validity of the use of prescriptive ethical decision-making models in the clinical setting is not known. This stimulated the author's interest in learning the process nurses use in working through situations of ethical conflict. From the author's previous experience in conducting a survey of neonatal nurses' attitudes and beliefs toward "Do Not Resuscitate" orders, the quantitative approach fell short in capturing the complexity of the decision-making process (Savage, Cullen, Kirchhoff, Pugh, & Foreman, 1987). From the volume of anecdotal notes written in the margins and on the back of the questionnaire, the respondents added comments regarding the details they would need to know to make a

decision, or they expressed frustration at the limits of the choices of responses. Based on the dearth of quantitative instruments to measure the use of ethical decision-making models and the author's own experience in using a quantitative approach, a qualitative methodology was sought. Given the inductive nature of the question: "What is the process by which nurses interact with others in order to deliver ethically appropriate care?", the author identified naturalistic inquiry as the methodology for this study.

Naturalistic inquiry is an inductive approach to knowing. It is atheoretical in the beginning, and potentially theory-generating, or through data analysis, the phenomena under investigation may be compatible with an existing theory. Penticuff (1991), in a review article of the state-of-the-art in nursing ethics research, points out the limitations of various theories used to underpin research in nursing ethics. The first, bioethical theory, does not adequately account for all the factors in nurses' ethical decision-making. Bioethical theory proposes that ethical decision-making rests on the application of principles, such as autonomy, beneficence, nonmaleficence, and justice. While nurses may use bioethical principles in decision-making, they do not use principles solely.

Penticuff (1991) also criticized the use of moral development theory as a research framework. She points to the lack of empirical evidence to support that people who are measured on some tools at higher stages of moral development will be more likely to act morally than those who are measured at lower stages. Much of the research in moral development and moral reasoning have used instruments based on Kohlberg's stages of moral development (Crisham, 1981; Ketefian, 1981a; Ketefian, 1981b; Ketefian, 1988; Ketefian, 1989a; Ketefian, 1989b; Munhall, 1980). The limitations of the use of moral development theory to explain ethical decision-making was identified by a student of Kohlberg's, Carol Gilligan. Gilligan (1982) described another perspective, the caring perspective, that she thought was used

predominantly by women in moral reasoning. Kohlberg's perspective, labeled the justice perspective by Gilligan, is used, but is not the sole framework. Reliable and valid instruments have been developed to measure stages of moral development according to the use of principles in decision-making. However, the measurement does not include context, relationships, concern for relief of burden, and prevention of harm that Gilligan found so pervasive in her studies of women and ethical decision-making. There is a lack of clarity of the concept of moral reasoning. For the purposes of this review, studies pertaining to the ethical decision-making or moral reasoning of nurses were reviewed. In studies that have attempted to use Gilligan's perspective, there is no valid and reliable measurement instrument (Chally, 1992; Cooper, 1991). Nokes (1989) calls for a new theory of morality that will include principles and contextual issues.

The final theory that Penticuff (1991) critiques is the use of role conception as a research framework. Nurses assume multiple roles and have multiple loyalties in their practice. Organizational influences have not been incorporated in research studies examining role conception and ethical practice. "Numerous studies of nurses' authority in hospitals have concluded that nurses do not have the autonomy or organizational influence necessary to carry out their professional responsibilities for patients" (p. 244). Pinch (1985) conducted a study of 294 nursing students and recent graduates on ethical dilemmas and the subjects' perception of the role of the nurse and nursing autonomy. She concluded "...the image of the nurse in the social and cultural context is a tarnished one when compared to the profession's vision of the ideal role" (p. 375).

Penticuff concludes with these recommendations for future research: 1) focus on transactions of patients, nurses and others within health care context; 2) integrate concepts of organizational and political environments' influence on nurses and their practices; 3) provide data on descriptive ethics as well as normative ethics,

describe the context and content in which normative decisions take place; and 4) describe the "complexity of the nursing role within the practice environments and the goals and values of nursing as they relate to human needs" (p. 251).

Other authors have concentrated on the context of nursing practice when facing ethical decisions. The American Nurses Association Compendium of Position Statements on the Nurse's Role in End-of-Life Decisions (1992) opens with an acknowledgment that nurses are often "in the middle" and are key facilitators in decision-making of patients.

The importance of integrity-preserving compromise in nursing ethics was described by Winslow and Winslow (1991). They argue that no theory of nursing ethics is complete without attention to the realities of relationships, coercion, and moral complexity nurses face daily. They too characterize the nurse as being "in the middle" and give suggestions for nurses to engage in integrity-preserving compromise.

Grundstein-Amado (1992) examined the differences in ethical decision-making processes among nurses and physicians. Via in-depth interviews with nine female nurses and nine male physicians, she found differences in the information each profession used in making decisions. She found that nurses had more difficulty with hypothetical situations because they needed more information, such as the patient's feelings and ability to cope, and the dynamics of the relationships between the patient and family, to arrive at a decision. Physicians in the study used medical and technical information; they wanted to know the patient's point of view but would not necessarily honor the patient's wishes if those wishes seemed to be in conflict with their medical judgment. Their commitment to the patient was to use their best judgment, according to professional standards of competency. Grundstein-Amado concluded that nurses demonstrated more moral sensitivity than physicians. "Moral sensitivity can result from either their having no power to control the action and to

act as a free moral agent, or from their inclination to support and sustain the patients who faced difficult moral choices. These two factors can contribute to nurses' moral distress...in which nurses feel that they have to sacrifice and compromise their integrity because of their peculiar position in the health care power structure and because of their conflicting loyalties and responsibilities." (p. 134).

The lack of nursing autonomy in ethical decision-making has been identified as a source of moral distress (Jameton, 1984). Nurses feel constrained to choose the course of action that would relieve the distress because of conflicting obligations or an inhibiting organizational culture. With changes in health care delivery, and the move toward nurses as case managers, there has been increased attention on collaborative and interdependent decision-making (McKay, 1983; Pike, 1991; Sherer, 1993). Nurses are seen as key players in ethical decision-making who have a unique perspective that needs to be known. Studies have demonstrated different styles of decision-making between nurses and physicians (Anspach, 1987; Gramelspacher, Howell, & Young, 1986; Grundstein-Amado, 1992). While there seems to be an acknowledgment that nurses have a contribution to make in ethical decision-making, there are also barriers to that participation (Yarling & McElmurry, 1986). The barriers primarily are related to the physician-nurse relationship (Baggs, 1993; Campbell-Heider & Pollock, 1987; Diaz & McMillin, 1991; Katzman & Roberts, 1988). Preliminary interviews conducted by the investigator as part of an independent study in qualitative research design revealed that nurses' actions are constrained by the need for physician's orders, or that the nurse must negotiate with the physician to write the order to legally cover the activity the nurse performed. The success of this negotiation is usually dependent upon the nurse's relationship with the physician.

There is a need to understand how the nurse identifies there is an ethical issue and how ethical decision-making by the nurse is done. From earlier interviews, it appears the nurse either abdicates responsibility to others (physician) or begins a process of inquiry and negotiation to resolve discomfort he/she feels related to the ethical problem(DeWolf, 1989). The review of the literature aided in demonstrating the lack of quantitative instruments for this investigation. It also prepared the author for the on-going analysis of the data gathered in the interviews. The review of literature became an on-going process through the study as new information or perspectives were identified and the author sought to find corroboration in the literature. Through a naturalistic inquiry method, the investigator learned from the nurse's point of view, the interactive processes the nurse uses to deliver ethically appropriate care. The ethical decision-making that occurs is the nurse's analysis that there is a duty to the patient--a duty to prevent harm, at the very least, or to do good. As Penticuff recommended, the focus of the inquiry was on the transactions between nurses and others, the concepts of organizational and political influences on the nurses. Further literature will be cited in the data analysis discussion.

II. METHODOLOGY

A. Naturalistic Inquiry

Naturalistic inquiry was selected as the most appropriate method for investigation of the processes nurses use in delivering ethically appropriate care. As previously stated, quantitative methods were too limiting in capturing the richness of the responses. The questions asked of the nurses needed to be open-ended and the interview needed to be semi-structured. Previous interviews had yielded interesting information that helped form an interview schedule, but the interview progression was dependent upon the issues and responses given by the nurses. The selection of nurses to be interviewed was dependent upon the analysis of the previous interviews. The relationship between the investigator and the research participants was another consideration in selection of a methodology. The investigator anticipated knowing many of the nurses who would be invited to participate in the study. It was likely many of the participants would know of the investigator by the elected position she held in the institution's professional nursing organization. A methodology was needed that recognized that the relationships between investigator and participants could not and should not be artificially suspended. The author found naturalistic inquiry methodology as being the most appropriate approach for this study.

As a research methodology, naturalistic inquiry philosophically differs from other methodologies by five axioms identified by Lincoln and Guba (1985). Those axioms are: 1) There are multiple realities in every phenomenon, 2) There will be interaction between those who know and those who seek to know, 3) Working hypotheses are bound to time and context, 4) It is impossible to determine cause and effect, and 5) Values cannot and should not be separated from inquiry. The researcher, or "naturalist" per Lincoln and Guba, is the instrument of inquiry. The

human instrument, with inherent values and biases, can adjust to the context and multiple interpretations of the situation. Subjective knowledge, clinical, experiential, and intuitive, is used to understand and explore the phenomenon. Naturalistic inquiry also differs from traditional research methodologies through its use of design and sampling approaches.

Confirmatory research design outlines from beginning to end the research process: the hypothesis, instrumentation, sampling technique, data analysis, and conclusion supporting or refuting the initial hypothesis. There are objective, quantitative checks and balances. The process can be replicated to produce the same outcomes and conclusions. Naturalistic inquiry begins with an inductive approach, a working hypothesis that is modified as the research evolves. A theory, grounded in the data, may emerge vs. starting with a theory that is deductively defended in traditional research. Patton (1990) describes the naturalistic approach on an inductive-deductive continuum requiring the investigator to move back and forth between the two approaches (p. 194). Sampling is purposive, so that the likelihood of gathering data on the typical and extreme cases is increased. Traditional sampling techniques provide for the generalization of the results to the population. Naturalistic inquiry does not have generalization as a goal; the aim of naturalistic inquiry is to gain greater understanding of a phenomenon in its natural setting or context at a particular point in time. Therefore those who can inform are sought. The interaction between the naturalist and the informer is important in the negotiated interpretation of the data. Findings may be transferable to similar contexts.

The selection of naturalistic inquiry for use in this study was fitting because it permitted latitude in the implementation of the research process--the selection of participants, the interview process, the relationship between the investigator and

the participant, while maintaining rigor in the analysis of the data and ethics of the research process.

1. Design of naturalistic inquiry

Lincoln and Guba (1981) define the focus of inquiry as a state of affairs "resulting from interaction of two or more factors...that yields (1) a perplexing or enigmatic state (a conceptual problem); (2) a conflict that renders the choice from among alternative courses of action moot (an action problem); or (3) an undesirable consequence (a value problem)"(p. 88). The process begins by identifying a focus of inquiry in order to understand or explain. Boundaries are established in the beginning, but can be modified if needed. Rules for inclusion or exclusion of information may be determined at the outset, but subject to change as the process evolves.

Once the focus of inquiry has been determined, the fit of the naturalist paradigm to the focus must be evaluated. There is no test for fit, so the investigator judges whether or not the focus is consistent with the axioms of the naturalist paradigm. In using the example of the focus of inquiry to be the moral authority of nurses in providing care for patients, the fit of the naturalist paradigm will be described. Lincoln and Guba (1985) pose these questions:

- Is the phenomenon represented by a multiplicity of complex constructions?
- What is the degree of investigator-phenomenon interaction, and what degree of indeterminacy will that interaction introduce into the investigation?
- What is the degree of context dependence?
- Is it reasonable to ascribe conventional causal connections to the phenomenal elements observed?
- To what extent are values likely to be crucial to the outcome? (pp. 229-231).

a. Multiplicity of complex constructions. The interactive processes nurses use in delivering ethically appropriate care reveal many complex constructs; for example, a nurse's behavior in a given situation depends on her socialization to appropriate professional nursing behavior on her specific unit, the relationship she has with the physician(s) involved, her reliance on subjective knowing and her assessment of whether or not the physician (or other authority figure, like supervisor) will accept her assessment as legitimate, her recognition of her ethical obligation to this patient, and her calculation of the consequences if she takes the next step, which is uncomfortable for her. These constructs are defined and interpreted in the context of the nurses who describe their experiences. There may not be a shared definition or interpretation by all nurses interviewed. Naturalist inquiry allows for the richness of diversity in perspectives.

b. Investigator-phenomenon interaction. In the nurses' reporting of how they deliver ethically appropriate care, concerns regarding the nurse's judgment of the appropriateness or rightness of the her actions may influence his/her accuracy and truthfulness. The nurse may desire that the investigator approves of his/her actions, so the nurse may withhold or embellish details. The naturalist paradigm, however, allows more latitude in gathering information by permitting the open-ended, less structured interview format than a quantitative design. Naturalistic inquiry enables the investigator to establish a trusting relationship between investigator and informer to discuss sensitive information by the lack of a restrictive sampling technique. Quantitative research limits the investigator's flexibility in gathering data and responding to the feelings of the informer by the rigid manner (fixed responses) in which data is collected.

There was a concern on the part of the author that her position as president of the institution's nursing organization could affect the interviews. In the milieu of the institution at the time of the interviews, there was a number of nurses

expressing a negative attitude toward the nursing organization. While there was no concerted effort to seek out those nurses for interview, the nurses were in a position to self-select by consenting or refusing to be interviewed. The organizational climate was important, and was identified by many nurses as being of concern in their quest to deliver ethically appropriate care; however, it was addressed in the description of socialization to the role of nursing on a particular unit. The author used the participants to find others and did not have anyone refuse to be interviewed. There was one nurse who consented, but scheduling problems prevented the interview from occurring. Nurses were open in acknowledging their discomfort in situations, their lack of knowing what was the right action to take, their interpretation that in retrospect they would have handled a situation differently, or their confidence that they would act in the same fashion again.

c. Degree of context dependence. In this study, nurses were asked to provide a description of situations in which they had to interact with someone to provide the care they believed was ethically appropriate for their patient. Context is critical, and the initial key elements of the context--the nurse's recognition that he/she must interact with someone to give the level of care that the nurse has determined is ethically appropriate--were discussed by the investigator, with the nurse describing the particulars of her specific experiences. Nurses described their decisions as being strictly context-dependent, relative to the particular patient and situation, or institution-dependent, relative to the nurse's interpretation of policy limitations or acceptable nursing actions on her unit. With prompting, the nurses described the context of a situation and the meaning of the context to her actions. For example, nurses were asked if they ever performed an action for their patient without a physician's order when the action requires a physician's order. Several described emergent instances in which they did some intervention, like bolusing fluids, getting a pulse oximetry, or starting oxygen, without an order in anticipation of

getting the order once the physician arrived. The patient's condition warranted a rapid response and the nurse accepted the responsibility of proceeding without physician's orders. They described in general, non-emergent situations in which they proceeded without orders because to obtain the orders would require additional time-consuming work on their part to contact the physician, or would require them to awaken an attending physician at home or bother a busy resident, and some of the nurses were comfortable in proceeding without orders in anticipation of getting the order by the end of the shift or by the next shift.

d. Conventional causal connections to phenomena. It is not anticipated that a single cause or a combination of causes will be uncovered to explain the moral authority of nurses. However, it is possible that a nurse may identify a single factor influencing moral authority. Additional data gathering may yield different factors or combination of factors, but no single agreed-upon factor or factors can be causally connected to the exercise of moral authority, as they may be nurse-dependent or context-dependent. As a clear connection between cause and effect , as in a chemical reaction, was not anticipated, the investigator judged a naturalist paradigm was appropriate for studying this phenomena of moral authority of nurses.

e. Values crucial to outcome. The values of the informers are critical to the outcome of the study. The informer (nurse) identifies those elements in caring for patients that he/she values: minimizing patient suffering, patient autonomy, nursing autonomy, respect of physicians, obedience to the policies of the institution, preservation of relationships with the attending physician, fellow nurses, or supervising nurse. For example, a nurse describes an instance in which she believed it was wrong to continue to treat a patient.

Nurse: I think she was 89, so she was contracted, she had not had any meaningful contact with the outside world in years, she did nothing but moan and would

grimace whenever you would turn her or touch her, and you had to do that every 8 hours at least to do the dressing changes all over her body, and to me and to most of the nurses that I worked with, that was really criminal, you know, to prolong this. She ended up dying and everybody knew that she would, and to us, that was prolonging this woman's agony.

Investigator: If you all felt that way, what steps did you take? How did you deal with it?

Nurse: We basically talked it out with ourselves, tried to talk to the attending, and make him see our point of view.

Investigator: How did you do that?

Nurse: Usually the procedure would be that somebody would try to say something initially, like when the decision was being made, like why isn't the patient on dopamine, well she's a DNR, well that doesn't make sense, she should be on dopamine, who's making the decision here? Well we need to treat this and I can't play God and we need to do this. Well, we don't think this is a good thing...we would go back to our colleagues, we would talk about it amongst ourselves, and then typically the unit leader would be elected to discuss this further with...

Investigator: Elected or drafted?

Nurse: Whatever, that was her responsibility to be the one to re-address this issue...the staff nurse perspective (would) go at it from a patient suffering-type direction.

In a quantitative research paradigm, a theory is applied to guide the research inquiry. In the naturalist paradigm, theory emerges from the data. Many of the nurses' stories resonate with existing theories, such as caring theory. Through data analysis, the fit between an existing theory and the data will be discussed.

Further design issues parallel other forms of qualitative research. A sampling plan is developed to identify those people who can inform the investigator on the phenomenon of interest. The plan emerges as informers are identified, usually through a snowballing of current informers referring the investigator to others. The goal is to sample to the point of redundancy, although the investigator tries to get atypical cases as well. In this study, the investigator asked the participant at the end of the interview if they could suggest another nurse for interviewing. Often the nurse has suggested to the investigator that another nurse may have a differing

perspective. For example, a nurse who works the day shift only frequently mentioned that certain physician-nurse conflicts occurred primarily on off-shifts, so she spoke to a nurse who works 7 pm to 7 am and she was the next nurse interviewed. There was an attempt to interview more than one nurse in each clinical setting, as a way of getting another perspective from one in the same milieu.

2. Trustworthiness A plan for data collection and data analysis was devised by the investigator. In conventional research, issues of reliability and internal and external validity are addressed in selection of instrumentation and throughout the conduct of the research study. In naturalistic inquiry, trustworthiness is sought through determination of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985, pp. 316-319). While absolute trustworthiness may never be achieved, certain strategies may bring the investigator closer to absolute trustworthiness.

Credibility may be enhanced by the length of time the investigator spends with the informer. Repeated and prolonged appointments with the informer may assist in building trust and flushing out important details. Many of the nurses interviewed were seen in the work setting by the investigator on a frequent basis, often weekly. All but one interview lasted a minimum of one hour, with several going more than an hour, and one lasting 20 minutes. Nine nurses were interviewed twice, one nurse three times. Benchmarks are established for comparison with future interviews. The next informers can attest to the similarities or differences of experiences with past interviewees. Lincoln and Guba (1985) called this "member checking" (p. 316). Member checking was done by discussing themes from previous interviews with later interviewees and determining validation, redundancy, or dissonance. It was also done by re-interviewing three nurses who were first interviewed for another assignment, but had similar themes in their interviews.

Another form of member checking in this study took place by asking later participants to comment on a practice or phenomena described earlier. For example, all of the nurses described situations in which they needed to interact with the attending physician at some point. Most nurses continued to relate what happened in that exchange. One nurse, however, said that she and other staff nurses did not go directly to the attending physician. She believed it was the practice on her unit that the unit leader was contacted at that point and was the person to interact with the attending physician. In every interview after hers, each nurse was asked specifically who interacted with the attending physician. An effort was made to find another nurse in that practice area to interview. All together three nurses who had worked in that practice area were interviewed and they all confirmed that nurses were socialized to take certain issues to the unit leader who would interact with the attending physician. Nurses in other settings were surprised that this was done in their institution, since they believed it was their responsibility, not the unit leader's, to work through these issues with the attending physician.

Quantitative research might compare credibility with internal validity, in that it measures what it purports to measure. In that sense, credibility is the determination that one is gathering data relevant to the focus of inquiry. Prolonged contact was accomplished through lengthy (greater than one hour) interviews, and follow-up interviews with several (nine) nurses. Additionally, the nurses were seen at the medical center and would comment to the investigator that they found the interview process cathartic and wished there were more opportunities to talk so freely.

Transferability is the determination of the usefulness of the findings to others. With a detailed description, someone else could decide if the study findings resonate with their particular interests. While external validity allows one to generalize the findings to the population, the decision to transfer the findings is

made by the "consumer of the inquirer reports" (Lincoln & Guba, 1985, p.328). This report will serve as the document to determine transferability of the findings. Further detail will be given in the discussion of each interview that will allow the reader to decide about the transferability of this study's findings to another setting.

Dependability, like credibility, points to the focus of inquiry, as well as the process of inquiry. The data must be both believable and dependable. The data, through repeated mentioning, is credible--one believes the situation occurred-- and dependable--one believes more than one person has had this experience. The investigator may be aware of this situation through personal experience, others' sharing of their experiences, or through citation in the literature. In establishing dependability, the investigator can use overlapping methods, such as expert review, literature review, member checking, or participant-observation, if possible. In this study, the investigator often returned to the literature to find mention of nursing adolescence, for example. Member checking was done at each subsequent interview and informally when colleagues at the same institution asked about the investigator's research. Much like triangulation, more than one method can be employed to check data and minimize error.

Repeatedly, nurses all had the experience of having to interact with someone to deliver ethically appropriate care. Almost all of them had the experience of contacting a physician to obtain an order for the patient. One person, who had been a nurse for only four weeks when her first interview was conducted, had not had the experience, but did need to interact with her preceptor in the course of delivering care to her patients. In her subsequent interview, she related having to call an attending physician to obtain discharge orders for a patient. These commonalities in clinical practice establish the dependability of the data.

Confirmability uses techniques for credibility and dependability. An audit is used in which the process and product of an inquiry are verified by another person.

Just as an accountant audits financial records, an auditor reviews the process by which the data were gathered and the product obtained. The auditor may be aided by the use of a journal kept by the investigator where the investigator leaves a trail of inquiry that an auditor can trace and use as evidence to attest to the rigor of the investigation.

B. Subjective Knowing

In naturalistic inquiry, the research participants share their experiences and, with prompting, describe their decision-making process. Naturalistic inquiry provides both a method for research and a mechanism for the construction of knowledge that includes subjective knowing as legitimate knowledge. Many of the nurses described gathering facts that were necessary to convincing another person, usually a physician, that some action needed to be taken. The nurses were socialized to gather the data and use more experienced nurses in validating their assessments and conclusions. Especially early in their careers, nurses described being hesitant in trusting their feelings about the changing condition of their patient. They believed that their concerns would be dismissed by the physician if they did not have objective data, yet they often changed their workload to increase their monitoring of a patient based on their subjective assessment of the patient. For example, one nurse described an experience with a patient who had undergone a heart transplant and was now having Guiaic positive stools and diarrhea. The patient was immunosuppressed and had a normal hemoglobin.

Nurse: I mentioned it to the person who was taking care of the patient that I was really concerned and was reassured by the physician that the guiaic positive stool was because of the diarrhea. She ended up coming back to the ER with an acute GI bleeding and abdominal abscess and ended up dying. You kind of knew something was going on there. You didn't have all the facts to back it...it was just something they were going to work up later.

She described another instance:

Nurse: It goes back to the amount of time you spend with the patient and what you see is going on...let's see exactly what's going on. And it's kind of like, No...we feel comfortable with her...they had to put her in the unit and intubate her. [She asked the intern to come see the patient]...just from his objective view, he thought the person was fine...he didn't draw a gas or do anything. I went back to the intern and, um, I admit kind of to the intern, that usually the nurses will be able to tell you if they think something has really changed. And he says, well, you know, I know that now with you, but there are some people who will wake you up in the middle of the night and ask you for Tylenol or Milk of Magnesia, so his counter was, there are different levels of nurses, and he doesn't know them, 'cause he's here a short period of time, and he doesn't know how to respond until he gets to know each nurse....my counter to that was, you're here for such a short time, you'd never be able to learn each nurse, and if it's a concern for someone, then somehow you should try to get up and follow up on it or at least check the patient.

The nurses believed concerns based on quantifiable, corroborated data would more likely get a response from a physician than concerns based on subjective knowing. The literature supports this. In an empirical, post-positivist climate of modern-day health care, subjective knowing is not considered legitimate knowledge (Code, 1991, p.222). Doering (1992) identifies a power relationship between nursing and medicine that affects the development of nursing knowledge, according to the feminist and post-structuralist perspectives. The logical positivists believe in a single truth which could be discovered through a scientific, objective, verifiable approach. The feminists and post-structuralists maintain truth, as knowledge, is contextual and phenomena-based (p. 31).

C. Epistemology

What is knowledge? Harding (1987) asks these epistemological questions: "Who can be a knower, what tests must beliefs pass in order to be legitimated as knowledge, what kind of things can be known, what is the nature of objectivity, what is the appropriate relationship between researcher and research subject, and what should the purposes of the pursuit of knowledge be?" (p. 181). Naturalistic inquiry accepts that there are different ways of knowing beyond empirical knowing. The naturalist paradigm captures the "epistemological plurality of nursing" (Schultz &

Meleis, 1988, p. 220). Carper (1978) described four patterns of knowing which she called fundamental: empirics, esthetics, personal knowledge, and ethics. She categorized nursing's use of these patterns of knowing at a preparadigm conceptual level, awaiting theory testing. Briefly described, empirical knowledge is based on facts and is publicly verifiable. Esthetic knowledge is more of the art of nursing than the science, requiring the nurse to interpret experiences and act in response to the interpretation. Empathy is an example of esthetic knowing, which relies upon the relationship between the nurse and the patient. Personal knowledge is the most difficult to describe. It is the actualization of a personal relationship. The patient is not seen as an object ("The melanoma in Room 712"), but as a unique, changing individual to whom the nurse responds.

Moch (1990) described personal knowing as a "discovery of self and other through reflection"(p. 155). Personal knowing is composed of experience, interaction with another, and intuition. Personal knowing would fit in the category of "subjective knowledge" according to Belenky, Clinchy, Goldberger, and Tarule (1986). Received knowledge, subjective knowledge, procedural knowledge and constructed knowledge represent women's ways of knowing. Women can pass through these stages or remain in one of them. The stages depict passages of the development of self and trust in oneself. Women's ways of knowing is crucial to the naturalistic inquiry methodology of the study as the research subjects are all women. The distinction between epistemology and methodology becomes blurred at this point. What is deemed "knowledge" and the way one gains knowledge are pivotal questions in naturalistic inquiry. The feminist perspectives on epistemology and methodology allow that there are other ways of knowing beyond the androcentric scientific method.

Feminist epistemology holds that knowledge has been shaped primarily by men and historically women's ways of knowing have been excluded as legitimate

knowledge. Feminist methodologies meld with feminist epistemology to challenge androcentrism, acknowledge women's experiences, and authorize alternative modes of inquiry that would be considered deviant to the scientific method. Feminist perspectives also provide insight into moral decision-making, which was of interest in the study.

D. Cultural Context of Knowledge

If knowledge is gained through nursing practice, then the practice environment influences knowledge both epistemologically and methodologically. The manner in which knowledge is gained is through empirical methods and subjective ways of knowing. The environment which is conducive to either one method, but not both, limits the knowledge which can be acquired and the way in which the knowledge is interpreted. The culture and community are the basis for interpretation of what is knowledge, and are the basis for moral agreement. Feminist epistemology maintains that gender bias and relationships of power influence community standards, and that the oppression of women is so pervasive in most cultures that it is accepted as the norm. There is no single, overarching feminist epistemology. Code (1991) believes that there can be no feminist epistemology as long as the post-positivists determine the "necessary and sufficient conditions for knowledge" and devise "strategies to refute skepticism" (p. 314). Harding (1987) concurs that no single feminist epistemology is possible "only many stories that different women tell about the different knowledge they have (p. 88). Just as there is no single version of feminist epistemology, there is no single form of feminism.

Sherwin (1992) discusses several types of feminism: liberal, socialist, radical, lesbian. Liberal, which advocates gender equality through enforcement of laws supporting women's rights, is probably the most predominant form of feminism. Socialist feminists believe that women must attend to the economic structures

underlying oppression. The self-interest of capitalism at the cost of collective responsibility is inconsistent with socialist feminism. Radical feminists see sexism underlying oppression of women and the power discrepancies between men and women. Lesbian feminism rejects the cultural norm of heterosexuality and declares an "independence from male-oriented relationships" (p. 30). In all forms of feminism, however, the position that women are oppressed is ever-present.

The feminist perspective is important in the study for two reasons: feminist methodology and epistemology are consistent with naturalistic inquiry and the moral authority of nurses as described by the nurses in the study has oppression in the form of bureaucratic, institutional hierarchy and political subjugation.

E. Commonalities of Naturalistic Inquiry with Caring Phenomenon

The caring phenomenon is a subject of scores of essays attempting to define and describe caring. The act of providing nursing care to another person and the affective nature of caring for or about another person are relevant to the selection of naturalistic inquiry as a methodology for the study. Nursing care involves an intimacy with another person. In the intimate relationship between the nurse and patient, the nurse is expected to use knowledge based on previous experiences to learn, anticipate, and meet the needs of the patient. Combining theoretical knowledge with past clinical experiences yields expert knowledge (Benner, 1984, p. 294). At times, "intuitive grasp, the direct apprehension of a situation based upon a background of similar and dissimilar situations and embodied intelligence or skill" (Benner, 1984, p. 295) is required. Nurses who use expert knowledge and intuitive grasp may not be able to articulate rationale for their actions, but describe their "sense" of the situation on which they based their decisions to act. Nursing judgments and interventions in providing care to patients most likely involve many ways of knowing, including expert knowledge and intuitive grasp. Naturalistic

inquiry presents a mode of investigation explicitly for gaining insight into subjective knowing. The nurses often used terms such as "gut feeling", "sixth sense" or stated "most of my decisions are based on a feeling", "you get a sense from people when you work with them on a regular basis...I think they've [physician] been taught not to [get a sense from people]. I think they've been taught to do too much data collection, and I think there are some physicians who work from a gut level, but I think they get fewer and fewer all the time, and they get caught up in the scientific data...I think that medicine, nursing, all of it, has really lost sight of the ability to sense things."

F. Research Design

Emergent design evolves with on-going data analysis and continuous decisions about sampling and types of data to be collected. The study began by the identification of nurses who were willing to be interviewed. In the interview process, they were asked to describe a situation which posed an ethical problem. Some nurses had difficulty in identifying a situation. They commented that they could not recall an incident, yet with general questioning about everyday decisions they had to make, and what prompted them to follow through until their situation was resolved, they categorized the situations in terms of "right" or "wrong". Yet they would not have considered the situation an ethical problem. Once the situation was described, the investigator asked the nurses to explain the process they undertook to resolve the situation. Each interview began with the same general questions, but varied as the content varied.

1. Data Analysis

Each interview was transcribed by the investigator and reviewed for themes. Data was reduced into coding categories. Sampling decisions were made based on the themes identified in previous interviews, and the next

interviewee was sought to learn if divergent points of view would find redundancy in the thematic categories. Data analysis was done in a hermeneutic-dialectic process that provides for interpretation, convergence, divergence, and mutual exploration of the data. In addition to peer debriefing and member checking, the investigator re-interviewed nine respondents to get their reaction to other respondents' point of view.

2. Trustworthiness In the quantitative research paradigm, certain precautions are taken to ensure the reliability and validity of the research instrument, and to demonstrate control of the research process to eliminate the likelihood the results occurred by chance. In the naturalist paradigm, different techniques are undertaken to ensure the quality of the research. In search of truth and knowledge, the naturalist researcher becomes a partner with the respondent in the respondent's context. To establish credibility in this study's findings, techniques such as prolonged contact, persistent observation, and member checking were employed. Additionally, peer debriefing to explore working hypothesis and discuss data analysis decisions was done. During data analysis, member checking, reviewing categorization and interpretations with a respondent was done. Another quality measure was the logging of the researcher's decisions in sampling, interviewing, and data analysis. This is part of the audit trail, to demonstrate the trustworthiness of the study.

In this study, prolonged contact with respondents was negotiated at the time of the consent to participate in the study. Interviews were arranged at the convenience of the respondents, and were scheduled for approximately one hour, but most interviews exceeded one hour, and one interview lasted only 20 minutes. The nurses interviewed were asked to consider the topics discussed in the initial contact and to call the researcher if they have a similar recent experience they want to

discuss with the researcher. It was hoped that the interview may have heightened their awareness of their interactive processes, which might enable them to attend to details and relate those details to the researcher. However, none of the nurses in the study initiated a follow-up contact with the researcher for purposes of discussing the study. There were inquiries in "how was the study going?" and an informal member checking occurred spontaneously as the researcher related the progress since the nurse's interview. Because the investigator worked at the institution employing all of the nurses who were interviewed, she would often see the participants in passing. None of these exchanges were tape-recorded, however, and notes were entered in the investigator's reflexive journal.

There is realization that the research process may have influenced the nurse's behavior in the clinical area. In one instance, the nurse expressed distress at having to care for patients who have been admitted for second trimester abortion. While the nurse respected the patient's right to seek a legal abortion, she did not want to be involved in the care of the patient.

Nurse: I strongly support pro-life and lately we've been getting a lot of abortion patients. For me, it's an ethical issue because I want to provide equally quality care to all my patients, and I just have a personal problem dealing with that issue, giving care to patients who have chosen to abort....I know Down syndrome kids who have lived very full lives, I personally have trouble knowing that late in the pregnancy a choice was made like that for that reason.

Investigator: Is that a source of distress for some people on your unit, you mentioned that's an ethical issue for you. Would you say that's true for other nurses on your unit?

Nurse: Yeah, I would. I'd say that some are bothered more than others.

Investigator: Are there any who refuse to participate in the care, you know, if there were no other person, they would care for the patient, but otherwise they would rather not be assigned to a patient undergoing that kind of procedure.

Nurse: I can think of a couple that might change their assignment if they had that, well, I shouldn't say that. I know they'd talk about it if they had it, if they had that assignment, they would talk in the conference room, you know, how they felt about it.

Investigator: But still carry it out?

Nurse: Yeah.

Investigator: Do you think there's anyone who might want to persuade her not to do it?

Nurse: Possibly, um hum.

Investigator: Did you know the Illinois abortion statute has the moral objection clause, so that if there's a health care provider who has a moral objection to participating in the care of a patient undergoing a procedure for which they feel violates their beliefs, whether based on religion or their moral beliefs, they are to be...this is within the structure of the institution, that they don't have to participate in that procedure?

Nurse: Really? No I didn't know that. That's really interesting because I know that personally if I worked in L&D, or the OR, I really don't think I could participate in the actual procedure. I really don't think I could.

Investigator: I have a copy...I'll make a copy of that and send it over to you.

After further discussion, she was sent a copy of the Illinois Abortion Statute and the Act of Conscience statute by the investigator.

Erlandson, Harris, Skipper, and Allen (1993) refer to the influence of the research on the respondent as the shared construction and connectedness that occurs in the naturalist paradigm. Shared constructions provide authenticity to the study. They describe five types of authenticity: fairness--the renegotiation of the terms of inclusion in the study; ontological authenticity--expansion of the shared constructions; educative authenticity--like ontological, their understanding of shared constructions has grown; catalytic authenticity--actions are facilitated by the research process; and tactical authenticity--empowerment of the respondents to make positive changes because of their involvement in the research process. The above example demonstrates a connectedness between investigator and research participant that is unacceptable in other research paradigms that caution "contaminating" the data. Naturalistic inquiry allows the above described

interaction, exemplifying the reciprocity of the relationship between investigator and participant in this research process.

3. Sampling Purposive sampling was done to find those nurses who can discuss the negotiation process in ethical decision-making. Decisions regarding the sampling choices will be discussed in the data analysis section. All nurses are (or in one instance, were) employees of a 1000+ bed, academic, tertiary care medical center. All are Registered Nurses. See Table I for demographic description.

G. Reflexive Journal

Another quality criterion for naturalistic inquiry is the journal kept by the researcher. On a regular basis, the researcher records rationale for certain decisions--sampling, coding, interpretations, redundancy, relevancy, and credibility of data--so that an audit trail is established. The audit trail is part of the documentation to demonstrate the dependability of the data, the confirmability of the data, and the transferability of the data. It documents the researcher's impressions, thoughts, and feelings at the time. For this study, a reflexive journal was kept, although in retrospect, it was not used to the fullest extent that it could have been. The frequency of entries should have been more regular. The pace of the data collection was in "fits and starts", such that several interviews were conducted over a short period of time, then a longer spell without interviews would pass during which transcription of the previous interviews would be done. Entries in the reflexive journal followed that pattern as well. Occasionally the potential interviewee would need to cancel, and a follow-up time was not immediately arranged.

H. Audit Trail

In addition to the reflexive journal, other notes were kept to build an audit trail. The audit trail adds to the trustworthiness of the study. Lincoln and Guba (1985) identify six categories for the audit trail: raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials related to decisions, and instrument development information. The raw data in this study is the audiotapes and verbatim transcription of those tapes. Data reduction and analysis products are kept as field notes, working hypotheses, and hunches entered in the reflexive journal. Data reconstruction and synthesis products are the conclusions and final interpretations, with links to existing theory or theory generation. Process notes begin with the proposal, amendments, and supporting rationale for evolution of the research design, and comments related to the credibility, dependability, and confirmability of the data. The reflexive journal and memos during transcription serve as materials supporting interpretations, and decisions on sampling, interview questions, or reviewing literature.

I. Human Subject Protection

The Institutional Review Board at University of Illinois at Chicago deemed that the study did not require IRB review. No data were collected at the University of Illinois. The Human Investigations Committee (HIC) at Rush-Presbyterian-St. Luke's Medical Center approved the study through exempt review because subject confidentiality was promised and with this methodology of interviewing, there was no risk of harm to the subjects. The initial research focus was on nurses' perspectives on comfort measures for dying patients, but the focus was expanded to include other patient needs and other patient types. The HIC was notified that the research question had changed, but the methodology was unchanged, and approval was continued for the duration of the study.

J. Setting

The nurses selected for interviews were all Registered Nurses employed at a 1000+ bed, midwestern, academic, tertiary medical center. The investigator was also employed at the institution, and at the time of the interviews, was the President of the Professional Nursing Staff, a shared governance organization of the institution. During the months of data collection, the medical center was undergoing two major changes: restructuring of the skill mix of professional to nonprofessional staff under a program called Operations Improvement, and implementation of a new nursing model that eliminated levels of practice and changed the title and responsibilities of nursing management. These two changes will be discussed in a little more detail.

Operations Improvement was a project involving an outside accounting firm. The firm sent small squads of two to three people to selected units to evaluate their efficiency and need for professional staff. The data were then presented to a committee of representatives from key groups. Nursing was represented by the Chairs of the six departments of nursing, the President-Elect of the Professional Nursing Staff (the investigator), and the Vice-President of Nursing. In the meetings, the data were presented as "quick and dirty" estimates of potential cost-savings, and the committee took a vote on whether or not the units merited further study. This process lasted several months and at the conclusion of the meetings, the "quick and dirty" estimates were compiled in a report and distributed as committee-recommended cuts. Using a formula extrapolated from several other staffing formulas used in other medical centers, a skill mix for each unit was ordered. Target dates were set and Unit Leaders (nurse managers) were told to meet the ordered skill mix by the target date.

In Nursing Administrative Council, a group comprised of the Vice-President of Nursing, the Chairs of the six departments, the Directors of Nursing Services

Research and Support, Continuing Education, the President of the Professional Nursing Staff, the Presiding Officer of the Faculty Senate, and Chairs of selected Professional Nursing Staff committees discussed the Operations Improvement. The Vice-President of Nursing, while critical of the intention to reduce nursing staff, argued that the marketplace dictated these drastic changes. She cited the data showing the medical center costs exceeding all other medical centers in the area, and that consumers will select cost over quality. She encouraged all of the committee to be team players and support the administration's efforts.

Over the period from July 1992 to July 1994, the investigator attended or was briefed on Operations Improvement committee meetings, Nursing Administrative Council meetings, had weekly meetings with the Vice-President of Nursing, and monthly meetings with the Senior Vice-President for Hospital Affairs. As Operations Improvement was implemented, there were a few lay-offs of RNs, closing of units that caused displacement of RNs, and a general climate of worry, disquiet, and anger. It was anticipated that the nurses might be uncomfortable in being interviewed by the President of the Professional Nursing Staff. The investigator was concerned that the negative feelings nurses expressed in Professional Nursing Staff meetings would permeate the interviews because of the investigator's position in the institution. With this in mind, many nurses who were interviewed were actively involved in the Professional Nursing Staff committees, and while they had feelings regarding the changes in the institution, they were well-informed of the investigator's role in those changes and were supportive. In subsequent interviews, the nurses either were unaware of the Professional Nursing Staff or were uninvolved so as to not connect the medical center changes with that organization. In the course of later interviews, two nurses expressed comments about the effectiveness (or ineffectiveness) of the Professional Nursing Staff and did so apologetically in deference to the investigator. The initial concern that the investigator's position

would affect the interviews was unfounded. The previously existing relationship between the investigator and the interviewees made for a common ground, if not a closeness, that should have facilitated communication. For those nurses who had not met the investigator prior to the interview, the introduction by another nurse who had been interviewed helped establish a comfort level.

The other major change that began prior to the Operations Improvement was the change from the existing nursing model to a new nursing model. The existing model was a clinical ladder with four steps: Level A was the beginning nurse; Level B was the nurse with more than one year experience; Level C was the experienced nurse on a unit, and Level D was the most experienced nurse who participated in special projects, probably had an advanced degree, and most likely participated in research. Nurses were hired at a given level, usually Level B, and were evaluated annually for promotion. Nurses presented a portfolio of their activities over the year to justify promotion to the next level. Four areas of activity had to be addressed: clinical (patient care), education (working with students), administration (committee work and special projects), and research (any involvement, from data collection to principal investigator). Patient care was based on the concept of primary care, in which the staff nurse was responsible for all the nursing care for a group of patients. Documentation such as peer reviews, committee minutes, letters of support from patients and colleagues, were included. Promotion to the next level meant an increased responsibility in maintaining the level of involvement in activities on the unit. Usually a salary increase accompanied the promotion.

Nursing management consisted of a Unit Leader, who had a Master's degree, or Head Nurse, who did not have a Master's degree. There were only a few nurses who held the title of Head Nurse, and they had held these positions prior to the existing model's introduction. Each unit had a number of Assistant Unit Leaders (AUL). These nurses were also prepared at the Master's level; many units had two AUL's on the day

shift or one for each shift. Every unit had several Practitioner/Teachers (P/T), who were nursing faculty assigned to the unit and had a percentage of their salary dollars coming from the unit. The P/T's had undergraduate students on their units during the school quarters. When P/T's did not have students on the unit, there were various expectations of their contribution to their units that were negotiated with the Unit Leader and their department's Assistant Chair for Education, the P/T's immediate faculty supervisor. The investigator, at the time of data collection, was a Practitioner/Teacher on the Pediatric Unit, with 60% time devoted to the elected position of President of the Professional Nursing Staff. During the investigator's term as President, a new department chair was hired and the previously negotiated release time for serving as President was disregarded. A full teaching load was assigned. Changes such as these were occurring frequently, and there were many nurses in leadership positions leaving the medical center and college.

The new nursing model collapsed the four level of staff nurses into three categories: Clinical Nurse I, the beginning nurse; Clinical Nurse II, the nurse with more than one year of experience, and the Senior Staff Nurse, the staff nurse with the most experience on the unit. According to budget, nurses would be hired into these categories. A staff nurse would not be able to progress to the Senior Staff Nurse position unless there was a budgeted position on the unit. There was no longer a clinical ladder and the evaluation method was heavily weighted toward patient care. Staff nurse involvement in nursing education was eliminated completely from the evaluation.

In addition to the changing structure and titles in the nursing model, the unlicensed assistive personnel was introduced. For this institution, this was a highly unusual move. While many other institutions across the city and country were bringing in assistive personnel, this institution had a national reputation for its nursing model and highly educated nursing workforce. The "new" model was

presented as an improvement to the old model in several ways. First, the nurse manager would have all ancillary staff on her unit report to her. This included clerical, housekeeping, and transportation. Additionally, the nurse manager would have responsibility for the budget for the unit, including staff, supplies, equipment, and miscellaneous expenditures. The new model was characterized as giving nurses the authority to operate their units as they deem appropriate. However, the skill mix was dictated to the nurse manager by the accounting firm, and the budget was less than it had ever been in the past. Primary care, the nursing care approach that had been taught in nursing education programs since the 1970s, could no longer be practiced as it had been in the past, although the nursing managers would not publicly acknowledge this. In closed meetings, the new model was seen as a return to the functional nursing of the late 1960s and early 1970s and a tremendous blow to the profession of nursing. The staff nurse who previously had been the primary nurse for three to four patients now had a patient load of six to eight. Vital signs, baths, treatments, and other direct patient care activities were delegated to another worker whose title varied, depending on the unit. On medical and surgical units, a worker called the Patient Service Associate would perform the direct patient care activities, pass meal trays, transport patients off unit, and clean the unit. This multi-task worker needed to have a high school diploma and had to pass a screening process in Human Resources that focused primarily on the worker's attitude and work habits.

Inservices on the model were held on units that were about to convert to the new model. One or two workshops on delegation were given to the nurse managers with the hope that they could relay this useful information to their nursing staff. Some units also hired licensed practical nurses (LPN). In the early 1980s, almost all the LPN's in the institution were laid off in a move to have an all professional nursing staff. Geriatric units retained their LPN's.

The new model was piloted on one unit, and was then introduced on other units in the medical and surgical departments. Psychiatric/mental health nursing, maternal-child nursing, and gerontological nursing were scheduled for a later time. Since community health nursing was outpatient, that department was not included in nursing model change, but did have Operations Improvement targets for nursing workload and middle manager position elimination. Since Operations Improvement and new model implementation was ongoing simultaneously, many staff nurses had difficulty distinguishing which project was responsible for which changes. As a result, both projects were viewed negatively. Nurses feared that they would not be able to deliver the kind of nursing care they had in the past. They feared their jobs could be eliminated and they would be replaced with an unlicensed person. Realizing that these changes were occurring during the data collection period, the investigator chose nurses from a variety of units and departments. The effects of these changes were not raised by the investigator, but were discussed if the research participant mentioned the topic. The political, cultural, professional, and ethical climate was changing.

K. Research Participants

Eighteen (18) nurses were interviewed. Three (3) nurses who were employed at the same institution had been interviewed previously for a school assignment and were re-interviewed after all the other nurses were interviewed as a member check. The sample was restricted to nurses who work with adult patients, as the decision-making involving children would add another level of complexity, although one nurse from pediatric intensive care was interviewed as a member check. Two nurses who were interviewed work on a unit serving antepartum patients, postpartum patients, and mother-baby couplets. Demographics are listed in Tables I through VI.

Table I

AGE AND MARITAL STATUS OF NURSES INTERVIEWED (N=18)

Age range		Marital status	
22 - 25	2	Single	9
26 - 30	5	Married	9*
31 - 35	6		
36 - 40	1		
41 - 45	4		

*Three nurses had one or more children

Table II

RELIGIOUS AFFILIATION

Religious Affiliation	
Catholic	8
Protestant	6
No sect identified	2
United Methodist	1
Methodist	1
Unitarian	1
Christian Reformed	1
No preference given	1
None	3

Table III

EDUCATIONAL LEVEL OF NURSES

Basic Nursing Preparation		Highest Degree Obtained	
Diploma	2	Diploma	1
BSN	16	BSN	9
		MS	8*

*All Master's degrees are in nursing

Table IV

YEARS OF EXPERIENCE

Years	Number of nurses
0 - 1	1
2 - 5	7
6 - 10	4
11 - 15	3
16 - 20	0
21 - 25	3

Mean number of years of experience as an RN = 9.1 years
(9.6 years if those with less than one year's experience excluded)

Table V

FORMAL ETHICS EDUCATION

Number of nurses who had formal coursework in ethics	
Undergraduate education courses	5
Graduate education courses	2
Number of nurses who attended a continuing education program in ethics	
Nursing Christian Fellowship program	1
Informal inservices, no CEU's	2

Table VI

SPECIALTY AREAS OF NURSES

Specialty	Number of nurses
Medical nursing (Cardiovascular, AIDS, pulmonary)	8
Surgical nursing (Transplant, neurosurgery)	3
Community nursing (Home health)*	3
Maternal-child nursing (obstetrics, peds intensive care)	3
Geriatric nursing*	1

*Two nurses from Community nursing worked several years in Geriatrics

III. FINDINGS

In naturalistic inquiry, the investigator seeks to interview an individual who can relate to the topic and provide a perspective. There are general questions that are posed, and based on the responses, follow-up questions are asked. On-going data analysis facilitated the identification of recurrent themes and provided foci for discussion. It also influenced the selection of research participants, which will be discussed in greater detail below. The major themes and illustrative stories are summarized below.

A. Selection of Research Participants

The first nurse was selected because she worked on an adult medical unit, had more than five years experience, and was willing to be interviewed. In the course of the discussion, she mentioned that she thought issues were different for nurses working on the off-shifts, meaning 3-11 pm or 7 pm to 7 am. With her assistance, a nurse from the night shift was interviewed. Another nurse from that unit, and two other nurses who formerly worked on that unit were later interviewed. Nurses working on surgical units or specialty units were recruited to participate. Two nurses who worked with both adults and their newborns in mother-baby couplets were interviewed. Nurses outside the inpatient units who now work in the medical center's home health agency were interviewed. Certain nurses were selected because they had previous experience in geriatrics or they attended school with one of the other participants and were now employed at the same institution. Nearly half (n=8) of the nurses interviewed had obtained a Master's degree; three of those nurses currently spend at least half of their time in direct bedside care on their units. The rest of their time is spent on administrative duties or teaching. Two nurses work (or worked) as clinical nurse specialists and one has moved into a full-time

administrative position. Much of their reflection on patient care stemmed from their experiences as a staff nurse. The current clinical nurse specialist believed that she had more prolonged contact with patients as a staff nurse, and thought back on her experiences when responding to questions in the interview. The former clinical nurse specialist and now administrator spoke from the perspective of advocating for her patients and helping them make treatment decisions, as well as from a nursing management perspective of being responsible for all the nursing care in her current institution.

After each interview, the content was reviewed for major themes, emerging themes, redundancy, and saturation. Half of the nurses were interviewed twice, and one nurse was interviewed three times. Although one interview lasted only 20 minutes, all the other interviews lasted at least one hour and usually one-and-a-half hours. All were taped and transcribed by the investigator. Eleven of the 28 interviews conducted were done face-to-face; the others were done over the phone. Each participant was interviewed in person or over the phone at their preference.

B. Major Themes

1. The nurse's role The nurses reflected on the nurse's role as they perceived it. While they all identified patient education as part of the nurse's role, there were different beliefs about how much and what information the nurse should give the patient. Some patients did not want information, such as pre-cardiac catheterization teaching, or a family member did not want the patient given information. The nurse would assess the readiness of the patient to hear certain information. Respect for the autonomy of the patient was the basis for the nurse's actions. Some nurses were troubled by elderly patients not getting what the nurses believed was age-appropriate data relevant to their treatment decisions. Other nurses experienced in geriatric care thought appropriate information was given but

the manner in which it was given was not always appropriate for the elderly. The informer, usually the physician, needed to speak slowly and clearly, avoiding jargon.

Another aspect of the nurse's role was to "prevent the preventable" (#001). To safeguard the well-being of the patient, the nurse had to monitor medical management of the patient. If the nurse surmised that a bad outcome was possible if a particular intervention was done, she would take steps to prevent the bad outcome. This might be holding a medication, getting a consultation, keeping the patient on the unit instead of sending the patient for a procedure, giving a medication, or discontinuing routine lab work. In order to prevent a bad outcome for a patient, the nurse had to interact with others, usually the physician. In this teaching institution, the nurse had to become familiar with the medical hierarchy and the chain of command in pursuing a medical concern.

2. Pursuing concerns When the nurse assessed her patient, she would make a judgment about the appropriateness of the plan of care. Based on her knowledge of the patient's wishes, she would detect an incongruity between the patient's wishes and the plan of care. Many nurses described this analysis occurring as a clinical insight, or a sense or feeling that something was not right. Nurse #003 described developing a "gut feeling, that sixth sense, or whatever you want to call it, where you know you need to continue to pursue something, put yourself more on the line to see if you can come to some kind of agreement, or at least that you're heard, you're on record as to what you feel is going on...the key thing is the fact that you spend so much time with the patient." Another nurse described her decision-making method. "Most of my decisions are based on a feeling. It's not anything I can put my finger on, but I can tell you exactly, clinically...if she is threatening suicide, I do this...you get that sense from people when you work with them on a regular basis" (#005). Nurse #007 acknowledges that she depends on her education and the

available background on the patient. "First of all, usually there's a background on it. Knowing education and knowing about the grieving process and things that help with that, understanding the basics...kind of a gut feeling, an intuition" (#007). If the nurse had clinical data, she would usually proceed as she had been socialized to proceed on her unit. On most units, the nurse would contact the first year resident, the intern. Nurses know more than interns in many of the areas because the units are specialty units. Nurse #004 believes that the interns often are unsure how to proceed, so that if she has a problem with the intern, she will go to the senior resident or directly to the attending physician. If there is an urgency to the issue, and the nurse believes the intern would not have the authority or knowledge to respond appropriately, she may contact a senior resident or attending physician first. If the nurse had a feeling, but did not have objective data to support her concerns, she would ask a trusted colleague either to assess the patient or to advise her on whether or not her plan to proceed was sound. "I'll usually run it by other nurses too that I work with. I'll explain the situation...and they'll say, yeah, you should go to the attending...Because of my experience, because I know the patients, I usually know what their likes and dislikes are, and what their wants and needs are"(#004).

> Nurse #008: "You would sit down with the next shift or the people working on your shift and you'd all say, 'Am I off-base on this, and are you seeing the same things I'm seeing, can you see any benefit to this, think she'll live any longer?' So you'd go to your colleagues and to the more experienced people, the practitioner-teachers, the unit leader. They'd get brought into this whole discussion at this point...'Would you try talking to him [the attending]?' gather the troops, we're all seeing, feeling kind of the same way."

Taking the step to notify a physician was approached differently by different nurses. Most of the nurses contacted the intern to inform them of the patient's condition and to seek an order. The nurse had usually decided what she believed was

the appropriate course to take, and would lead the intern to the answer she wished.

Nurse #011 talked about a problem in caring for a man who was an alcoholic.

> What really bothered me was that we weren't appropriately treating this man...the housestaff didn't order enough Ativan for this guy and nursing staff didn't administer enough to him...they wouldn't give him enough Ativan to keep him from having symptoms of withdrawal. I just kept going to them and going to them and they finally said, give what you want. Okay, I will...At the time, they'll turn it over to me 'cause they know me and they know I would do okay, but then you get the next nurse who comes on who's afraid to give the drug, 'Isn't this a little bit too much to give?', and then the control goes back. And part of me blames them and part of me doesn't.

She continued with giving her rationale for pursuing issues so vigorously.

> As a nurse, probably as a person in general, I'm pretty willful, and what I want to have done for a patient, and what I believe is the right thing for the patient, I'll keep going after the service or whoever until I get the results that I want...I just know I'm right. As I've gotten older, I believe in what I feel inside and sometimes I just know I'm right. And I believe that feeling now. I never used to believe it when I was younger. I used to push it down 'cause other people always knew more than me. I don't believe it anymore (#011).

Even nurses with the least experience would weigh the intern's response and question the orders if they were not convinced the plan was appropriate. They would also persist in getting the physician to see the patient, despite discouragement from the physician.

> There were other situations where you'd call, and you'd get blown off and if you persisted enough somebody finally shows up and says, 'Oh well, you didn't tell me it was like this', and you say, 'Why have I been calling you every hour on the hour?'(#013)

Two additional themes are embedded in the nurse's pursing a concern: interacting with physicians and socialization of the nurse.

3. Interacting with physicians The nurses would assess their patients, determine the need for an order or the need for the physician to be informed of a change, and would decide what to do next. In urgent situations, most of the nurses said they would act first on behalf of the patient, such as increase an intravenous

fluid rate if a patient is hypotensive, then notify the physician. In other less urgent situations, the nurses would follow a process they were educated and socialized to follow. The socialization aspect will be discussed later. If the unit practice is to contact the intern, the nurse would either attempt to find the intern on the unit, page the intern, or speak to another intern at the same level in the medical hierarchy but not assigned to the particular patient at the time. Some nurses described seeking out the person they believed would be more likely to respond in the manner the nurse desired. An intern who was thought to be lazy, arrogant, not as competent as the other interns, or not well informed was avoided if there was an alternative. Some of the more experienced nurses would contact the intern as a matter of protocol and believed that the intern needed the opportunity to learn, therefore needed to be informed. Other nurses would take the most expedient approach to resolve the issue. They might contact an intern who is available, or a more senior physician, if they are on the unit. Once the nurse decides to contact a physician, the next decision the nurse makes may be a conscious or subconscious one of how to interact with the physician. This aspect is influenced by socialization. The nurse will gather data, present the data to the physician, and ask the physician what he wants to do (#001). Nurse #001 believes the nurse leads the intern to the conclusion she finds acceptable. If the intern does not do what the nurse thinks should be done, she uses techniques of intimidation, such as telling the intern she will call his resident if he does not do what she thinks should be done. The decision to go over the intern's head is not taken easily. The nurse bases her decision on her experience, support from her nurse colleagues, and the perception of how important this confrontation is. There is a concern for the ongoing relationship between the nurse and the intern. Although the intern may be assigned to the unit for a period of two to six weeks a year, the intern may be on-call to cover the unit throughout the entire residency of three to four years. The nurse will take into consideration the

effect of their current interaction on their long-term relationship and weigh that against the needs of the patient. If there is no other way to meet the needs of the patient, as the nurse perceives them, then the nurse will risk damaging her relationship with the intern for the sake of the patient.

The nurses believed there was a difference in the emotional energy required when interacting with housestaff versus attending physicians. Nurse #002 had experience in a community hospital where attending physicians were the only physicians available to cover the patient.

> You got yelled at by attendings for calling them and waking them up on a feeling...here I don't have to wait until something happens. Even though I knew something wasn't right, but I didn't know what, no, I wouldn't call the attending at home because they would just blow up in your face. You'll call and say what you want to do. But if you don't have anything to go on, like the patient says, 'I feel funny' and you check everything, and you're like, oh God, I hate it when patients say that...when it comes to calling an attending, you get every little...you get as many facts as you can before you would call them. But with interns, if a patient said, 'I don't feel right, something's wrong', I'd go get the intern...'Come in here, do you see something that I'm missing?' With interns, now I don't have a problem with ever waking them up and having them come in and listen to a patient.

Another nurse learned that the residents were being reprimanded for doing as the nurses ask without first checking with the attending.

> We found out the residents were really getting chewed out, and that's not fair to them so you want to back off. You don't want to put somebody else in that position, even if it might be the right thing for the patient. I think that they went along with the nurse's request sometimes because they didn't want you to keep asking. When they get yelled at at the other end, they sort of pay more attention, and that's not good for your relationship with the residents. What we do now is to generally talk to the attending (Nurse #005).

One nurse who is completing her Master's degree while working as a staff nurse finds the interactions between staff nurse and physician different than the interaction between the advanced practice nurse and physician.

> If the primary physician isn't around, I can page him, I can sit there with the patient and do other things while I'm waiting for him to call back, and my time is my own. As a staff nurse, if I need to get changes made, half of the time you can't find...I have trouble finding the resident, when I do get him he says, well,

> we'll talk about it on rounds when the seniors are with us and then they talk about it on rounds and they say, well, I have to think about it, we have to look at the labs, and by the end of the day, you still don't have the order you wanted written, and that could be anything from a change in pain medication to IV fluids (#009)

The less experienced nurse thought the task of calling a physician was scary. She attributed her fear to not having a lot of confidence in her judgments and observations. Another nurse thought that if she brought a concern to the physician and the physician did not think anything needed to be done, the nurse would accept that and monitor the situation. She would go to another physician if the issue were major, and if she felt strongly about it, she would go up the medical hierarchy, but with a great deal of trepidation (#012). In her area, the usual method of pursuing a concern is to work with the housestaff, and if the issue remains unresolved, to involve the nurse manager. The nurse manager would raise the issue with the housestaff and would take it to the attending, if necessary. This approach was atypical of the way most staff nurses practiced. In all other areas, the staff nurse would also be the one to contact the attending physician if that move seemed necessary. The exceptions were in emergency situations, where the staff nurse is caring for the patient in distress and another nurse makes the contact with the attending, and in home health. The home health nurse deals primarily with attending physicians, however, there are some issues that require diplomacy and in the interest of keeping a referral base, the nurse managers are sometimes asked to address issues with the attendings. This practice may be more common among the less experienced nurses.

In the geriatric area, one physician covers many of the hospitalized patients and has a reputation of being particularly unpleasant in his interactions. It was not clear if the practice of referring matters to the nurse manager was his preference, the preference of nurse managers to reduce the fall-out from unhappy staff nurses who interacted with him, or the preference of the staff nurses to avoid any further

interaction. An ethics consultant, who was frequently called regarding this physician's management of his elderly patients, told the investigator that he (the ethics consultant) had an agreement with the physician that only he would discuss the cases with him, and would shield him from others on the health care team who wished to discuss their ethical concerns about patient care. Although nurses reported only one physician with whom they had great difficulties, almost every nurse mentioned this physician and only one nurse said she would contact him again if her patient needed his attention. All the other nurses who had an interaction with him said they would insist the housestaff, who also avoided any additional contact with him, call him or they would permit a harm to come to the patient instead of submitting themselves to his verbal abuse. Other physicians who were identified as "especially nasty" were surgeons. Nurses learned to change their style of interaction when dealing with attending surgeons.

> It takes me a long time, or it has to be a certain situation before I will come out and say, this is a problem, and this is what you should do about it. I'm much more likely to...help the person come to a conclusion on their own...I'm also very sensitive to what physician I'm dealing with..it depends on whom I'm talking to and there are some people that I have enough experience with that I know won't get what I need or what the patient needs unless I do it that way [doctor-nurse game]...it's funny, I didn't even realize I did it...it's ingrained in me before I ever became a nurse and nursing just probably reinforced it, but I didn't realize that I had a right to be resentful...occasionally when I had forgotten and I had come out and said something [directly], that it didn't happen. If he asked me what I thought, I told him, then it was okay, but if I came out and told him what I thought without [being asked], then it didn't go anywhere (#013).

The nurses learned by watching other nurses to interact with physicians in a way that resulted in the outcome desired by the nurse. Although they said they resented having to act in that manner, they believed a greater good was served if they got the order they wanted.

4. Socialization When a nurse is hired on a unit, an orientation takes place. Along with the formal orientation, an informal orientation occurs. The nurse

observes how other nurses get things done, how they proceed when they have a problem, and how they advocate for their patients. The nurse learns the common process taken to pursue a concern. As mentioned previously, on most units, the staff nurse interacts directly with the attending when necessary. The exceptions were noted earlier. For most nurses, although they did not appreciate the "game" they had to play with physicians, continued to interact with attendings in that game-playing manner.

An experienced nurse talked about the socialization process on her unit.

> What I try to socialize the younger staff, the brand new RNs, it's a challenge for new graduates to start on this unit, because these patients are critically ill. Things occur rapidly with them and therefore clinical judgment, clinical decision-making is very sophisticated on the unit. And what I encourage them to do, support them to do, for six months to a year is validate with experienced RNs, not only their preceptor, but who they see as the clinical nurse coordinators, the level C staff nurses, their clinical judgment and a follow-up decision. Daily there should be several occurrences like this where you are sharing and validating with experienced RNs on the unit. But we certainly teach them the norms in this culture which are in fact the R 1, the intern, is the person that you go to first if in fact the patient's blood pressure is lower than their normal blood pressure and you're giving an antihypertensive or if the patient has chest pain...if you believe the intern is not addressing the problem, or maybe discounting you, then you go to the R 2, and in our system, after that, it's the cardiology fellow, and the attending is the usual chain of command (#006).

She viewed the interaction with the intern as the appropriate process to follow in caring for the patient. She also saw the interaction as very important in the intern's education. Residency, from her perspective, was a time for the newly graduated physician to learn how to practice medicine and how to interact with nurses. She expressed patience and respect, while most of the other nurses expressed more frustration and petulant tolerance upon working with residents.

Other nurses echoed the reinforcement of following the chain of command. Nurses #008 recalled what she often tells her orientees, and Nurse #009 remembered when she first felt comfortable approaching attendings.

> If you think that something is important to your patient, then we got to talk about it. If you're not sure it's a good idea or not, then ask one of us who's been around longer...if you really think it is important, don't give up on it (#008)

> One of the more experienced nurses, maybe would be the one who approached the attending about this situation. Level As were uncomfortable addressing attendings about issues like that...I can remember the feelings that went along with starting out being very inexperienced and uncomfortable with the attendings. And then as I got more confident in my abilities and I got to know nursing and patients better being more comfortable as time went on, and by the time I was a level C nurse I felt pretty comfortable with approaching attending...it was three years, I was pretty comfortable with talking to the attending about whatever the issues are (#009).

It was interesting to note that for one nurse, the socialization she received early in her career persisted even though she changed areas. She began her career in the geriatric area in which any contact between the staff nurse and attending was discouraged. When she transferred to a surgical floor, she continued to avoid contact with the attending physician and related a story of a bad outcome with a patient because she had not involved the attending early in the patient's deterioration. She had been socialized to avoid contacting the attending physician, and had found surgeons unpleasant to interact with, so in the middle of one night, she hesitated, to the detriment of the patient, to call the attending. Another nurse, whose story is unusual because she began her career in home health, was socialized to make frequent and direct contact with attending physicians. She expressed no hesitation in calling them, albeit she only called during daytime hours. Her frustration dealt more with learning each physician's parameters for concern, as she sometimes sensed their annoyance with her calls.

> You start to be a little more subjective in your parameters and I think that's a disadvantage because you get so many annoyed physicians, you get tired of having physicians treat you like an idiot (#014).

The nurses argue that they interact with physicians on behalf of their patients, and they base their decision to do this on their knowledge of the patient. One nurse questions the nurse's ability to know the patient.

> I don't think the work setting facilitates this [establishing trusting relationships with patients] because you have quite a few patients and you are able...you have enough for the basic care for that patient, but when it comes to things outside of that, and when it comes to social issues you don't necessarily have to deal with, you can avoid those issues...you get what has to be done for the next shift basically. You're taking care of their physical needs, but the psychological needs aren't always met...I'm focusing so much on learning my skills and learning the way (institution) does things that right now I don't see the big picture. Sometimes I do recognize these needs but can't deal with them (#012).

The same nurse observed that many times, her fellow nurses would proceed without obtaining written physician's orders for an action.

> I ask a lot of questions...when am I overstepping? That made me a little nervous, what I could do and what I couldn't do...If that's what they normally do, I didn't have a problem with that. I just take their word for it on how they do it. And then I would do that also (#012).

The expectation was that the nurse would not simply accept the physician's response unless she was convinced that it was the right thing to do. If she was not convinced, then there was conflict. One of the nurses stated that the residents were told never to believe the nurses. "I had a number of situations in the hospital where a resident would tell an intern, don't ever believe the nurse. Check the blood pressure yourself, do this yourself" (#008). Another nurse asked the physician why he didn't believe her when she told him something was wrong with the patient, and he responded that in the short time he is on the unit, he cannot get to know everyone well enough to know whom to trust. Some nurses will wake him up in the middle of the night for a Milk of Magnesia or Tylenol order, so he had not yet developed a sense of trust on this unit. The nurses responded that he should trust anything the nurse tells him unless he has reason not to believe them (#003).

5. Conflict with physicians The next major finding was that nurses often had conflict with physicians. The conflict occurred when the nurse did not get the response she sought. Most of the nurses decided what they believed was the right course of action for the patient and if the physician did not agree and did not give an

explanation the nurse found acceptable, there was conflict. Only two nurses, one with a few weeks experience and one with 2 1/2 years experience, said they would not pursue an issue if the physician did not take the course they anticipated. The nurses believed that the physician had more knowledge and they both trusted that the physician was competent. Neither one felt experienced enough to question the physician. Upon further inquiry in a follow-up interview, the less experienced nurse reported that she abandoned that attitude, and learned to question the physician until she was satisfied that the physician had a good reason for not doing what she believed was best for the patient.

The other nurse, who worked in geriatrics, shared that she did not embrace Western medicine and had concerns about most of modern medical treatment of the elderly. One wonders if this attitude, along with the custom of avoiding direct attending contact, influenced her decision not to question physicians. She related a story of side effects experienced by patients with Parkinson's disease, a disabling movement disorder. A medication used to treat the movement disorder causes orthostatic hypotension, so her patients were fainting and suffering injuries when they fainted. She documented the blood pressures and the frequent falls and injuries that occurred, and she attributed the problem to a certain medication. She would not call the physicians in the movement disorder specialty group to discuss her concern. When asked why, she responded that she did not attend medical school and had not devoted her career to treating movement disorders, therefore she did not have the knowledge to challenge the physicians. She trusted that they knew what they were doing, that they were carefully reading the nursing notes, and that they probably would resent her implication that they were not acting in the patient's best interests. She seemed deeply troubled that the quality of life of the elderly patients was being drastically altered by the fainting and resulting injuries, yet she had been socialized on this unit, not to question attendings. Another nurse who attended her

undergraduate program with the geriatric nurse mentioned above was interviewed. She also was completing her Master's degree. Having experienced a role of the advanced practice nurse in her educational program, she found interactions with physicians more frustrating. She frequently felt that her concerns were summarily dismissed.

> As a colleague or as a member of the team working for this patient, I frequently do not get responded to...I try and always back up what I'm saying with facts...we really insist that we're with them in rounds and this is when we try and get orders done and makes plans for the patient...and let them know nursing issues and frequently when I do this they look at me like I'm an idiot...like, well, that nice, but you're a staff nurse and I've been to med school so I know more about this than you and what I find is that in many instances they don't, this is one area I know my stuff (#009).

She acknowledged that she had to approach physicians differently when she is in her staff nurse role. When she notifies the physician of an abnormal finding and anticipates the physician will treat, she often finds the physicians do not share her aggressive approach. She cannot persuade them with her rationale, so she uses another approach.

> I sometimes have to approach them differently than I would if I were working in my clinic situation where I will talk to the head endocrinologist...I almost have to act more stupid. It's almost like I have to talk to this resident who is five years younger than me, and say 'Well, gosh, Dr. Bob, the way you handled the sugars on Mrs. Smith, I thought we could try something similar to it.' I really hate doing that. There have been times where the resident [gets one chance to do the right thing], then I'll go straight to the attending. I really try not to waste time because I just don't have the time (#009).

Nurse #001 has spoken directly to a resident when she questioned his decision. She said to him "I don't think you know what you're doing and there's nothing wrong with that, but there is a problem with your making decisions not knowing what you should." Attempting to protect the patient, the nurse confronted the physician. A heated debate ensued, and was resolved when the nurse waited until rounds and, in a manner she described as passive-aggressive, presented the issue in a way that revealed to everyone the intern's lack of knowledge. The nurse would prefer not to

have a confrontation with a physician and believes too much energy is wasted in confrontational interactions, but felt in this one instance it was unavoidable.

Fifteen of the 18 nurses mentioned that they believe the housestaff act as though their residency is a prison sentence. The nurses will contact the attending directly because of the attitude they perceive from the housestaff.

> I'll call the fellow or the attending. A lot of the guys and women, by the end of the service, it's like, 'Oh I don't give a shit, I just want to get out of here and be done with it', and so, a lot of times you end up interacting with the attending (#011).

This attitude interferes with patient care. While many interactions with physicians result in improved patient care, the interactions of conflict between the nurse and resident consume the nurse's attention and energy. The conflict interferes with the nurse's ability to care for the patient. It also fuels frustration the nurse experiences as a moral agent. Because of the limits of the Nurse Practice Act, the nurse is unable to deliver care she believes is appropriate without physician's orders. Most of the nurses thought they could anticipate what the appropriate action would be for their patients and when the physician did not order that action, give acceptable rationale, or take a different acceptable action, there would be conflict. As previously described, most nurses would then pursue a course to protect their patients. If they took the matter to the attending, and still were not satisfied that the most appropriate action was going to be taken, they were resigned that they had no further recourse. One nurse mentioned that in that kind of situation, she has encouraged the patient and family to seek a second opinion (#017). She identified Risk Management or Legal Affairs as being the only possible authorities who could intervene once the matter had gone all the way to the attending physician, but she has never been in a situation where she felt it necessary to go to either department. She granted that the issue would have to be grave for her to take such a step.

A nurse with over 20 years in nursing shared one experience with an abusive resident.

> They're [surgeons] given a pass [because of the pressure they're under]. And they shouldn't be given one. And if they aren't given a pass, they'll generally calm down...in the past I have been know to get a housestaff who was being verbally abusive, telling him to leave and to come back when he got it together...it was kind of fun. I said, you know, you're obviously out of control. Let's talk about this when you get back in control, you can leave now. And he kept trying to talk to me, and I said no. I dismissed him. And believe me I heard about it the next day. And [the medical director] took the resident to task. That was such a good feel. You use whatever interpersonal skills you've got. (#005).

The next major finding is a culmination of the changing role of nursing and conflict with physicians, and is included in the socialization of nurses--proceeding without written orders. All of the nurses reported carrying out an action for their patient for which a written physician's order is needed.

6. Proceeding without orders Although the nurses focused on those frustrating instances in which they had conflict with physicians, all of them acknowledged at some point in time carrying out some action that requires a physician's order, but they did not have the order. The most frequently given reason was that the patient's condition was changing so rapidly that a rapid response was needed and the nurse surmised that she could not take the time to contact the physician before acting. Actions such as increasing the IV fluid rate, holding a medication, or not sending the patient off the unit for a procedure were example given by the nurses. The other reason mentioned frequently was that the nurse assumed the physician would approve of the action and would prefer not to be contacted just to give the order. At night, when the resident may be sleeping or involved with a new admission or a sick patient, the nurse decides, based on what is commonly done on her unit, to proceed without contacting the physician. The actions are usually benign, according to the nurses, such as giving Dulcolax, Milk of Magnesia, or Tylenol. On specialty units, the nurses would know what actions and for

what types of patients they could proceed with the intention of getting orders at a later time. If the nurse did not know the resident, or had experienced an unpleasant interaction with the physician, she would not proceed without an order, or she might ask another resident who was available on her unit at the moment to write the order.

During the day and evening hours, the nurses would proceed without orders for a number of reasons: 1) they know the routine of the housestaff and know that the resident they need is in rounds or a conference where he/she would rather not be interrupted; 2) the action is so "minute" that the nurse does not believe calling the resident and obtaining the order prior to implementing the action is an efficient use of her time; and 3) the action is significant, but the nurse is confident the physician will order it the next time he/she is on the unit. An example of this is giving a medication, such as nifedipine, an antihypertensive, when the patient's blood pressure is above certain parameters, but the resident "forgot" to write the order. Another example is giving insulin when the patient's blood sugar is very high, and the nurse has had difficulty convincing the residents to treat the blood sugar. She stated that she has given insulin, then told the physician, "I hope you don't mind, Mr. So-and-so's blood sugar was 400 and he was about to eat a big lunch, so I gave him a little insulin" (#009).

All nurses mentioned the admonition they received in orientation not to accept verbal orders. They feared being given a verbal order, carrying it out, then having the resident renege and not write the order. While all nurses had been told this, and some knew a nurse that experienced this, none of the nurses had experienced this themselves. They would occasionally write an order for their desired action as though they had obtained verbal orders from the physician, yet they would not have discussed the action with the physician. They anticipated the physician would co-sign the order, and they all said in their experience, they had never encountered a situation where the physician would not co-sign the order.

Even when the physician would tell the nurse he would not have ordered whatever she had already done, he would still co-sign the order and legally cover her actions. Nurses gave these examples: doing an EKG, drawing blood for blood gases, electrolytes, or blood culture, getting a pulse oximeter reading, starting oxygen, obtaining other bodily fluids for cultures, starting a Heparin lock, giving Tylenol, Milk of Magnesia, Dulcolax, ordering a consultation from enterostomal therapist, giving a sleeping pill or pain medication, increasing the pain medication, and ordering physical therapy. Not all nurses would agree that they would perform these actions without orders. Based on their experience and what they learned was acceptable (or even expected) on their unit, the nurses decided what actions they would do without written orders. When asked if they thought their nurse managers approved of proceeding without orders, all the nurses thought the nurse managers were aware of the common practice, but if confronted with it directly, would state that the policy is to obtain a written order. However, the nurse managers themselves would practice in the same way and often proceed without written orders. One of the research participants holds a management position and talked about this point.

> I've started oxygen on people...when I was in intensive care I'm sure I drew blood...there were never orders for all these things we did...I figure that's just part of the job...and I think I didn't have that connection then at the time when I did that...do I feel the freedom to do that? I guess I do. I'm practicing medicine without a license (laughs)...why don't I call for the order? These are lame excuses now that I think about them. I don't want to bother the physicians, it's more convenient for me to do it this way, and those are lame, those aren't appropriate excuses, now that I think about them (#011).

Since proceeding without written orders was such a common practice for all the nurses in the study, they were asked if they wanted the authority to write the orders themselves, legally. They admitted they had the knowledge, and often they would challenge physician's orders if they did not agree with them. So it was surprising to learn that very few of the nurses wanted the authority to write the orders. Four of the nurses thought it would be more expedient if they had the

authority to write the orders for situations that frequently arose for their patients, such as the need to obtain specimens for cultures, giving Demerol for rigors in AIDS patients, writing diet orders for surgical patients, obtaining a stool culture and starting metronidazole for AIDS patients with diarrhea. They felt competent to handle many of these situations without obtaining a physician's order, and at times thought the time taken to get a written order was an inefficient use of their time. They thought the physicians should be informed of the patient's condition, but they say waiting for written orders was unnecessarily delaying the patient's treatment. One nurse characterized those actions that she felt comfortable in doing without orders as those that have short-term effects ((#004). Treating their diarrhea, their rigors, or their pain are all short-term in the patient's course. Writing orders for actions such as transferring the patient to a long term care facility or withholding resuscitation were considered long-term in the patient's course and beyond the scope of the nurse's practice (#004). The nurse would be involved in discussions with the patient about these issues, but does not want the responsibility of writing the orders.

Another nurse thought that while she had the capability of deciding what the patient needed and writing the orders, she did not want to assume the official medical management (#001). She could not envision doing both medical and nursing management as she barely had time to give nursing care. She also saw the current arrangement as a "luxury of doing what I want with medical backup". Other nurses could not imagine how the present system of resident education could continue if the nurse had the authority to write orders. It apparently did not occur to them that the residents could learn, and do learn, from the nurses. There is no public acknowledgment that the residents learn about managing patients from the nurses.

Some nurses questioned whether or not all nurses have the knowledge and experience to write orders. Nurses with several years experience in intensive care may not know the subtle nuances of the patients on a transplant unit, so while they

have a vast pool of knowledge, they may not be capable of managing patients without gaining some experience on their new unit. Some nurses thought their colleagues gave excellent nursing care, but had no interest in taking on additional responsibilities that writing orders entails (#001, 002, 009, 011).

Nurse #011 summarized her thoughts on nurses writing orders.

> I feel frustration about that [having to get the physician to write orders], but I don't feel as much frustration about it as I did even like two or three years ago. For me to have stayed in nursing, I've had to move beyond that frustration because, yes, some of these guys are dumb as stumps. I look at them and I think, oh my God, why aren't I doing that? Why did I decide to become a nurse? I should have gone to school [to] become a physician because these people are stupid that I have to interact with...I've had to change my focus to interacting so much with these stupid residents...I don't think I could still be a nurse if I hadn't moved beyond that, because really, the stuff you have to call and ask permission for is really just stupid stuff. And I guess I know the boundaries...like orders for Demerol...anti-rejection meds, but IV orders or...ice chips? Of course I give them ice chips. Or should their diet be advanced or not. Well yeah, I hear bowel sounds, they're passing gas, they had a bowel movement. Well, let me call your doctor and ask him. Well, that doesn't take rocket scientist to figure out, you start them on clear liquids.

Nurses find the process of obtaining orders tedious, but necessary. None of the nurses was willing to take over the total medical management of their patients, but would consider expanding their practice to include some activities for which they now need physician's orders. The aspect they express the most reservation about is the concomitant accountability that accompanies the privilege of writing orders. Under their covert system of doing things without orders, the legal responsibility remains with the physician. The use of critical pathways on the units was seen as the way to function without needing to contact a physician for orders. This is a misperception as the critical pathways still required that the physician write orders; the pathways reflected the progress the patient was expected to make and was used as a benchmark, rather than a clinical guide for care. One of the nurses thought "that as an RN I would have even a more legitimate structure [in using the critical pathways] for my presentation" (#006).

7. Subjective knowing The nurses were asked how they knew their decision to proceed without an order or to interact with a physician was the right decision. They referred to the feelings that they had, "a gut feeling, a sixth sense" (#003), "you kind of knew something was going on there. You didn't have all the facts to back it" (#002). Nurse #005 stated that most of her decisions are based on a feeling. "You get a sense from people when you work with them on a regular basis....I think medicine, nursing, has really lost sight of the ability to sense things" (#005). Other nurses described how they felt when caring for patients and how this influenced their actions.

> She moaned...and it was a moaning, painful type of sound. And so it was just a very bad feeling of I'm contributing to this and then as the week went on, it wasn't quite the same kind of feeling as the first day, but it was that same kind of 'this isn't right' feeling. I feel very bad for the person I'm doing this to. And then when the patient eventually died, the feeling of relief was certainly prevalent, because everyone was glad the patient was no longer suffering because of what we were doing to her (#008).

It was difficult to get some interns to respond to the nurse's feeling that there was a problem. The interns needed objective data, although the nurses reported that some of the interns would agree to see the patient based on the nurse's feeling.

> I'll say to them now, I don't know exactly why this is going on, but I know that there's something going on and it's not right. And I don't always know a lot of the attendings, so I can't say, oh they know me and I've worked there a long time. I feel that I've gotten some respect for that. That I know that it's not right and I just need you to kind of take a look at this person It's just a feeling that I have...I think that when you're with those people [patients], you get to know them so well that it's like with your child, you get to know them so well and you just know that something's not right (#011).

The nurse with the least experience at the time of the study was asked about her use of feelings, or her sense of knowing if something is wrong with her patient. She could not recall having a sense or feeling about a patient; she relied on her assessment abilities and lacked confidence in her ability to detect all problems (#012). Nurse #008 agreed that when she was a fairly new nurse, she hesitated to act

on her assessments, let alone her feelings. Over time, she gained confidence in her assessments and began to trust her feelings.

> It's a hard thing to describe...they're [patients] just different...if there was a resident around, I would say, could you come look at her? There's something not right, she's different today...typically your hunches would be verified by something..if a nurse really noticed something different and couldn't put her finger on it, something would come up (#008).

8. Interacting with patients and families The focus of the research question was how nurses get things done for their patients, with the assumption that nurses often have to interact with others to get things done for their patients. In the course of delivering patient care, the nurses get to know their patients well enough to detect changes and to advocate for their interests. Motivated by respect for the patient and respect for the patient's right to decide, the nurses tailor their interactions to each patient. For example, in pre-operative teaching, the nurse assesses the patient's readiness to learn, current level of understanding of the procedure, and the most effective way to teach the patient. In the course of this assessment, the patient may refuse to hear the information. Nurse #001 has encountered situations where the patient refused to hear any of the precardiac catheterization teaching because he thought the information would cause him to worry. The nurse explained that most patients do better when they know what to expect, but the patient maintained he would not. She respected his wishes and did not attempt to change his mind. Patients' refusal of medication or life-saving interventions were also respected by the nurses, although there were varying degrees of persuasion exercised by the nurses. A patient refused a proctoscopy despite three admissions for abdominal pain. The nurse explained the need for the procedure, what the procedure entailed, and asked the patient what could be done to make the procedure more tolerable for him. He continued to refuse and she

respected his right to refuse; the other nurses on her unit thought the patient should have been discharged and not readmitted unless he agreed to the procedure.

> I usually go along with what the patient wants, what they want to have done for themselves...I believe they have the right to decide what happens to their body. I believe they have the right to decide what happens to them. I don't think I'm more knowledgeable than they are about how they're feeling (#011).

In another case, a patient was offered a heart transplant, but refused, stating that she was old, a grandmother, and it was her time to die. The nurse argued with her that she was only 50 years old and did not have to give up and die. The nurse gave her information on heart transplantation and even called a previous heart transplant recipient to persuade the patient to accept the transplant. The patient refused and died during this admission. The nurse thought the refusal reflected the patient's culture that a person is considered old upon becoming a grandparent. The nurse also concluded that in the patient's culture, the patients do not take control of their health problem; they let the health problem control them (#001).

When asked directly about how the nurses influence the decisions of patients, all the nurses offered that they saw their role as ensuring the patient was well-informed. They are not responsible for informing the patient, and they even experience some degree of moral distress if they believe the patient lacks essential information. They will not take the initiative to give the patient the information as they have been socialized that informing the patient is the physician's responsibility. To share data, such as outcome statistics on elderly patients who undergo angioplasty would be overstepping the bounds of nursing practice and intruding into the physician-patient relationship. Nurse #006 believes that elderly patients who consent to angioplasty or coronary by-pass are not given outcomes for people their age. She questions the appropriateness of performing these procedures on patients over 80 years of age. While she is familiar with the studies, she does not think it appropriate for her to give the patients the information.

In others instances that Nurse #001 and other nurses related, the family would often request that the patient not be given information about how serious their condition is, or in one case, that the patient was not dying, although the family had told the patient that she was. Nurses admitted being rather loose with information when talking to patients' families. In situations where the patient can no longer participate in the decision-making process, the health care team turns to the family. Nurses have seen patients' expressed wishes ignored once they can no longer express their objections. An elderly patient with prostate cancer was admitted from home when the dying process was too difficult for his elderly wife to manage. Upon admission, he was treated aggressively, which upset his wife who was ready for him to die in the hospital but had panicked at home. The nurse first contacted the intern and asked the intern to speak to the attending physician about the patient and wife's wishes to stop treatment. The intern agreed with the nurse that the patient was dying and did not want the dying prolonged, but he was afraid of the attending, who told him since the patient was brought to the hospital, he must be treated. The nurse then spoke to the attending physician on the patient and wife's behalf.

> And I talked to the physician about it, saying that she's frightened, she's scared, and she just wants it over. She's comfortable he's here and he kind of went off on me. [His rationale for treatment was the wife was not ready for her husband to die.] And that's what I tried to point out. She's ready now. That was...a really ethical kind of thing to try to interpret the physician's feelings to the patient's wife, and the patient' wife's feelings to the physician (#003).

The nurse tried to get the physician to talk to the patient's wife and he reluctantly did, but did so at the patient's bedside during rounds with the housestaff. The physician finally agreed not to institute any further treatment, but would not withdraw any of the current treatment. The nurse later commented to the investigator that the attending physician called her "gerophobic" and said that she just wanted to let old people die. She found his epithet offensive, but said he accuses everyone who criticizes his medical management of being gerophobic. The nurse

avoids all direct contact with this physician now. Eleven of the 18 nurses interviewed either mentioned this physician in their interview or had a comment to make about him when the investigator mentioned him. They all found interacting with him stressful and most of them would not call him directly, but would insist the resident do it. Two nurses stated that they would not submit themselves to his verbal abuse, even if it meant a possible harm could come to a patient.

In addition to family members, nurses identified building managers as having significant influence in health care decisions for elderly patients. Nurses working in home health were often concerned about the safety of elderly patients living alone. If the family does not want to discuss alternative placements, the nurse feels ethically compromised. By continuing to provide home visits, she feels she is contributing to an unsafe situation. At those times she will involve the building manager.

> The building managers are somewhat involved with people because of their ability to function independently in that kind of a setting is questionable or compromised...they have the authority to say to people 'You will either get these supports or move out'...The resident [elderly person] often is not the one making the decision, because the resident is one who, because of mental status changes, functional changes or whatever, is no longer coping appropriately, so because of the building manager's responsibility to maintain the building and the safety for other residents, will be called in for an opinion. The issue is whether or not the family is willing and able to provide that, so a lot of times, the family is the deciding factor in what goes on. The patient abdicates responsibility of decision-making to a family member (#014).

The nurse justifies her paternalism based on her assessment of the elderly person's inability to make decisions or live independently. Other nurses in home health describe ethical problems in working with families in the home setting. They reiterate Nurse #014's feelings of contributing to an unsafe situation and a duty to change the situation.

In most decision-making situations, the nurses in the study did not believe that they influenced patients in their decisions. The role of the nurse was described as passive, in that they responded to the patient rather than initiate the topic; they

listened to the patients, clarified information, and helped the patient think about the implications of the decision. None of the nurses felt that they advised patients to accept or refuse a treatment. Even thought patients would often ask the nurse what the nurse thought they should do, the nurses would avoid giving their opinion. Their stories, however, present a different picture. In the case of the 50 year old woman who did not want a heart transplant, the nurse argued with her that she was too young to die and that she should accept the benefits of technology. A previous patient who had a heart transplant was contacted to speak to the current patient and persuade her to have the heart transplant. Yet this nurse did not view her behavior as influencing the patient's decision. She was merely informing the patient.

Another nurse described her involvement in a patient's decision.

> And so it's more of the explaining, and letting the patient explore by asking questions...By having them asking questions, you say, 'Do you have any questions? This is the rationale.' By asking them 'What's the quality of life you've had, and now that you've been sick, how do you feel, and what do you think is the quality of life you'll have in the future?' Trying to explore to see what their perceptions are to know which way to kind of assist them, more so, in making decisions. You do that quite frequently here, but again, I think what is difficult for the nurses if you guide somebody who is 'Well, okay, you said that this wouldn't'...and they start the 'you, you, you' and then you're trying to get them off the 'you' and that this is FOR you...then they go to the cath lab and then you're pooping on yourself because you're thinking if he's going to be the 1 in 10,000 who strokes out, and you helped them in this decision, but kind of directed him in the way you feel he should go, although sometimes it's bad. I remember a long time ago a guy was going for a CABG [coronary artery by-pass graft] and we had discussed it and we went through all the benefits, pros and cons, quality of life issues, he was young, had family, and all that kind of thing, and I got him on the cart to go, and he said, "I'm doing this because you talked me into this." And I freaked! Let me go to the chapel, let me go anywhere, 'cause if this guy doesn't make it, I'll die! So...off for this bypass. And his family was there, his wife was there, his mother was there. And he just let every know he was doing it because of me (#003).

This same nurse worked with a patient who was a candidate for an implantable cardiac defibrillator (ICD). The nurse was aware of the complications of the device and was not convinced that this patient should be a candidate.

> I think the closest I ever came to really exploring a person's quality of life was with an ICD patient, an implantable cardiac defibrillator. Simply because the

> patient was....had so many other problems, vascular problems, just kind of like multisystem problems, long term cardiac patient, that the surgery is pretty expensive, they have to do a thoracotomy, sewing patches into the heart, the whole nine yards, that the patient...the patient was kind of iffy about it, and I wasn't gonna be gung-ho with this guy. I was really concerned whether this patient would make it off the table...but that was the only time that you have to really think of all the consequences, what happens when this fires, what you need to do, do you have the access to get back into the system to have this thing checked out, you need to call your physician, you need to do this. If you think of traveling, you'll need to get yourself all hooked up with doctors. So I think what I was doing was pointing out more the cons of the device to him, than the pros and cons, like I usually do. I did do the pros for the device , but I think that was the only time (#003).

The nurses saw their role as facilitators and advocates. They took their cues from the patients on what information the patient wanted or needed and what other issues the patient should consider. Although they believe that they remain neutral in swaying the patient's decision, they usually have decided what they believe is the right thing for the patient to do, and their opinions can be discerned from their described interactions with the patients and families. This is consistent with their interactions with physicians, in which the nurse has decided what action the physician should take and pursues her concern until she is satisfied. The nurses characterized the motivation for pursuing concerns as doing the right thing. Yet when asked to identify ethical issues, they often needed time to think of one and usually searched for the dilemma.

9. Ethical concerns None of the nurses identified their everyday interactions with patients as ethical interactions, although one or more ethical principles were undergirding their actions. Examples of ethical concerns they identified are represented in Table VII. When asked how the nurses decided what was the right thing to do in these various situations, none of them used ethical decision-making models or referred to the Code for Nurses with Interpretive Statements (American Nurses Association, 1985). They operated more from their sense or feeling of what was the "right" thing to do. They relied on their knowledge of the patient's

values, or their own values if they did not know the patient's values. As they gain experience, they become more confident in trusting their sense of right and wrong. The degree to which they pursue the ethical issues varied and was related to the initial socialization of how these issues are resolved on their units. Primarily they were motivated by respect for the patients, the patient's autonomy, the integrity of the family if the family is supportive of the patient, the sense of obligation to prevent harm, and their desire to do good. Issues of justice the nurses articulated were allocation issues in transplantation and health care rationing, such as inappropriate discharging of patients or inappropriate placement of patients based on how physician revenue is impacted.

The nurses cited many ethical issues and could relate what they did in the situations. As they recalled the instances, their voices revealed feelings of distress, anger, frustration, uncertainty and relief. They were not always pleased with the outcomes, and they often commented on whether they thought they had done all they could have done. There was a difference in the confidence in facing ethical issues between the more experienced nurses and the less experienced nurses. When given a hypothetical case, the more experienced nurses seemed to have less difficulty in suggesting a number of strategies that they might employ. The less experienced nurses (those with less than five years experience) struggled more with what they would do, and were more likely to say they would follow orders even if they did not think doing so was in the best interests of the patient. They guessed that with more experience they would know what they should do. Much of how they resolved an issue had to do with how they had been socialized to resolve ethical issues on their unit. In the socialization process, one nurse observed a phenomena she coined "nursing adolescence". All nurses interviewed subsequently were asked about this maturational phase in the nurse's career.

Table VII

ETHICAL CONCERNS OF TEN OF THE INTERVIEWED NURSES

Not letting patients with HIV smoke in their hospital rooms (#004)
Transferring a patient to a nursing home owned by the attending physician when the patient should have gone to a rehabilitation facility (#004)
Obtaining urine for toxicology screen on newborns whose mothers did not have prenatal care without consent (#005)
Discharging mothers and keeping the baby until newborn screening blood can be drawn at 48 hours of age (#005)
Tube feeding or bottle feeding a breastfed baby when the nurse is pressed for time (#005)
Not fully informing elderly patients of risks and outcomes for people in their age bracket for certain procedures (#006)
Prolonging a patient's hospital stay until insurance is exhausted (#006)
Performing circumcisions without anesthesia (#007)
Discharging a patient too soon after giving birth (#007)
Medically complex patients getting pregnant (#007)
Putting gastrostomy tubes in elderly patients who have very little meaningful contact with the outside world (#008)
Pain management in patients with AIDS and placement issues in patients with AIDS (#009)
Not providing comprehensive care such as prescribing medication to treat the side effects of another medication (#010)
Prescribing medications of questionable value that are not covered by Medicare (#010)
Transplanting another organ in patients who are rejecting their first organ but are exhibiting the same behaviors that lead them to get the first organ (#012)
Providing home health nursing to patients who should not be home and would otherwise be in a hospital or nursing care facility (#013)
Not complying with DNR orders and resuscitating the patient (#013)
Transplanting patients who cannot ever resume self-care (#014)

10. Maturational phase Nurse #005 described a phenomena that she called "nursing adolescence". During the orientation to the unit and the institution, the nurse learns the policies, procedures of both the institution, department, and unit, and the unit-specific practices, nuances, and preferred problem-solving approach used on this unit. The nurse also observed how nurses actually function, whether or not they adhere to policies and rules all of the time, and they act to effectively get

what they want. At some point in the first year on the unit, the nurse "tests the limits".

> [Sometime after] the first six months, they go through nursing adolescence and they decide they know it all and they're going to do what they're going to do. And they do it. And that's when you want to kill them all...because they're doing things not based on things, they've tasted freedom and they want to go with it...between six months and a year and a half, that they just all go nuts. And they tell you that they don't need you, they know the answer, and every time you try to give them [help], they go (she looks away and sighs), and they generally either change jobs at that time or go through a real rough time. Usually after about a year most people will change jobs and it's usually when they're in this nursing adolescence. 'These people don't treat me like I know anything and I've done these things before, why are they looking at me. I've been out of school for a year and here I am.' They make a little more rash decisions than they do otherwise, just like teenagers. They decide they know this stuff and they come up with this, and that's when you're going to see them, that's probably when they're really going to fight for things, like sending babies home early and maybe they want the more difficult patients, but really don't have the skills to do it. I generally do just watch them a little closer...You can't tell them [you're watching them] and when you start to tell them something because you've gotten used to giving them information every time you do something and they start looking at you like (makes a face), then you stop telling them. You wait for them to come and ask. You try to keep an eye out, and they'll come and ask when they need to know it...The phase generally lasts until they move to another job or until they find a new niche...they finally get to a point where they can come up with a solution, and they start moving out of it, but it's the kind of thing you see with children when it's time to grow up and they've got a picture of what they want, but they can't quite do it, and they get so frustrated, and it's the same thing in nursing...with some people, you see it to a lesser extent than others. There is always a little of it...it's absolutely healthy (#005).

When this phenomenon was described to the other research participants, almost all agreed that they had either observed it in others or recall experiencing it themselves. Nurses struggle to conform with the expectations of the role of nursing on their unit, and often the role is inconsistent with what they expected based on their clinical experience in their nursing program. In addition, the nurses face the realities of health care delivery in their institution and may not philosophically be in synchrony with the way medicine and nursing is practiced in their institution. One nurse recalled experiencing the phenomenon not as a new graduate, but when she transferred from one unit to another.

> I've seen it and I've experienced it, not as a new nurse, but when I transferred ...when you're a new nurse, you're insecure enough where you kind of appreciate that...people [on the new unit] acted like I didn't have a brain in my head...they dumped on me, tattled on me...the agenda was to make the new person miserable. [One weekend, I worked very short-staffed, but got through the shift.] I come back on Monday and I was an idiot again. And I was outraged. I was yelling at my preceptor... who do they think got them through the weekend when they all called in? It felt like being rushed in a sorority (#013).

A nurse who does not recall experiencing it yet had started her career in home health nursing (#014). She did not think the phenomenon was valid in home health, but also acknowledged that it was highly unusual that an inexperienced nurse would be hired into home health. She was aware that her roommate, who is also an RN, had a difficult transition when she began working as an RN on the same unit where she worked as a nursing assistant.

A nurse who spends half of her time in direct patient care and half as an assistant nurse manager commented on her observations as a nurse manager working with new nurses. She echoed Nurse #005's perspective of the difficulty in integrating the new nurse who is going through this maturational phase.

> We lose a lot of nurses after that first year because they think the rules on the unit are too hard, a lot of people can't stand seeing IV drug abusers and alcoholics get organs, they just think that's not right...they just decide the grass is greener elsewhere...when we were in the middle of the shortage, we just kept those people, we kept their bad attitudes, sometimes even the quality of their work slides, but now we talk to people...counsel them, tell them maybe they need to look around elsewhere, find something new, but that's how I usually talk to them....These people I think really cry out for help, they'll say really weird things in front of you, really inappropriate things...like complaining about the patient assignment, 'I always get all the heavy patients'...when they're giving report they obviously haven't taken the time to find out what's going on with their patient (#011).

Nurse #016 agreed with the description of this maturational phase but would categorize it at an earlier developmental level than adolescence. She compared it to the toddler phase, Erikson's shame and doubt vs. autonomy, where the child ventures away from the parent but wants the parent close by. New nurses want the challenge of the more difficult patients, but want more experienced nurses close by in case assistance is needed. Whether or not each nurse would categorize this period as

"adolescence" or "toddlerhood", all nurses recognized a period of time where nurses felt some frustration in the restrictions of their practice. It is a time of being tested by colleagues and learning the unit-defined customs.

The two major findings in the study were the moral agency of nursing and the process by which nurses accomplish their objectives in delivering patient care. Each finding will be discussed in greater detail.

11. Moral agency Moral agency has been defined as "action by the nurse based upon self-embodied principles and knowledge to facilitate a perceived positive outcome for the patient, family or society" (Raines, 1994, p. 7). Other authors describe moral agency as actions taken by the nurse on behalf of the patient to bring about a biomedical good (Husted & Husted, 1994). Raines (1994) draws a distinction between moral agency, which she sees as internally motivated and highly complex, and advocacy, which is externally motivated and embedded in the professional nursing role (p. 10). Composed of environmental conditions, such as "modeling, ethical dilemmas, alternatives and information", antecedents precede moral agency (Raines, 1994, p. 8). An individual's own attributes of "sound knowledge, courage, duty/role, and privileged relationship" determine how the nurse as moral agent responds to a situation (Raines, 1994, p. 8). Raines' view of moral agency is contingent on the occurrence of an ethical dilemma in the nurse's practice. The nurses in the study behaved as moral agents in response to patient needs, whether or not an ethical dilemma existed.

Nurses in the study relied on their clinical competence in identifying a need of the patient. Their response to the patient's need stemmed from a number of factors: the nurse's conception of her role and obligations to the patient, her socialization as to the expected way to meet patient needs, her analysis of the most expedient way to meet the patient's needs and the consequences of the alternative

actions she has identified. The reasoning that the nurses gave for taking action to meet their patients' needs was that they wanted to prevent a harm to the patient. Their innermost motivations were not investigated. They probably had their own interests to protect, in terms of pride in their nursing care and avoidance of a bad outcome that would reflect on their nursing care, concern regarding malpractice, but none of these reasons were given. Nurses gave the reason of wanting to prevent harm to their patients.

Raines mentioned courage and the risk to the nurse in enacting her moral agency. In order to meet their patients' needs, the nurses in this study had to interact with physicians. Most of the time they began with the housestaff, usually the intern. The nurses described varying levels of comfort and frustration in taking the step of contacting the intern. Only the least experienced nurse in her first interview revealed some hesitation in contacting the physician. All, including the least experienced nurse by her second interview, had felt comfortable in making that contact. Once the contact was made, the nurse then had to decide if she was getting an acceptable response. This level of moral agency required reliance on the nurse's clinical knowledge and experience, knowledge of how a situation like this is usually handled on her unit, and knowledge of the other physicians who may need to be contacted if this situation is not resolved to the nurse's satisfaction. At this point, Raines' description of moral agency is inadequate to describe the nurses' behavior. The distinction she draws between moral agency and advocacy is artificial. If advocacy is a "process of working through channels for the benefit of a powerless group...providing outsider assistance to a group or individual, unable to obtain what is right or justly deserved" (Raines, 1994, p. 10), it is unclear how advocacy differs from moral agency. The nurse, in order to meet patient needs, decides what she believes is the right action for the patient's behalf, and follows a process of going up the ladder of medical hierarchy that she was socialized to follow until she either gets

the response she believes is right or gets an acceptable explanation. As a moral agent and as a patient advocate, the nurse acts on her perception (which may be validated through discussion with the patient and family) of what is right for the patient. An ethical dilemma, a problem for which the solution is between two mutually exclusive and equally unpleasant alternatives, may or may not be present. In examples of ethical dilemmas, the nurses assessed the urgency of the situation and sometimes by-passed the medical hierarchy by contacting the attending physician directly without first going through the first year, second year, and third year residents. Raines recognizes the emotional stress that nurses experience in varying degrees when acting as moral agents. She holds that if the nurse is not at liberty to "act in the preferred manner" (p. 8), she cannot be a moral agent. That perspective ignores the actions the nurse has taken up to the perceived limits of the nurse's moral freedom. It also represents the double bind facing nurses today--a moral imperative to act, but limits to actions the nurse can take, or impediments encountered by the nurse in enacting moral agency. For instance, the following case illustrates an example of a nurse who felt unable to prevent events leading to resuscitation that the patient did not want.

Nurse #006 came on one morning to be urgently summoned to a patient's room by the patient's nurse. The patient, who was not oriented, was rapidly deteriorating and had told his nurse earlier in the hospital stay, in the presence of his family that he did not want to be on a machine. Housestaff was notified of the patient's condition and both the staff nurse and Nurse #006 got involved in this patient's care. With the staff nurse and housestaff giving the patient emergency drugs, Nurse #006 tried to call the attending physician to direct the patient's care to avoid intubation. Although she had anticipated the patient's deterioration and had implored the attending physician to discuss resuscitation with the patient and family, the discussion had not taken place. The nurse was unable to reach the attending physician. She and the

staff nurse reported the discussion with the patient regarding his wishes, but the housestaff would not accept the nurse's report as sufficient to withhold resuscitation, and in the absence of any orders from the attending, they resuscitated. The patient was intubated, placed on a ventilator in intensive care and subsequently died. When Nurse #006 was asked why she did not insist that the patient did not want to be intubated, she answered that to assert that she knew what the patient wanted and she would not allow the intubation to occur would have been a "leap in her practice". She felt that she does not have the authority within the health care system to follow the patient's directions when they are in conflict with medical directions.

Moral agency and advocacy are limited by the fear of reprisals from the physician, fear of legal sanctions if her actions are considered outside the scope of nursing practice, fear of a change of heart by the family when their relative dies, and fear of reprimands from nursing administration for acting outside policy. Preventing harm to the patient, as the patient has defined the harm of being on a machine, was the lesser evil of the dilemma. Moral agency involves taking actions that will bring about the desired outcomes. Moral agency and moral authority differ. As a moral agent, the nurse is acting on behalf of the patient, and to meet patient needs. What cannot be separated from moral agency is the nurse's own moral character, her personal sense of right and wrong. While she can work on behalf of the patient to bring about an outcome that she may not choose for herself, but that the patient has chosen, she is acting as a moral agent. She negotiates the system as best she can since it is likely the patient is not able to work the system as well as the nurse, who is a part of the system. Moral agency is the implementation in the nursing process to bring about a good or prevent a harm.

Moral authority implies that the person who has moral authority determines the actions to be taken (or withheld). In the health care system, the person with the legal authority for making those decisions is the attending physician. There is an

assumption that the attending physician is following the wishes of the patient, and the physician's authority stems from the permission of the patient to make the decisions. The ethical principle of autonomy, respect for persons, underlies the patient's authority in decision-making. Nurses have described many situations in which the patient is not consulted, or the patient's expressed wishes are ignored. As in the case described by Nurse #006, the patient had stated his desire not to be on a machine, and the nurse had urged the physician to discuss resuscitation with the patient, but that had not occurred. The physician is recognized in this context as having the moral authority to decide if resuscitation is good or bad, a benefit or a harm. The patient has accepted the physician on his case, but does that also mean that the patient abrogates decisions to the physician on all matters? There are valid reasons why the physician resuscitates this patient, such as believing the patient's condition is reversible and readily treatable, but in light of the nurses' report that the patient and family did not want resuscitation, it appears that the physician is paternalistically deciding what is in this patient's best interests. The action of defying the patient's wishes would seem to negate the physician's moral authority. So moral authority has more to do with the social context and power relationships than with respect for persons.

In the health care system, the nurse works within the system as she has been socialized to do and weighs the consequences of her actions in relation to the importance of the desired outcomes. The nurses felt the obligation to act on behalf of their patients but were frustrated by the limits on their moral authority. Nurses have the moral authority to refuse to act or participate in a manner which they believe would compromise their ethics, although they may feel pressured to participate, such as in assisting in an abortion or resuscitating a patient who did not want to be resuscitated. If they are aware of their institution or agency policy on moral objection, they can ask for reassignment to avoid being placed in a position of

potential compromise. Only one of the nurses mentioned a situation in which she could not continue to participate in a patient's care because she believed the patient was being coerced into consenting to an abortion (#005).

The patient was on a psychiatric unit and had been told by her long-time psychiatrist that if she did not consent to the abortion, this psychiatrist would no longer accept her as a patient. Nurse #005 could not facilitate the patient's choice in continuing the pregnancy, so she felt she could not participate in the patient's care any further. In trying to bring about good for the patient, the nurse is limited in her moral authority. She perceives that she cannot legally act on behalf of the patient without written physician's orders. None of the other nurses described situations in which they excused themselves from a patient's care because they felt ethically compromised. They described feeling bad that they could not bring about the desired outcome for their patients, and they would participate in care that they felt was inappropriate. The nurses decided what was right or wrong for a patient in a situation, and most of the time, the nurses wanted to bring about the outcome the patient desired, whether or not the nurse thought it was the best outcome for the patient. If the patient's (and family's) wishes were unknown, then the nurse would operate from her own sense of what was right or wrong for this patient.

Nurses in this study often proceeded without written physician's orders so that they would meet their patients' needs in a timely fashion. They enacted moral agency, they advocated for their patients, but they believed they lacked moral authority. They learned how to get their patients' needs met by circumventing or manipulating the system.

12. Meeting patients' needs: By hook or by crook Most of the time the nurses could get orders written for their patients without difficulty. They expressed some frustration at having to contact the intern for problems that the nurses were

clinically capable but legally prohibited from solving. Some nurses had difficulty with an intern's attitude or lack of competence, but persevered until they got the desired outcome or an acceptable explanation. Those instances in which the nurse was unable to easily get the desired outcome, or anticipated difficulty related to a short timeframe, inexperienced intern, or reluctance of the housestaff to make a decision, the nurse would either disregard the chain of command and go directly to the attending physician, proceed without written physician's orders, or contact an intern or resident other than the one assigned to the patient whom the nurse expects would give the desired order.

Hutchinson (1990) studied rule-bending among nurses. Actions varied from allowing visitors to violate visiting hours to rupturing the membranes of women in labor to accelerate labor. Reasons given for bending the rules were to improve efficiency and to benefit the patient, and there were private reasons not given. The way nurses covertly met the needs of their patients was described by one nurse in the study as "invisible practice"(p. 14). There was the hope that when rules are bent, the exception becomes the new rule. The risk remained, however, that if the rule-bending was discovered, the rule-bender would suffer consequences. The impetus for the nurses' actions in breaking the rules appeared to be meeting the needs of the patient and family, although there may be other reasons not as altruistic. Hutchinson characterized the nurses' behavior as "responsible subversion" (p. 30). She did not attempt to explain their behavior but called for further study of "an important area of nurse ethics and socialization by explaining how nurses make decisions about what is professionally right and wrong in a context of ambiguity, conflict, and frustration"(p. 15).

Subversion implies that there is an intent to overthrow. The Random House Dictionary of the English Language Second Edition Unabridged (1987) defines subversive as "tending to subvert or advocating subversion, especially in an attempt

to overthrow or cause the destruction of an established or legally constituted government, a person who adopts subversive principles or policies; traitorous, treacherous, seditious, destructive" (p. 1898). In the present study, the nurses did not say that they intend to change the way they learned to operate to get their patients' needs met. In fact, they offered reasons why they would not want the authority to proceed without orders, to write the orders themselves, to inform the patients themselves, or to follow the patient's instructions on end-of-life decisions. A few of the nurses would accept the responsibility and accountability for writing orders for their patients. Nurse #004 would accept the authority to write routine-type orders for treating diarrhea or rigors in patients with AIDS. Nurse #009 would be comfortable writing orders for medications, such as insulin or oral hypoglycemic agents. Nurse #011 would be comfortable writing orders for advancing diet, managing post-operative pain, and treating delirium tremens. Other nurses would be comfortable in writing orders for routine problems in their specialty, and usually have proceeded without written orders in many instances. However, the most telling insight into the nurses' hesitation to accept the responsibility and accountability of writing orders was given by Nurse #001. She is capable of writing many of the orders for her patients, but does not want the responsibility of managing the medical care as well as the nursing care.

> I have the luxury of doing what I want with medical back-up...it's so rare that there's a conflict. I guess I'd have a bigger problem if I had to go to people and they wouldn't cooperate...I guess sometimes we have to check on things that are stupid, that we do have the knowledge, but I would say, I guess that goes against my practice act, that I could treat things. And I guess I do all the time, but it's some gray area that I'm not quite sure of..I guess that would make things a lot easier. Then I guess that would be good, except, I would have to sit and think about that because then where would that end? Then at some point, you wouldn't need much management because if that was my role, say even just with the potassium, say we would have to do it all the time, so do you want to take responsibility for it? It couldn't be just here and there...do I even want to adopt the responsibility? Sometimes I would say yes, when I was well-staffed but sometimes I'd say no when I'm not because, when I said I'd present the data I had, I also have the luxury of saying, "This person has v tach [ventricular

> tachycardia] and I don't have the time to check their potassium, so go check it. And take care of it, do this, this, and this, and take care of it (#001).

She does not want to overthrow the current system. There are other nurses in the study who want to have the authority, and are pursuing changes in terms of critical pathways, but most have accepted the "invisible practice". They find the process frustrating and oppressive at times, but prefer these frustrations to having broader accountability and responsibility.

IV. DISCUSSION

A. The Nurse's Role

The nurses reflected on their behavior as they defined it within the role of the nurse. References were made to the Nurse Practice Act, as the nurse understood it, and the nurse's own interpretation of her practice and her perception of its boundaries. The nurses were usually conscious of acts which went beyond the boundaries of nursing practice, such as giving medication without a written physician order or obtaining specimens and sending them to the laboratory without orders. The nurses' understanding of policies and laws that governed their behavior influenced them, but primarily their decisions were based on observing the behavior of other nurses on their unit and the consequences of those observed behaviors. If other nurses gave Tylenol without orders and there were no untoward consequences suffered by the patient or the nurse, then, in a like circumstance, the observing nurse may decide to give Tylenol without an order. The nurse understands that she should have a written order for any medication she gives, but accepts the unit practice of obtaining an order after giving the medication. Unit practices varied between units and between shifts on the same unit. Learning the acceptable behavior on a unit was accomplished through a socialization process that began in their educational program.

B. Socialization

Socialization into the nursing profession begins upon acceptance into a nursing education program. The student has selected nursing and the reasons for this selection are widely varied. The role of the nurse is presented and shaped through the formal educational process which exposes students to nursing instructors and staff nurses. The ideal behavior is taught and the actual behavior is seen. Discrepancies between the ideal and actual behaviors are often sources for

clinical conferences and the student is expected to verbalize support for the ideal behaviors. Upon graduation the nurse accepts a position as a registered nurse and begins an orientation program. Some institutions have orientation programs for new graduates that provide a transition from the role of student to registered nurse. This institution had only a brief orientation program that covered mandatory information only, such as the Occupational Safety and Health Association (OSHA) required videotapes on fire and electrical safety and personal protective equipment, and review of pertinent policies and procedures, such as for cardiopulmonary resuscitation. The rest of the orientation occurred on the nurse's specific unit.

The nurses were socialized to acceptable nurse behavior in their orientation to their units. In their formal orientation, they were most likely advised to follow the written policies and procedures, and their preceptors modeled the "right way of doing things". Just as in their nursing program, they were warned that they would see the "shortcuts" to the "right way of doing things" but they should not adopt those shortcuts. The informal, or unstated orientation, however, was the role-modeling of the nurses on the unit, how they practiced, and the nurse's conclusion that the "right way of doing things" was sometimes more time-consuming and less efficient as the shortcuts that were quietly accepted. After orientation, the nurses were still considered novices and, as some research participants described, initially found comfort in the supervision and support of more experienced nurses. There came a point, however, when the supervision became a source of frustration rather than a comfort. Many of the nurses either recalled experiencing this maturational phase or had observed it in others. Most nurses thought this phase occurred sometime between 6 and 18 months after beginning on a unit. This critical period of the socialization process has been described by Perez (1981) as the "surrogate parent" phase and she sees similarities between this phase and Erikson's stage of autonomy versus shame and doubt. The nurse has decided what constitutes her acceptable

standard of practice, usually based on her own values. When there are value conflicts with other providers or with patients and families, Perez (1981) believes the nurse exercises her rights as a surrogate parent and tends to tell others "what to do"(p. 7). The frustration in these situations can lead to burnout and eventually resignation from the unit. Perez confines her description to perinatal nursing practice. Nurse #005, who described "nursing adolescence", works in the perinatal area, and was not aware of Perez' literature.

Another aspect of socialization involves the nurse's prenursing attitudes and personality and the enculturation into the organizational hierarchy. Students may select a profession based on their perception of that profession. In a previous school assignment, the investigator interviewed four physicians who worked closely with master's-prepared clinical nurse specialists. The purpose of the assignment was to learn how the physician's viewed the nurse-physician relationship. Various topics were discussed, including the status difference between physicians and nurses, the discrepancy in addressing nurses by their first names and physicians by surnames and titles, and the expectations of the functions the nurse performs in a joint practice relationship. Three of the physicians were male, one female. All of the physicians believed that persons who chose nursing versus medicine did so because they either did not think they were smart enough to complete medical school, were low achievers (versus high achievers who would choose medicine), or did not want the responsibility the physician has and would prefer to be the order-taker rather than the order-giver (Savage, unpublished manuscript, 1991). Along with these physicians, the public perception of nursing is not necessarily consistent with the nursing profession's image of itself. Students entering nursing education may have been influenced by a public perception of nurses having an "assistant" status to physicians, and may have chosen it for that reason. In reviewing applications for entry into a baccalaureate program, the investigator often read narratives in which

the prospective student described her fascination with medicine and her desire to relieve suffering. In personal interviews with the applicants, the investigator would ask why the student selected nursing rather than medicine, and often the answer was related to lack of funding for medical school, concern about the rigor of the medical curriculum and the assumption the nursing curriculum would not be as rigorous, desire to be gainfully employed sooner through nursing than medical school and residency, and, rarely, the desire to practice nursing rather than practice medicine. In their nursing program, they would learn the distinction between the role of the physician and the role of the nurse. Often it is not until the nurse has graduated and is employed that the different roles are understood.

Winslow (1984) explains where some of the confusion about the nurse's role is rooted. Early in the profession, nurses were socialized to be loyal to the physician and employing institution above all else. In addition to being loyal, nurses were expected to be self-sacrificing and to live lives of obedience and hard work without complaint or need for recognition. As the profession evolved, the nurse was expected to protect the patient against errors by the physician, such as in the Somera case described earlier. The consumer movement demanded accountability for health care outcomes, which in turn put greater responsibility on institutions for protecting patients' rights. The feminist movement focused on shedding the subservient role of the nurse. The nurse became the patient advocate in the arrogant, paternalistic health care system. Winslow acknowledges the role of patient advocate as unclear, not necessarily supported by state's nurse practice acts, unrecognized by patients and families, frequently controversial, and often presenting a dilemma of conflicting loyalties for the nurse. Nevertheless, this position of patient advocate has been embraced by nursing education and nursing departments, so that this aspect of the nurse's role is socialized into an expectation of acceptable nursing behavior. The spectrum of the expression of the role, however, has a wide range.

In this study, in the descriptions of the extent to which nurses would go to advocate for their patients, some nurses were socialized to pursue the issue vigorously until they are satisfied, while others were socialized to refer the issue to their nurse manager, or to disregard the issue if more than one physician thought the issue was not significant. In one area, the nurse would not talk to an attending physician even for clarification when her patients were experiencing what she thought were drug-related side effects; she trusted that they were reading her and other nurses' documentation of the patients' reactions. Most nurses, upon hearing this example, thought the nurse's behavior was atypical for the expectations of the nurse's role at this institution, but thought her behavior was more culturally or gender-related. They speculated that ethnic origin and gender predisposed the nurse to deferential behavior to physicians. Other nurses cited gender as a factor in how nurses were expected to interact with physicians, the assumption being most nurses are female and most physicians are male. In this study, all the research participants were female and they almost exclusively referred to physicians using male pronouns. Several nurses thought the way in which nurses were socialized to interact with physicians was based on gender stereotypical roles of the physician as authority figure, the father figure, and nurses in the subservient, or child role.

In the previously mentioned school assignment, one physician described the physician as the father-husband figure who earns the paycheck and rules the house, the nurse as the mother-wife whose role is to facilitate the work of the father-husband and care for and nurture the children, and the patients are the children. The physician spends little time with the patients, but directs their care, while the nurse obeys the physician's orders, carries out the plan, and watches over the patients. The patients follow their physician's orders and are cared for and nurtured back to health by the nurse. The family hierarchy parallels the medical hierarchy as the physician sees it. Whether or not the physician is male or female, the

physician assumed the dominant role and the nurse the subservient role. The pervasive attitude in the health care system is one of the nurse as an assistant or extender to physicians in spite of the inculcation of the nurse's role as patient advocate in nursing education and employment orientation.

The frustration of nurses to be expected to advocate for patients, yet only be an extension of the physician is a double-bind. Nurses who experience cognitive dissonance in trying to assume both roles are probably those nurses who experience the maturational phase described by Perez (1981) and Nurse #005. To successfully pass through this phase, the nurse adapts to her environment by emulating the acceptable behavior of others or leaves the environment in search of another one that is compatible with the nurse's expectations. Those nurses who remain may channel their energies toward more rewarding efforts. For example, they may become the clinical experts with certain types of patients, like diabetics (Nurse #009), or certain services, like bereavement (#007, #016). They accept the "politics" of the culture and learn to work within the culture while preserving their integrity. Some nurses may not reconcile their dissonance and may resent the profession for "misleading" them. This attitude is consistent with descriptions of oppressed group behavior.

Characteristics of the oppressed group, such as being female, warm, nurturing, are not valued; the characteristics of the dominant group, such as being decisive, smart, and unemotional, are valued. Nurse #016 talked about nurses who would not be perceived as competent and would not be trusted by physicians if they appeared emotional, impulsive, and excitable. Nurse #011 and #013 discussed their realization that they had not been aware of their behavior in relating to physicians until others pointed it out to them. The socialization had been so effective they were not aware that they changed their style of interaction when talking to physicians.

In the literature on oppressed group behavior, the anger and frustration of the oppressed group are vented toward each other, rather than at the oppressors (Hedin, 1986; Roberts, 1983). Groups that are oppressed display self-hate and low self-esteem. The dominant group keeps the oppressed group on the margins of their culture. Since the oppressed group feels second-class and submissive, they do not vent their rage on the oppressors, but on each other. Skillings (1992) called this behavior "horizontal violence" and identified it as the source of the nursing profession's in-fighting. When the research participants sought advice or affirmation from their colleagues, they described those colleagues they respected and those they did not. The nurses they did not respect were those who simply did their jobs and no more. As Nurse #009 put is, "they're very, very good at maintaining the care plan and giving absolutely beautiful, wonderful care, and if you want to know anything about a type of drug or a cardiac rhythm or what's the best way of handling this patient situation, they're right there. But they're not real research-oriented or interested in confronting the docs, they want to leave at change of shift and go home and be done with it." Nurse #009 devalues a nursing colleague whose nursing care she admires, but attitude she does not. Perhaps she viewed that nurse as "settling" for the role that the oppressor permitted.

The whole socialization process is critical in the nurse's view of her role and her obligations to her patients. The nurse discovers how to practice what she has learned in the culture of the organization employing her. In the course of providing nursing care to her patients, the nurse often has to interact with others, such as the patient, family, other nurses, but primarily physicians. Much of what the nurse does for the patient requires a written physician order. If the physician does not routinely write orders that cover the particular tasks that the nurse or other perform, it is the nurse who discovers this and seeks orders. If the patient condition changes, the nurse notifies the physician for orders to cover what needs to be done

or what she may have already done. The nurse's actions are based on her sense of ethical obligation to the patient first, then, second, the concern for acting within the Nurse Practice Act. The nurse's clinical decision-making is motivated by and informed by her ethical decision-making. She first decides what is the "right" thing to do, then follows the process she was socialized to follow when pursuing a concern. In identifying an issue, the nurse often relies on subjective knowing.

C. Subjective Knowing

In order to identify issues, the nurse engages in the assessment process, which includes examination of the patient, listening to the patient and family, gathering objective data, such as laboratory and X-ray results, blood and urine tests performed on the unit, and subjective data, the "intuitive grasp" (Benner, 1984, p, 295) or "Nursing Gestalt" (Pyles and Stern, 1983, p. 52). Benner describes intuitive grasp as "direct apprehension of a situation based upon background of similar and dissimilar situations and embodied intelligence or skill" (p. 295). Nursing gestalt is defined as "a matrix operation whereby nurses link together basic knowledge, past experiences, identifying cues presented by patients and sensory clues include what nurses call 'gut feelings'," and "is a synergy of logic and intuition involving both conceptual and sensory acts" (Pyles and Stern, 1983, p. 52). These two phrases have been used in the literature to describe the subjective knowing that nurses develop with experience and prolonged contact with their patients. In a post-positivist environment, subjective data is acceptable as an indicator to search for objective data, but not necessarily as evidence of a problem requiring action. Subjective knowing is the trust one develops in the subjective data one gleans from an interaction. The nurses recognized their reliance on subjective data, yet were reluctant to take risks based on subjective data.

The nurses described examples where they acted on behalf of their patients and took steps that could have had unpleasant consequences for the nurses, such as contacting a physician or proceeding without orders. They weighed the risks to the patient in balance with the risks of the consequences to themselves and opted to risk the consequences to themselves. None of the nurses expected praise for acting on behalf of their patients and were pleased when they were praised. Most of the time they anticipated a conflict in convincing the physician that their concerns were legitimate, especially when they based their actions on subjective data.

In oppressed group behavior, certain characteristics, such as relying on subjective data, could be seen as being undesirable because it is seen in the oppressed group. Regardless of the outcome of the use of subjective data, it is not valued because the oppressors do not hone the skill and do not value it. Nurses have described the physicians' reluctance to rely on subjective knowing, either their own or the nurse's. So nurses takes risks when they heed their feelings and initiate interactions based on those feelings. They are following their moral imperative to prevent suffering, and that imperative outweighs the nurse's concern for unpleasant consequences for herself. Another aspect of assessment is the nurse's identification of an ethical concern.

Nurses described their sense of right and wrong as being internalized. They "felt", and they acted on those feelings. It was difficult for them to articulate how they knew an issue was an ethical issue. Rarely did the nurse mention that an ethics consultation had been requested for a case. Most of the interviews revolved around the nurses' efforts to provide nursing care that would meet patient needs, which was the fundamental ethical issue for every nurse.

D. Ethical Concerns

When asked to recall an issue, perhaps an ethical issue, that they faced, the research participants usually tried to think of an instance involving an end-of-life decision, abortion, resuscitation, or other dilemmatic situation. As the interview continued, they would identify other issues, such as informed consent, aggressive treatment of the elderly or very preterm infant, or providing inappropriate care. The ethical issues the nurses face are the everyday interactions they have on behalf of their patients. The "dilemmas" are the infrequent events that involve a great deal of energy and usually unpleasant stress. The nurses described their decision-making process in providing patient care and undergirding the steps in their decision-making process are ethical principles of autonomy, nonmaleficence, and to a lesser extent, beneficence and justice. Their every-day interactions with patients reveal their respect for the patient's autonomy and their desire to protect the patient from any possible harms. Levine (1989) argues that much attention in the nursing literature has been focused on dilemmas and less on the every-day interactions between nurses and their patients. She begins her article with this quotation, "Every nursing act is a moral statement." (p. 124). She recognizes that nurses have two moral imperatives that permeate all interactions: sanctity of life and prevention or alleviation of suffering. The nurses in this study held to those imperatives.

While the ethical principles are the foundation for the nurses' actions, they are integrated in a socialization process that serves as a model for all nurse behaviors. Most of the nurses may recognize an issue as having ethical components and will follow a course they have learned to pursue the issue. They have a "sense" of right and wrong, but that sense is influenced by their socialization and the culture of their unit. (See Table VII for a listing of ethical concerns.) With varying degrees of intensity, the nurses would pursue their ethical concerns. The greater the

perceived threat to the patient's life, the more vigorously the nurse pursues her concerns.

Nurses often mentioned concern for the patient's quality of life. They identified with the patient and remarked that they would make a judgment about their quality of life if they were experiencing what the patient was experiencing. They expressed a feeling of responsibility in the outcome, especially if it was a bad outcome for the patient. The nurses were most concerned about informed consent, and questioned whether or not the patient was fully informed of the possible outcomes or possible complications of a procedure. Although the nurses were troubled by the concern that patients may not be fully informed, they would not divulge information that they believed the patients should have. That behavior was viewed as over-stepping the boundaries of nursing practice. One nurse has recommended patients get another opinion, but getting that next opinion does not guarantee the patient will be fully informed by the next physician.

Nurse #018 speculated that divulging information to a patient has not typically been within nurses' purview and carries with it a degree of responsibility and accountability unfamiliar to nurses. Even those who are in advanced practice roles are initially uncomfortable in informing the patient when the information is traceable to them. Perhaps the oppressed group behavior has influenced the advanced practice nurse as well, so that there is some insecurity about treading into unfamiliar and previously "off-limits" territory. Instead of characterizing the nurse's action as emancipatory, it is likely the nurse's action is being done with a physician's tacit approval. Even the research participants with the master's degree thought it was the physician's responsibility to fully inform patients and would permit patients to undergo a procedure without information the nurses believed the patient should know.

In summary, the nurses were motivated to act on behalf of their patients out of respect for the patient's autonomy and the desire to prevent harm to the patient. The nurses' actions followed a process consistent with the process they were socialized to follow in resolving issues on their unit.

E. Planning and Implementation

In the nursing process, after an assessment is completed, the nurse formulates a plan. The plan is then implemented and the results evaluated. Based on the evaluation, the original plan may be revised and modified. A revised plan is then implemented. Once nurses have identified a concern, they formulate a plan to pursue the concern. They may discuss their plan with other nurses and revise it based on their input. They then implement their plan, which usually involved interaction with a physician. The process begins with the identification of a concern.

1. Pursuing nurse's concerns In deciding to pursue a concern, the nurse first "feels" that she should take the next step. Usually she bases her decision to proceed on her assessment and her belief that a certain action should be taken or should not be taken, or that an intervention should be implemented or discontinued in the best interests of the patient. Although the nurses were cognizant of their role versus the physician's role, the nurses often felt obligated to influence the medical management of patients. Most nurses felt they knew as much as the physician in managing the short-term problems; in specialty areas, the nurses thought they probably knew more than the first year residents, and would often direct patient care in an indirect fashion.

The nurses first assess their patients to discover the issue, then would validate their concerns with another nurse whose opinion they value. If the issue was

within the boundaries of nursing practice, as the nurse defined her own boundaries, she would handle the issue. An example might be advancing a diet--a physician's order is needed, but some nurses described how they would assess the patient and advance the diet as they believe the physician would, but they would not wait for the physician's order. Another example the nurses gave was to obtain cultures and give Tylenol to patients who spike a temperature. Based on the length of time spent with the patient and based on the nurse's past experience, the nurse would decide whether or not this issue should be addressed. Nurses used their subjective knowing to determine if proceeding was the "right" thing to do. They described how they knew they were right, in using these terms and phrases: "gut feeling", "sixth sense" (#003), "knowing that it's the patient's wish" (#004), it "feels right", a "feeling", "you get a sense from people when you work with them on a regular basis"(#005), a "gut feeling, an intuition"(#007), "I just know I'm right"(#011). Depending on how the nurse was socialized to pursue a concern, the next step involved interacting with someone.

The nurse has selected others, usually nursing colleagues on the same shift or from the other shifts at change-of-shift report, to hear her concerns. Some nurses would specifically seek out certain fellow staff nurses they respect, or a clinical nurse specialist, practitioner-teacher, or the assistant nurse managers, or the nurse manager, in that order. They would poll others to validate their concerns as well as to garner support. Infrequently they would seek assistance from the nurse manager, and usually only when they perceived that they needed clout from an authority figure to bring about a change.

They might consult someone outside their unit, such as a nurse from an intensive care unit or a nurse specialist, such as the doctorally-prepared nurse who consults on pain management or the nurse who works with the electrophysiologist physicians. They accomplish two goals in these interactions: 1) they continue to

validate their concerns; and 2) they can effect a change through the contacted nurse who then interacts with a physician. Most steps taken at this point involve starting up the medical hierarchy in the medical center "pecking order". The first year resident, the intern, is the first-line contact for the staff nurse. The nurse brings her concern to the intern for various reasons. She was socialized to the medical structure and the intern is supposed to write all the orders and manage the patient. Nurses believe that the intern, as part of the learning process, must be aware of all the issues with the patient. Attitudes toward working with interns range from respectful collaboration to petulant tolerance. The personality of the intern influences the nurse's decision on how to interact with the physician.

2. Interacting with physicians In emergent situations, the nurse may by-pass the housestaff and begin interactions with the attending physician. The nurse decides if the situation warrants "going over the heads" of the housestaff, such as when a patient is deteriorating and the resuscitation status is inconsistent with the patient's wishes, or the patient is expected to be sent off unit for a procedure that the nurse believes should be postponed. In almost all instances except urgent ones, the nurses begin interactions with the housestaff. (The other exception is for nurses in home health whose patient care is managed by attending physicians). Before contacting the physician, the nurse has collected data, both objective data such as vital signs, laboratory values, patient and family statements, and subjective data, expressed as a feeling or intuition the nurse has about the patient. She decides what she thinks should be done at this time in this particular situation. The patient's intern is the person the nurse needs to contact; however, some nurses may try to get another intern to see the patient and write the necessary orders. The personality of the intern influences the nurse's behavior. Nurses complained of interns they viewed as being "lazy" or "half-assed". In other instances, the nurses thought the

interns were often scared and knew that the nurses knew better how to medically manage the patients.

Many nurses believed that while the interaction must begin with the intern, the actual decision will be made by the attending physician because the housestaff are either reluctant or prohibited from making a decision without the attending physician's approval. The "smart" physicians would ask the nurses what should be done and would follow the nurse's recommendations. Almost all the nurses admitted that they rarely told the intern what should be done unless the intern asked. The nurses believed that the intern would not welcome unsolicited advice because it would demean them as physicians to accept advice from nurses. The nurse would phrase the information to lead the intern to the conclusion that she has drawn. Even those nurses who spoke respectfully of working with the housestaff would only tell the intern what to do if directly asked. Viewing this communication style as gender-related, some nurses accepted it as "politics" or the way to get what is wanted. While several nurses attributed this communication style to subordinate females interacting with dominant males, others acknowledged that it occurred between subordinate nurses with dominant physicians, and gender was irrelevant. Some speculated that nurses as women were socialized as women to interact with others in this indirect, nonconfrontational manner and this pattern was reinforced in nursing education and in socialization into the profession. This pattern is consistent with the "doctor-nurse game" (Stein, 1967). Stein, Watts, and Howell (1990) "revisited" the doctor-nurse game and believes the game has evolved toward a more collegial relationship, although there are forces that want to retain the old hierarchical model. The subservient nurse has been replaced by the "stubborn rebel"(p. 267) who challenges the physician in an "overdetermined" and "hostile" way (p. 267). Physicians respond with confusion, because they never did view nurses as being oppressed, and they conclude that nurses who challenge them no

longer want to do nursing. The nurses they characterize as no longer wanting to do nursing are nurses who have advanced their education and wish to practice in expanded roles, or nurses who work in utilization review and can "directly threaten physicians' authority in clinical decision making" (p. 266). As long as the quality of care is not compromised by the power struggle that may ensue from a new doctor-nurse relationship, these authors see the new doctor-nurse game as positive.

The Stein, Watts, and Howell (1990) article does not seem relevant to staff nurses who actively avoid interacting with attending physicians. The nurses who express little hesitancy in calling an attending were usually the nurses with graduate education, who have practiced more autonomously than a staff nurse. The exception was the staff nurse who went directly into home health nursing upon graduation and was not socialized in hospital nursing. She primarily interacts with attendings or with a group of physicians who see indigent patients only. Even in her limited experience, she has encountered physicians who act annoyed with her for initiating contact with them, especially when they interpret her concerns as minor or insignificant.

3. Conflicts with physicians Nurses decide what they believe is best for their patients. Often in order to deliver nursing care consistent with what the nurse believes is best for the patient, the nurse must have orders written by a physician. Unless the physician gives the nurse an acceptable explanation for not writing the orders the nurse is seeking, the nurse will pursue her concerns by following the chain of command in the medical hierarchy. Nurses are socialized to advocate for their patients and protect their patients from possible harms. When a conflict arises between a nurse and a physician, the nurse has a recourse to speak to other physicians with increasing authority. Should the nurse get an acceptable explanation for the physician's decision, she would be satisfied and would consider

the issue resolved for now. If that explanation was not acceptable or if she is not given an explanation, she would continue up the chain until reaching the attending physician. It is at this juncture nurses differ on their approach.

Most nurses involved in direct patient care feel a responsibility to pursue an issue up through the chain of command to the attending physician. They view attending physician as having the final word on an issue. If the attending physician does not agree with the nurse, the nurse may try to persuade the attending with additional data, but this step of interacting with the attending physician depends on the nurse's comfort level. Most nurses speak of and speak to attendings in a deferential tone. Even those nurses who define their relationships with certain attending physicians as very collegial, they admit that they do not interact with attendings in the same way that they interact with housestaff. Some nurses are reluctant to call the attendings at all, and have been socialized to direct conflicts to their nurse managers. Most believe that it is their responsibility to interact with the attendings, but may quickly accept the attending's answer and will let the matter drop. Others describe another strategy of returning to the patient and family, and urging the patient and family to pursue the issue with the attending. One nurse described this method empowering the patient and family, yet her reason for using this approach is that she does not feel empowered to interact with the attending physician, and she's using the patient to get what she believes is best for the patient. This method most likely protects her from unpleasant interactions with the attending physician, as she has not been admonished by the attending for this behavior.

If the attending physician does not agree with the nurse, all nurses acknowledged that, except for using the patient as a go-between, they are powerless in this situation. One nurse supposed that she had an alternative of contacting the legal department or the risk management department, who were viewed as being more powerful than a single attending physician. She could not imagine a situation

that would provoke this action, and would be extremely reluctant to take this action. The nurses were resolved that even if they thought the patient could be harmed, they had no reasonable recourse if the attending physician was not in agreement with their requests for the patient. The nurses described consequences of incurring the wrath of the physician should she challenge or argue with the physician. One physician in particular was mentioned by almost all the nurses as being so unpleasant in his interactions that all but one avoided any contact. The nurses would permit a harm to occur to his patients before they would pursue an issue beyond the most senior housestaff with him. One nurse, who was verbally abused by him when she paged him in an urgent situation, stated that she would indeed page him again in the same situation because she believed that the issue required it. Even in this instance, where she anticipated and suffered his wrath, she apologized to him for making the contact, and asked him to furnish her with an alternative to paging him.

None of the nurses characterized the unpleasant interactions they had with physicians as "nurse abuse", although the above exchange described by Nurse #005 constitutes nurse abuse, according to the definition provided by Diaz and McMillin (1991). "Abusive behavior is defined as behavior of one person which, through words, tone, manner, or other nonverbal cues, uses the power of a dominant position inappropriately toward an actual or perceived subordinate. Nurse abuse is, then, abusive behavior by a physician directed toward a nurse" (p. 98). Nurse #005 was the only nurse who would repeat the action that resulted in the exchange. Other nurses stated that they would seek another avenue, such as putting more pressure on the resident to act or convince, or encouraging the patient and family to contact the attending physician directly. Most nurses did not excuse attending physicians who were abusive, but viewed the situation as beyond their control to change. They did not seek any recourse to correct the attending physicians' behaviors except to limit

their interactions with the abusive physicians. The nurses felt powerless to change attending physicians' behavior.

The conflict with physicians was identified by Erlen and Frost (1991) as an ethical dilemma. With housestaff, however, they would either speak directly to the resident, or speak to the resident's senior. In a less direct approach, the nurse would structure a public situation, usually rounds, and ask questions that would result in embarrassing the abusive or "lazy" resident who did not respond affirmatively to the nurse. This passive-aggressive approach, described by Nurse #001 and confirmed by others, is a characteristic of oppressed group behavior (Roberts, 1983, p. 27). It is usually ineffective in bringing about change and continues to perpetuate the behavior. Nurses usually would not jeopardize their relationship with the resident as it could affect future patient needs. Occasionally the nurse expressed concern for the resident's feelings; she did not want to get the resident in trouble. Instead she would put herself in a position of interacting with the attending when she anticipated a negative response. This behavior is consistent with Gilligan's (1982) views of self-sacrifice and the preservation of relationships. Again the nurse faces a double-bind of trying to advocate for her patient while preserving her relationship with physicians.

Since the nurse feels a responsibility to pursue a concern, yet feels powerless to act unless the physician agrees, she is caught in the middle. Murphy (1984) recognizes that this "in the middle" position can result in nurse burnout. Nurses do not feel part of the decision-making process, they lack self-worth, and they have poor professional relationships with physicians. The recourse that Murphy recommends is the use of ethics committees. Some situations are not overtly appropriate for ethics committees. In the investigator's experience, ethics committees are reluctant to comment on issues related to professional relationships. There is encouragement to improve the quality of the communication between

professions, otherwise instances of conflict are referred to other channels such as chain of command or morbidity and mortality conferences.

4. Interacting with patients and families The nurses describe their role with patients as one of information-sharing, teaching, protecting, and advocating. In order to meet the patient's needs, the nurse assesses and negotiates daily with the patient. Based on the prolonged and/or repeated contact with the patient, the nurse makes judgments about the interpretation of signs and symptoms, the patient's emotional well-being, the patient's sincerity in his/her declarations, and the patient's quality of life. The nurses admitted they were often "pretty loose with information with the families" (#001), and often depended on information from the family about the patient. The patient or sometimes family could validate the nurse's assessment and strengthen the nurse's resolve to pursue an issue. Respect for the autonomy of the patient was pervasive in the nurses' actions. Even when patients refused information, such as precardiac catheterization teaching, the nurse explained the reason for giving the information and allowed the patient to decide if any further information was wanted. If a patient refused medication or a test, the nurse would attempt to learn the reason and correct any misinformation the patient may have. If unable to persuade the patient to take the medication or go for the test, the nurse would respect the patient's decision and inform the physician of the patient's decision.

The nurse often acted as a liaison between the patient and family and the physicians. The nurse would ask a question for which she knew the answer so that the physician, in answering the nurse's question, would be actually answering the patient's question. The nurse would be careful to ask the questions that she thought the patient would ask or is ready to hear.

In those instances where the nurse had feelings in conflict with the plan of care, such as caring for a patient undergoing an abortion, or caring for a patient who is rejecting a transplanted organ secondary to substance abuse, the nurses stated they could provide care without letting their personal feelings influence their care. They admitted that, depending on their relationship with the patient, they might even tell the patient how they felt. Most of the time, they believed the patient would not have any indications of how the nurse truly felt.

When the nurses were asked to describe their role in patient decision-making, they all described the role as one of providing limited information, clarifying the information previously given by the physician, and then helping the patient think about options, outcomes, and effect on their quality of life. The nurse may not be involved in the decision-making at all. Many times they would not be present when consent was being obtained, although they said they made every effort to be present when physicians talked to patients and families. They denied influencing the patient's decision, although they were aggressive in "informing" the patient. They would call former patients to talk with current patients, they would bring data supporting one option over another, but they would deny that they were influencing the patient's decision. In instances in which the nurse was told by the patient that the patient was persuaded by the nurse to choose one option over another, the nurse "freaked" and was terrified that the patient would have a bad outcome and it would be her fault.

The "passive-aggressive" behavior of the nurse, as described by Nurse #001 in physician-nurse interactions, appears in the patient-nurse relationship. The nurse may not recognize her influence over the patient and therefore discount her input as "taken with a grain of salt". When she is held accountable for the input, the position is new and uncomfortable for most nurses. The degree of discomfort is related to the degree of risk to the patient and the degree to which the decision is

congruent with the nurse's values and beliefs. When a nurse persuades a patient to undergo cardiac surgery and the patient said that she had talked him into this procedure, the nurse was extremely anxious awaiting his outcome. She believed in the use of technology, but knew there was substantial risk to the patient, so she experienced a high level of discomfort. Another nurse attempted to persuade a 50 year old woman to accept a cardiac transplant. The patient's reasons of being too old and being ready to die was inconsistent with the nurse's values and beliefs, yet the nurse respected the patient's point of view. The nurse provided information to the patient and even had a previous patient call and talk to the current patient at length about pros and cons of the decision. In the end, the patient refused the heart transplant and died. The nurse, while believing that the patient was too young to die when technology was available to save her, believed that the patient ultimately has to decide what is best. The reluctance to accept responsibility for a behavior that is typically in the physician's domain is consistent with oppressed group behavior.

The nurses rarely described conflicts with patients and families. The conflicts pertained to interacting with others on behalf of the patient. Nurses were uncomfortable about situations in which patient safety or autonomy were actually or potentially compromised. To protect and advocate for their patients, the nurses would usually need to obtain a physician's order for some aspect of the patient's care.

F. Physician's Orders

1. Pursuing physician's orders Nurses described the time involved in obtaining orders for routine care. Examples of the orders needed are when nurses obtain specimens of bodily fluids from their patients and cannot send them to the laboratory without a written order, or when a medication not previously ordered, such as an antipyretic or laxative, is indicated. Other routine orders include orders for intravenous fluids to follow the currently infusing fluids. When the nurse

cannot provide appropriate care for her patient because orders have not been written, the nurse must contact the physician and ask the physician to write the orders. In selected instances, the nurse may take telephone orders, but verbal orders, over the phone or in person, are discouraged. The rationale is that the physician may change his mind before the order is co-signed and could deny giving the order, leaving the nurse legally "uncovered". Although none of the research participants had this experience, they were aware of it happening to other nurses and reiterated the practice of not accepting verbal orders.

2. Proceeding without written orders Many of the nurses, however, would proceed with routine actions, such as advancing a diet or hanging "to follow" IV fluids, which are identical to the previously ordered fluids. The nurses trust that these actions are approved and they are acting in their patient's best interests by proceeding without written orders, or writing the orders as though they received verbal orders from the physician. The nurses justify doing this by stating they are saving their time in chasing down residents, saving the resident's time in permitting him to just co-sign the order, and sparing the patient from any problem in the delay. Nurse #016 expressed discomfort with the legalities of proceeding without orders, but she qualified her situation by granting that residents were almost always available in her unit. Other nurses considered the importance of the order. For something they considered minute, they would proceed. For more significant orders, they would weigh the consequences to the patient, and would take the action to minimize harm to the patient, even if it meant initiating invasive interventions or giving medication. Usually the situation would be perceived as being urgent and potentially life-threatening before the nurse would take such drastic action such as starting an IV line or giving a medication, such as insulin or an antihypertensive. The nurse's experience, confidence level, and culture of the unit play a part in the nurse's

actions. The nurse may know exactly what should be done, but not feel comfortable in doing it without a physician present. All nurses would proceed in life-threatening situations, even if it were not the patient's wishes. For example, in a resuscitation decision, the nurse would proceed even though she was aware that the patient did not want resuscitation, in the absence of a "Do Not Resuscitate" (DNR) order. One possible motivation for this, other than the legal compulsion to resuscitate, was identified in a study of nurses' attitudes toward "Do Not Resuscitate" orders in neonatal intensive care (Savage, Cullen, Kirchhoff, Pugh, and Foreman, 1987). Using Ajzen-Fishbein theory of reasoned action, the authors found that subjective norm, the nurse's desire to do what she believes others think she should do, was a more powerful influence on the nurse's behavioral intention than her own attitude about whether resuscitation was good or bad for a patient. The sample size was small (n=27) and hypothetical cases were used, rather than relying on the nurses' recollection of similar cases, so interpretation is limited. However, if subjective norms exert a more powerful influence on nurse behavior, socialization plays a large part in the subjective norm. The culture of the unit conveys to the nurse what is acceptable and unacceptable behavior. What stimulated the DNR study was the investigator's observation of the almost reverent compliance to DNR orders in one nursery, and an almost cavalier and unpredictable compliance to DNR orders in different nursery. The gravity of the decision had an impact on the nurse's behavior. When a nurse decided not to comply with an order, it was always in the instance of ignoring an order to withhold resuscitation, and the nurse would resuscitate despite an order to the contrary.

If a patient condition changed, the nurse would analyze a number of factors. Her perception of the need for physician assessment of the patient at this time, her workload, her relationship with the physician, and the acceptability of the nurse proceeding without orders at this point. Most nurses described their decision to

proceed without orders as based on their lack of time to pursue orders, their confidence in knowing what the physician would do, and the acceptability on this unit of her decision not to pursue orders at this time. At some point, the nurse would notify the physician of the changes and of her actions, and anticipates the physician will approve of her actions and will write orders to cover all she has done. She expects that the physician will appreciate not being bothered and even if the physician may decide that an action was unnecessary, he will write the order and cover the nurse rather than chastise her. Both the physician and nurse have concern for their ongoing, working relationship and realize the effect that a strained relationship will have. The physician may end up getting paged for every order, regardless of how minute, and the nurse may have to wait to carry out interventions until the physician decides to write the orders. The patient has the most to lose in this power struggle. No nurse mentioned any consequences for operating without written orders, although they were aware of the concern that their manager would face if the Joint Commission on Accreditation of Healthcare Organizations discovers the practice. In certain circumstances the nurses would even write orders as though they had obtained verbal orders from the physician when they had not spoken to the physician. The nurses did not have standing orders, PRN orders, or protocols as coverage. They trusted that the physicians would write the orders at a later time.

It was surprising, then, that when asked if they wanted the legal authority to write such orders, most of the nurses said they did not. They offered reasons of not having time to do both medical management and nursing care, yet they were virtually managing care under the current system. If there were such a system in place where nurses wrote orders, they did not think all nurses should have the authority to write orders, but could not think of how to determine who gets the authority. Not all nurses are capable of making correct medical judgments, they said.

Even the most experienced or the most educated nurses may not be capable of making medical judgments. One nurse described the current system of nurses writing orders with medical back-up as a "luxury" for the nurse to have the freedom to do what she thinks is appropriate and the physician takes the responsibility. She acknowledges that the nurse has responsibility as well, but believes the current system puts the onus of responsibility on the physician.

V. SUMMARY

Over a period of time, eighteen (18) nurses working in eleven different units of the same medical center were interviewed; half of them were interviewed two or more times. The initial question posed to each nurse was "Who do you have to interact with to deliver the kind of care you think is appropriate?" The major findings in this study pertain to these nurses, and through comparison of the thick descriptions provided on each interview, others may find these conclusion will resonate with their group:

- Every interaction the nurse has with a patient is a moral interaction
- Nurses are motivated by respect for the patient's autonomy and desire to prevent harm
- Nurses have internalized their sense of right and wrong and operate from their feelings
- The "doctor-nurse game" first described by Stein in 1967 continues
- Nurses pass through a maturational phase, usually early in their career or in orientation to a new unit, in which they experience cognitive dissonance
- Nurses decide what they believe is the right course of action, then proceed in the manner in which they were socialized to bring about the outcomes they desire
- The interactive style nurses use with physicians is characteristic of oppressed group behavior
- Nurses feel a responsibility to safeguard patients and thereby monitor their medical management, but do not want the legal authority to write orders
- Nurses believe they provide information, clarification, and reflection for patients when they are making major health decisions, but that the patients freely make their choices

- Nurses will frequently act without written physician's orders in anticipation that a physician will eventually write orders to cover their actions
- Interacting with attending physicians is usually uncomfortable for nurses and is avoided

In the naturalist paradigm, an inductive approach guides and informs the investigator. Moving from reductionism to theory-generating, the data are analyzed, explained, and interpreted. The raw data are reviewed for common themes. For example, each interview discussed socialization of the nurse to the way nursing is practiced on her unit. In each interview, several topics were discussed and the responses were then categorized into major themes. Often the research participant would raise a new issue or a new perspective on a topic, and then those points would be used in seeking the next research participant to be interviewed. The on-going data analysis of naturalistic inquiry permitted the investigator to pursue a new line of inquiry not previously discussed with past interviewees. At the conclusion of the study, the interviews were reviewed again for commonalities and atypical points of view, and the categories were reduced to two major categories. The next step was to identify an appropriate theory that fit the data or to generate theory from the data.

The investigator searched the literature for a theory that might fit the data. In the investigator's previous study, the theory of reasoned action (Ajzen and Fishbein, 1980) was used to develop an instrument to measure nurses' attitudes toward resuscitating despite orders not to. In brief, the theory of reasoned action states that a person's behavior is influenced by that person's attitude toward the behavior (attitude), and what that person believes other people think he/she should do (subjective norm). However, the quantitative approach used in that study was too limiting in capturing the complexities of nurses' actions. Additionally, the element of measuring a behavior that was being dictated by another profession, to resuscitate or not resuscitate, seemed to confound the theory. Ajzen (1988) revised the theory

and added a component of perceived control. The theory of planned behavior states that a person's behavior is influenced by that person's attitude, subjective norm, and perceived control over the behavior. It has an appeal in explaining the nurses' actions as they described them in this study, however, the perceived control variable still does not capture the nurses' actions. The nurse does not have legal control over many interventions she would perform, yet she can and she did physically perform those actions. For example, she assesses that the patient should have blood cultures drawn, she knows a physician's order is required for drawing blood from a patient, and she decides whether or not to proceed and draw the blood. She has control over whether or not she draws the blood, yet she does not have the legal sanction to do it unless she obtains a physician's order. While she has the physical control to do it, she is acting outside her hospital policy and outside the Nursing Practice Act, so one could argue she does not have control of the decision to draw blood cultures. Yet almost all the nurses stated they have drawn blood cultures when there were medical indications and they thought the physician would write the order to cover them.

A. Structuration Theory

Giddens' structuration theory (1987) provides a model for explaining the nurses' behaviors. A sociological theory, the structuration theory is a duality of structures--subjectivism and objectivism. Giddens maintains that structure "consists of the patterns or relationships observable in a diversity of social contexts" (p. 60). Subjectivism is "practical consciousness", knowledge that is "embedded in" and "constitutive of" a person's actions (p. 63). Objectivism is the empirical, measurable phenomena. Allen (1992) believes Giddens' theory "provides a perspective on the relationship between individual action and social structures" (p. 10). He advocates the use of this theory as an explanatory framework to help understand "how to restructure social institutions so as not to reinforce or merely reframe current

injustices" (p. 9). Allen's interpretation and synopsis of Giddens' theory resonated with the conclusions of the study.

Giddens argues that a comprehensive explanation must include three dimensions: Action (what the people being studied believe they are doing and why they are doing it), unintended consequences of action (consequences that "escaped" the knowledge or goals of the people [agents]), and unacknowledged conditions (resources that made the action possible but were not acknowledged in the actors' accounts). These dimensions will be applied to the study's findings.

1. Action The nurses believed they were following a process to bring about a desired result for their patients. They were acting on behalf of the patient, for the patient's safety and well-being. The actions consisted of direct patient care, documentation, and verbal interactions with patients, families, fellow nurses, physicians, and others involved in patient care.

2. Unintentional consequences of the action The intended consequences of the action are to provide for the patient's safety and well-being and to preserve the status quo in the nurse's culture. The nurse would follow a process that she was taught and that was approved, overtly and tacitly, by those in authority. What the nurse may not intend to perpetuate is the oppressive nature of providing nursing care, and the "game" or the "politics" of the manner of interaction. The nurses may wish to change the status quo so that the physicians performed their roles without requiring the nurse to monitor and protect the patient. The nurse could then devote all of her energy to nursing care rather than monitoring the medical management.

3. Unacknowledged conditions of action The image of nursing is an unacknowledged condition of the nurses' actions. Patients, families, and physicians

form an impression of the profession as a whole based on their interactions with nurses. Positive experiences that patients have with nurses often leave patients with the impression that the nurse is smart, ("You're so smart; why didn't you become a doctor?), implying that if a person is smart, they would choose medicine over nursing, or caring, ("I bet you're a good mother"), implying that nursing, like motherhood, is innately female. The physicians may see nursing as their eyes and ears when they are not there. Physicians behave as though they are complimenting nurses when they call them their "eyes and ears", implying that nurses are extensions of physicians, and that they are instruments of data collection that feed information to the organism's brain, then await feedback. The Nurse Practice Act is an unacknowledged condition of the nurses' action. As long as nurses operate in a way that ignores the Nurse Practice Act instead of actively working to change it to be more compatible with actual practice, their actions maintain this unacknowledged condition. It is unlikely the nurses in this study want their actions scrutinized according to the Nurse Practice Act, but it has been more expedient and less confrontational to continue their practice of proceeding without orders.

As an oppressed group, an unacknowledged condition is the perpetuation of the oppression. Nurses object to the oppressive nature of the physician-nurse relationship, yet find it is again more expedient to "play the game". The insidiousness of the oppression is such that the nurse may not realize she is perpetuating it.

Giddens' theory of structuration lends a framework for explaining the conclusions of the study. The action of the nurses should be examined in greater detail, the unintentional consequences and unacknowledged conditions shared and explored. Do nurses recognize that they are oppressed? Do they want to be oppressed? Are patients better served by nurses who are oppressed? Do physicians

want nurses to be oppressed? Does society want nurses to be oppressed? Further research could illuminate these issues.

Nurses need to decide if they want to 1) change the system so that they are no longer oppressed in the health care system, 2) make no change and acknowledge their oppressed situation, or 3) continue the status quo. Their decisions have implications for the future of nursing.

B. Implications

To return to Penticuff's (1991) recommendations for research in nursing ethics, this study focused on the transactions between patients, nurses and others within the health care context, integrated the influences of the nurse's organizational and political environment on their practice, provided data on descriptive ethics as well as the context and content of normative ethics, and gave some insight into the complexity of the nurse's role within the practice environment and into the goals and values of nursing as they relate to human needs.

This study has implications for nursing practice, education, and research. The profession, not just the associations and the activist, but the nurses like the research participants, must decide if they want to change the system in which they practice. Until they decide that they are more frustrated than not, nurses will remain oppressed in the medically-dominated health care system.

1. Implications for the future of nursing

Nurses in this study were highly educated and functioned in an academic environment that was nationally known for its nursing practice. The medical center was undergoing drastic restructuring that affected nursing care delivery and had ramifications for the image of nursing in the institution. The overt message to nursing was to deliver the highest quality of care, advocate for the patients, collaborate with professional colleagues, always follow

policies and procedures, and contribute to the profession of nursing within the institution by donating time to the Professional Nursing Staff organization. The covert messages were that it is acceptable to ignore policies and procedures within the customary practices of the nurse's own unit, it is acceptable to proceed without physician's orders on behalf of the patients if the nurse is confident that the physician will support the nurse by writing the order, and it is preferred that nurses following a chain of command and not disturb the status quo.

A maturational phase in a nurse's career represented a dissonance between what the nurse thought she could do, should do, and was capable of doing, and what others, primarily her fellow nurses on the unit, thought she was capable of. Benner (1984) commented that with novice nurses, managers often underestimated their competence (p. 189). Nursing students are taught to identify their patients' needs, advocate for their patients, and uphold the Code for Nurses. The Code for Nurses (American Nurses Association, 1985) poses high standards for ethical behavior, yet for nurses to realistically uphold this Code, they would be pitted against their institution. The messages sent to nurses are conflicting: advocate for the patients but don't get caught breaking the rules. To overcome this double bind, the nurses in this study have accepted an "invisible practice" as the way to meet their obligations to care for their patients and advocate for their patients and not get caught breaking rules. Should they get caught, they risk being sacrificed so as not to disturb the status quo. Biordi (1984) also found nurses's work to be "so routine and private" that it seemed invisible to others (p. 78).

The caring literature supports the predicament facing nursing. Throughout nursing history, nurses have been expected to function in a subservient capacity and were told if they really cared about their patients, they would remain obedient and uncomplaining (Reverby, 1987). The lack of control over their own practice also interfered with nurses' ability to deliver the kind of care they believed was

appropriate (Reverby, 1987). In this study, the nurses are not expected to be subservient at the cost of harm to their patients. They are expected, however, to accomplish meeting the needs of their patients through "invisible practice". If nursing practice was visible, patients would be aware of the role nursing plays in their health care. Since patients would then be aware of the role of the nurse in their medical management, physicians would need to acknowledge the nurse's role. The doctor-nurse game would be replaced by mutual respect for professional colleagues. Medical schools would need to recognize the educational contribution of nurses in the education of residents and medical students. Nurses must then embrace the new role of visibility and accountability. Nursing practice would be transformed into a profession on a par with medicine. At that time, many of the actions for which nurses must now have a physician's orders could be within nursing's purview. This would require a change in the Nurse Practice Acts in every state.

The major transition will require nurses who have been educated and socialized to function in the invisible way to accept a visible practice with greater responsibility and accountability. Commensurate with the responsibility will be greater autonomy in practice and appropriate compensation. The entire way health care is delivered in institutions would change. Instead of having departments of nursing, nurses may come together in service corporations or practice plans to devise their own schedules and negotiate their own assignments. Third party payors (or a single payor plan) would purchase nursing services in the way they now purchase medical services. The revolution in cost-containment will most likely continue, but will be influenced by nursing input on the effect on patient care versus preservation of physician income or market share.

The effect on nursing education will be the emphasis on autonomous yet interdependent, collaborative practice. The implications for nursing is that nurses may continue to experience the dissonance and oppression that many have learned

to accept as less troublesome than being permitted to practice in a way that assigns greater responsibility and accountability to the nurse. An educational program that reflects the visible practice of nursing and extends into the first few years of nursing practice through the socialization process would be the vehicle for transition from current nursing practice to futuristic nursing practice.

A leading medical ethicist recommended including these points when designing a curriculum for teaching nursing ethics:

1. Nursing ethics should be taught in the clinical practice area.

2. The ethics curriculum should be clinically-based from nurses' everyday experiences.

3. A relational ethic should focus on patient problems, not system problems.

4. A religious dimension should be included in the training that would assist nurses in thinking critically, exploring their own values, and developing the ability to discuss these issues with maturity.

5. The nursing educational programs should include more humanities, such as philosophy, ethics, and religion.

6. This focus on nursing ethics in the curriculum may refocus the health care system "in that the latter will be aimed more and more at prevention and individual control over health risks. Such individual control cries out for encouragement, the kind of encouragement a nurse can provide by promising to help, to be 'there' at the junction of a person's life and values." (Thomasma, 1994, pp. 96-7)

If nursing programs incorporated his recommendations into the curriculum, nurses would have the content area, knowledge, and language for critically analyzing situations in the clinical arena. They would be better prepared to identify ethical issues and work toward resolution employing a repertoire of strategies they have learned.

2. Implications for bioethics A change in the way nursing is practiced has implications for bioethics. In the study, the nurses were motivated to act on behalf of their patients to prevent harm or to respect the autonomy of the patient, both actions grounded in ethical principles. Most nurses in the study did not have coursework in ethics. They applied their clinical reasoning skills in a situation, and when assisted, could name the principle that supported their actions. The language to articulate the ethical issue was usually not used by the nurses. The lack of language to articulate the problem, though, was not necessarily frustrating for the nurses. The frustration for nursing occurred when they did not have the authority to carry through in their actions (or would do so invisibly). A change in practice would give nurses the authority to act on behalf of their patients. Nurses would take a primary role in ethical decision-making, both in making decisions about their own actions and in working with patients who have decisions to make. There has been a greater emphasis on ethics in nursing education over the past few years, especially since there have been advances in health care technology. The role of the nurse in ethical decision-making has been unclear. The need to employ strategies for ethical decision-making seemed to be reserved for those situations that posed a dilemma. Nurses would not recognize any clinical decision-making situation as an ethical situation. From the response of the nurses in the study, they see their role as one who informs the patient so that the patient can make the decisions, yet they differ on what is acceptable for the nurse to share with the patient. And most of the nurses were reluctant to initiate discussions with the patient regarding ethical issues such as end-of-life decisions or to acknowledge that they influence patient's decisions. A new nursing practice would include a visible role for nurses as moral agents. Writing a "Do Not Resuscitate" order after the competent, adult patient has been fully informed and chooses not to be resuscitated could be a nursing action.

Collaboration between medicine and nursing would be motivated by patient needs and mutual goal-setting, not by the current compulsion of nursing requiring physician's orders. Moral authority, granted through the nurse-patient relationship, would not be strictly within physician practice, but would be exercised by the provider authorized by the patient. There would be an incentive for physicians to work more closely and communicate more effectively with nurses if they wish to participate in the patient's care. It is imaginable that the nurse would become the primary provider with consultation from physicians when diagnostic tests, surgery, or specialty treatment are needed. The decision-making process, where many of the nurses in the study felt they had no legitimate place, would be owned by the patient and assisted by the most appropriate health care provider, which may be the nurse. Nurses should be prepared for the role.

To prepare nurses for the role, clinical decision-making and ethical decision-making should be taught as simultaneous processes. The step-wise models for ethical decision-making are valuable as templates for sorting information and identifying issues. The socialization process will continue as professional development after completion of educational programs. Borrowing from Maher and Tetreault (1994), the socialization process and knowledge development beginning in undergraduate programs and continuing into the first professional nursing positions would include four critical elements: mastery, voice, authority, and positionality.

Mastery is built upon clinical skills and experience. The nurse needs to gain confidence in assessment abilities, then learn to trust her findings. A clinical sense is then developed. The nurses in the study spoke of the encouragement they were given to validate their skills and to pursue concerns based on their clinical feelings or sense. Mastery includes trust in oneself. Others, especially non-nurses, need an indoctrination into nurses' ways of knowing so that they too will have regard for the mastery of nurses. In the objectivist environment of health care, support and

respect for nurses' ways of knowing have been missing. Nurses described the discomfort they felt if they only had subjective data to give to the attending physician. They often would wait until objective data were available before notifying the physician. In a more trusting and supportive environment, the nurses' subjective data would trigger an exploration into the patient's condition. Early detection of a potentially life-threatening condition could occur and complications could be avoided with a higher level of surveillance that includes the nurse's subjective knowing. There would no longer be the need to wait for an objective catastrophe to occur.

The next element proposed by Maher and Tetreault (1994) was voice. They maintain that one must pass through the various ways of knowing before finding their voice. Nurses gain mastery, then they become the knower. Many of the nurses in this study, however, were not ready to find their voice. In doing so, they would need to confront the issues that made them uncomfortable: being visible by exercising moral authority, accepting the responsibility for making clinical decisions, changing the system so that their actions are open and recognized. They do not have voice when invisible, although they have influence. Having voice involves the nurses interpreting situations for themselves instead of having others tell them what to think and do. Gaining voice means having an identity as a nurse, as a professional, as a moral agent. This identity, in concert with mastery, gives the nurse a visibility in the health care system. With mastery and voice, the nurse next develops authority.

Authority in the traditional sense implies a hierarchical structure, or a specialized knowledge. Maher and Tetreault (1994) use it in the latter sense, that the one with the most knowledge in a given area has the authority. Authority is a negotiated concept. In the health care setting, the authority shifts from the knowers and informers. The patients are an authority on their experience, their condition,

their feelings. The health care team shares information about what the patient may or will experience, what is learned from those experiences, and what options are available to the patient. The authority shifts from patient, to nurse, and back and forth throughout the relationship. In certain specialty areas, nurses have authority by virtue of a body of knowledge, such as in pain management, skin care, ethics, or accreditation regulations. They share their information with the patient, giving the patient the authority to direct their care. Nurses observe more experienced nurse colleagues as role models for these types of interactions with patients. Several nurses in the study were distressed by the apparent disregard for the patient's wishes, or lack of full disclosure of pertinent details the nurses believed the patient should have. The health care system is structured on a hierarchy in medicine, nursing, and administration. The informal structure involves a hierarchy of the "knowers"--the novice nurses, the range of experienced nurses from those with six months seniority to those with over 20 years seniority, the nurses with graduate degrees, the nurse consultants, the line managers. A number of nurses mentioned deviating from the formal and informal nursing hierarchy when seeking support and validation. In that respect, authority is conferred to the nurse who is sought out by others nurses. The socialization experience has not traditionally been a nurturing experience. As one nurse described it, she felt like she was being rushed in a sorority. Another common adage is that "Nurses eat their young", meaning that the initiation into the profession has been painful, demeaning, and cruel instead of nurturing, supportive, and facilitative. Since the official preceptor is not always the person the new nurses turns to for advice, all nurses on a unit share responsibility for mentoring the new nurse. That shared responsibility and the new nurse's inquiry gives the approached nurse authority. Nurses must then learn how to accept authority, negotiate authority, and acknowledge authority in each other.

The final element pulls together the three previous. Positionality is the positional aspect of knowledge and power (Maher and Tetreault, 1994, p. 164). Positionality in the health care system is having the vantage point in a given situation based on the knowledge and power one has. Nurses traditionally have been in a position of having knowledge, but no recognized power. Any attempt to display power, such as having a discussion about resuscitation leading to a "DNR" order is neutralized by the power of others, usually physicians in terms of their legal authority in directing care. The example where the nurse felt powerless in preventing an undesired resuscitation of a patient illustrates the positionality of the invisible nurse. Maher and Tetreault view positionality as situational, based on the mastery, voice, and authority of those involved. In the health care system, nurses need to claim their positions, exercise their mastery and voice, and negotiate authority to function as moral agents with moral authority. Their positionality is relative to the position of others, but nurses can orchestrate the situation to maximize the patient's authority and position in the health care setting. In that situation, had the nurse documented her discussions with the patient and family in the patient's medical record, the patient's authority to direct care is facilitated by the nurse's actions. In the interactions with the patient and family, the nurse uses her mastery in having the discussion and providing information to the patient and family, she uses her voice in sharing her experiences with other patients and resuscitation situations, she uses her authority in proceeding with the discussion that previously had been relegated to the physician, and she gains positionality in taking a stand for the patient. Her actions will not be invisible. These types of actions require the "leap in practice" that one nurse mentioned she was not ready to take.

C. Conclusion

The two major findings in this study were moral agency in the every day interactions of nurses and the invisible practice of nurses to meet the needs of their patients. The interactive processes nurses use in ethical decision-making in patient care involved the various ways nurses worked with others to bring about what they believed was right for their patients. They acted to prevent harm and hopefully to do good. They found the most expedient way to meet their patients' needs was to work in an invisible way of leading the resident to write the order the nurse wants, proceeding without orders, or going over the head of the resident to the attending physician when the resident did not agree with the nurse. While the patients benefit from the nurse's actions, the nurse goes unrecognized as a moral agent. The mastery is invisible, the voice silent, the authority unapparent, and the positionality obscured. In constructing a nursing practice, nurses will gain mastery, find their voice, negotiate their authority, and position themselves for visible nursing practice. Future qualitative research can explore the satisfaction of the patients and nurses when nursing practice is visible.

The study has left the investigator with an "unfinished" feeling. As with most qualitative studies, the decision to stop collecting data and draw conclusions from the data is arbitrary. The act of asking the questions and sharing the working hypotheses with the research participants is the beginning of the transformation of nursing into a full-fledged profession. The introspection into the investigator's own practice has brought the conclusions about the comfort of invisible practice into sharper focus. The insidious nature of the doctor-nurse game and the seemingly overwhelming and unstoppable restructuring of health care to reduce the nursing workforce (to cut costs and increase profit of the institution) and limit nursing autonomy (to protect physician's control of the patient and the health care delivery system) contribute to the nurse's hesitation in becoming visible. History has shown

that nursing has been threatened and successfully oppressed by powerful physician resistance. The nurse anesthetists' history leaves a telling example. Initially being recruited by physicians who thought anesthetizing patients was too boring for physicians to do, nurse anesthetists had a nasty public relations campaign launched against them to frighten patients into asking for anesthesiologists only (Bankert, 1989). The tension was fueled by internal strife in the nursing ranks, typical of the horizontal violence of oppressed groups described by Skillings (1992). Health care reform promises more autonomy and respect for nurses, especially for the advanced practice nurses, but the wagons are circling, in terms of organized medicine's resistance to an expanded nurse practice act, health care administrators' discounting of the importance of the professional nurse, and nursing's internal conflict over entry into practice, unionization, and additional licensure for advanced practice. The transformation of the nursing profession into a full-fledged profession will begin with the nurse-patient relationship. The processes that nurses use to get things done for their patients need to become visible through the nurse's exhibiting mastery, voice, authority, and positionality. Continued research as praxis to raise the awareness of nurses about invisible practice and how to become visible is needed. Then nurses can function as moral agents with moral authority.

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