



Original Research Article

Nurses' Lived Experience with Ethical Problems: A Phenomenological Approach

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ABSTRACT

Introduction: As nursing is ethically grounded profession guided by moral principles, ethical problems are also an integral part of the nursing work situation. Therefore, this study was undertaken to explore nurses' lived experience of ethical problem in clinical practice.

Methodology: Nurses' experience of ethical problem was explored qualitatively by using a phenomenological hermeneutic approach. Four nurses, involved in patient care for more than five years and working in a teaching hospital of Nepal were selected purposively. After receiving ethical approval, in-depth interview was conducted in Nepali language using a semi-structured interview guide. The interview was audio taped with written permission of the participants. The recordings were downloaded to a password protected personal computer and transcribed verbatim by the Investigator. After transcription, data was analyzed thematically.

Results: The four main themes of ethical problems experienced by the nurses were: Negligence and care error; competency of care worker; causing problems; and managing the problems. Regarding negligence and care errors, respondents experienced neglected patient's autonomy, confidentiality and privacy. Working with less experienced and unskilled staff was stressful for the respondents. Inadequate nurse patient ratio and lack of resources caused problem in patient care. Therefore, they used diverse coping mechanisms such as discussion with those involved, self control, reporting matter to the higher authority, feeling guilty, praying and seeking forgiveness to manage the problem.

Conclusion: Nurses in their clinical practice, experience a variety of ethical problems regardless of their effort. In order to prevent and control problems, awareness program to stakeholders is recommended.

Key words: Clinical practice; ethical problems; nurses

INTRODUCTION

Though, nursing and the health related disciplines are moving into a new era through advancement of technology, there is no substitute for nursing and ethical behavior. ⁽¹⁾ Hence, nurses in their efforts

toward patient's recovering from illness, should be aware of patient's ethical rights in fulfilling their caring needs. ^(2,3) But many factors in today's healthcare environment may challenge nurses in adhering to ethical values. ⁽⁴⁾ As nursing is ethically grounded

profession guided by moral principles, ethical problems are also an integral part of the nursing work situation. ^(2,5-7) Some of the distressing issues experienced by the nurses that revealed from the literature are violation of patients' right to know, implementation of do not resuscitate orders, inadequate treatment for patients, and inability to provide appropriate care for the patient due to lack of resources. ^(2,8-13) ethically distressing situations contribute to diminished workplace satisfaction, stress, burnout, and staff turnover. ⁽¹⁴⁾ Sometimes these problems bring conflicts among health professionals in caring situation. ^(8,15) To overcome the problems they try to compensate quality care ^(16,17) by prioritizing task only to the routine work that included interruptions and shortcuts in patient care. ^(9-11,18) When ethical problems lead to decline nurses' morale, they will not have inner motivation to work, and in some situations, they may also violate the law. ^(5,19-22) However, ethical problem among nurses of Nepal is yet unknown about how do they experience and handle the ethical problems. Therefore, this qualitative study was done to explore the nurses' lived experience of ethical problems during patient care in their clinical duty.

MATERIALS AND METHODS

This was a qualitative study. Because qualitative technique can provide a "human context", nurses' experience that they have lived through was explored by using a phenomenological hermeneutic approach. Phenomenology ensures an open attitude to the informants' life-world, while hermeneutics allows a participatory dialogue and inter-subjectivity between the interviewer and informants. Hermeneutic phenomenology allowed explicated meaning of ethical problem experienced by four nurses of a Teaching Hospital of Kathmandu Valley, Nepal, who were involving directly

in patient care for more than five years. The respondents were selected purposively by the researcher.

Data Collection

After taking ethical approval from the Institutional Review Board of IOM, and administrative permission from the respective hospital authority, 11 nurses were approached individually by the researcher to ensure voluntary participation. Four nurses gave written consent for their participation in in-depth interviews. Data was collected between the months of June and July, 2014. Date, time and place for the interviews were established with individual participants. Interview was conducted in Nepali language by using semi-structured interview guide that contained 10 questions, as participants felt comfortable with this language. Effort was made to engage each participant in the interview and to ensure clarity by asking probing questions such as, "Can you give me an example of what you mean by that?" or "What was that like for you?" Two interviews lasting for 40 to 60 minutes were conducted with each participant and audio-taped on two digital voice recorders. The digital recordings were downloaded to a password protected personal computer and transcribed verbatim by the Investigator. Two recordings were made to ensure that at least a copy would be available in the event of either a power or mechanical failure. Following transcription, each tape was listened to on at least one further occasion by the investigator to verify accuracy of the transcription and then on at least one other occasion in the context of subsequent interviews by the participants.

On the day of subsequent interview, memory call was given to the participant and asked for consent. When participants started to repeat the same the information, data saturation was assumed and no further interview was taken. At the end of the interview, each participant was asked, "Are

there things that we have not talked about, that you think I should know” as a strategy to facilitate participants’ free engagement in the interview and gave a worldly ending point to the interview. The recorded information had access only to the researcher.

Initially, the researcher clarified and confirmed the information with the participants during individual in-depth interview. The interview was transcribed by the researcher, after transcription, data was analyzed thematically. During thematic analysis, individual data/meaning was coded, when patterns began to emerge, these were combined and consolidated into common themes.

RESULTS

All the four participants had completed bachelor degree in nursing. Three of them had work experience more than 10 years and halves of them were unmarried. This study delve that nurses in their clinical practice experienced ethical problems regardless of their effort. Participants’ description of ethical problem is placed into four main themes; negligence and care error, competency of care worker, causes of problems, and managing the problems.

Negligence and care error

Nurses expressed that they experienced negligence and care errors in patient care management by health personnel. They shared that they have capacity and wish to provide quality nursing care to their patient, but due to high work load; they cannot provide satisfactory care to them. This resulted in provision of decreased quality and even inadequate care to their patients. Negligence and care error was a remarkable experience. This theme is derived from following subthemes.

Neglected patient’s autonomy, confidentiality and privacy

Participants described the situations where patients’ right to know about his illness, right to choose treatment options and right to refuse treatment was neglected by health care providers. Situation of neglected autonomy gave stress to the participants. One of the participants expressed following: *We have practice of taking consent from the patients for major procedures, but we do not have practice of informing in details about their treatment. Therefore, they give signature about not knowing in detail about the procedure.*

On the other hand, they perceived that the consent was only formality of taking signature for procedures, and the patient and family were not informed properly. Another participant narrated:

Whenpatient developed pneumothorax after tracheostomy, the family of the patient made argument withby making a claim that they were not informed properly and given options for the treatment.....

Participants expressed that due to lack of resources, it was almost impossible to respect confidentiality and privacy of the patient. Therefore, sometimes it may become possible as a normal practice of ignoring and giving less priority for the patient’s confidentiality and privacy.

Negligence in patient management

Participants experienced negligence in patient care and management. They detailed their experience of negligence was an unfortunate for both patient and the health care providers and sometimes it contributed for greater morbidity and mortality. Participant expressed following:

During....patient complained that ‘I have redness on my leg’. I looked his leg, it was hard and warm, but.....didn’t take any action. After some days, he developed oestomyelitis, and undergone for incision and drainage. I felt bored because

Participant shared that negligence in patient care, contributed for more burdens to the involved patient. Such as increasing preventable complications and hospital stay. Another participant had following experience:

In my night duty, emergency operation was done for a patient with peritonitis. During history taking, I find that he visited the facility at 9:00am, and diagnosis was appendicitis. He was waited for operation. It was very distressing, why he had been waited till the development of complication?

Negligence in patient's medication was the frequent situation experienced by all participants. They shared that the error in patient management not only contributed for economic burden to the patient, but also contributed to the adverse reactions that threats life of patient. Nurses' negligence makes more suffering of patient. Participant had following to say:

I took hand over.....patient had no urinary output since morning. In assessment, his bladder was full, and the reason was kinked catheter. There was 1100ml output after.....very careless.

Another participant detailed following:

...patient was treated with very expensive medicine; his economic condition was not that strong. The prescribed dose of medicine was 2.5 lacks unit. Butgave 5 lacks unit. The patient was already in renal compromised condition and was received double doseThough they did not say, but it also contributed for renal dysfunction. I wish if they considered economic and renal condition of the patient.

Care worker and Competency

All participants experienced problems because of their co-workers' behavior, attitude, communication skill and competency in their task. This theme is further divided in following two themes.

Less experienced and unskilled staff

Nurses frequently have to work with less experienced/new staff. In this situation, nurses felt extra burden to teach new staff along with their routine task of patient care. This happened frequently because of staff turnover for their higher education, abroad migration and marriage. Participant narrated following:

.....has transferred, and again I have to work with new staff, she is not competent in this environment. I have extra work to teach her, by the time when she will be competent, she will be transferred or leave this jobit is stressful.

Sometimes lack of knowledge and skill of staff make patients more suffering. Therefore, working with incompetent health personnel was stressful for the nurses. Participant shared following:

....patient in ventilator was sent for CT room with While I was receiving her after investigation, her oxygen saturation was 65%. Immediately I suctioned the patient with high flow oxygen. Ifhad skill he could notice cyanosis of start bagging with injection medazolam.....

Participants perceived that sometimes procedures are performed on patient only to increase skill of health care professional and the patient become sufferer. Because they experienced that health personnel did not give up the procedure despite their repetitive failure. Another participant shared following experience:

.....was pricking the jugular vein offor several times and was not successful. I could not see the situation, so I stopped him for doingand called senior.was junior and had no skill of that procedure.

Communication problem

Participants experienced communication gap between co-workers about the patient care, that contributed to care errors and unnecessary stress for both the patient and health care providers. Sometimes,

inappropriate way of communication with patient and family contributed for conflicting situations. Participant had following experience:

.....did inappropriate response forquestion of a patient's visitor. That created a big issue in the ward. Finally I called police to control the situation.

It is noteworthy that, inappropriate way of communication contributes for conflict in work, as well as negative public image of the profession.

Causes of Challenging Situations

Participants expressed different preventable factors that bring problem to the patient care. Participants' narration of situation that cause problem in their practice are distributed in the following subthemes

Shortage of resources for patient care

Participant described situations where they knew what to do but they had difficulties to carry out because of shortage of nursing staff. One instant narrated by a participant:

.....in my evening round duty, inward all, the nursing staff were busy, and there was overflow of patient....so I don't want to talk about quality nursing care.....

A nurse complained that because of limited number of nursing staff, and time constrains they were over loaded; hence, for sometimes they need to involve patient's family for patient care. It is worth noting that patient's visitors complain that nurses neglect their patients and leave their work. This situation gives stress to the nurses. As narrated by a participant:

.....is in last stage, but I cannot provide adequate care to him, because I have to take care of all other 36 patients too. Therefore, I involved family members for.....care.

Because of staff crisis, nurses needed to prioritize their task for patient. Hence, patients did not have equal access to the nurses and nursing care. It is noteworthy that this leads to compromise quality nursing

care and impair nurse-public relationship. As narrated by another participant:

In....., I was the only nurse in duty. A patient was in crash, and another patient also became serious, so I prioritize to manage, but anotherin need was out of nursing care, very distressing.

In some instances timely services and quality care could not be provided to patients due to shortage of even basic supplies such as wheel chair, trolley, bed sheet, cold bag, gloves, gown etc. the experience from a participant was:

It was night, a patient was admitted. But there was only a damaged bed sheet for the patient. When patient saw that, he shouted at me, made a conflicting environment and threw outfrom the window, I was helpless, what can a nurse do?.....distressing.

Lack of basic supplies especially in general ward, contribute for conflict and unnecessary stress between nurse-patient.

Lack of public awareness and education and economic condition

In Nepal, especially the people from village are unaware and uneducated. They come to health facility when they become serious, or their condition become critical. It gave them more economic burden. Experience reported by participant was:

....was admitted for two weeks. At the time of discharge, when he saw the treatment bill of hospital, he got heart attack and again admitted for

Behavior of colleagues

Participants reported that miss behavior of health care workers play a role to bring problem in caring situations. This behavior included humiliation to nurses, not doing their job properly by health care provider and miscommunication. Experience reported by a participant:

..... had no insight and did misbehave with staff. After his recovery ... shouted and behaved negatively to him. That was a

reaction forbehaviors while no insight. It should not be done to the patient.

Another participant had following experience:

A doctor shouted at us (nurses) in a morning round, by saying that “we ordered intravenous drip for this patient and you are not started yet?” But there was no written order of it till the doctor round, and the patient was dehydrated.

Mismanagement by superiors

Nurses felt that supervisors and ward in-charges favored some nurses and not others in respect of politics, cast and creed. The favoritism was with regard to duty roster, recommendation, and transfer from the unit. One participant explained that:

.....made medication error, but the supervisor did not take any action. But when fail to put curtain during patient care, supervisor.....shouted at her in front of all health team members....., becausewas not favorite of

Participants shared that they were not given work according to their education qualification, skill specialization, and the area of interest. This may cause frustration to the nurses and decrease quality of nursing care. A participant said following:

Before here, I was working in ICU and I was satisfied there. But in this general unit, I'm not interested to work, but.....

..... had specialized in women's health, but she is placed in medical unit.....

Nurses also blamed the patients and family that every patient wants first priority of care to them, which is almost impossible. Management was also blamed for biased during recruitment of staff, not giving proper orientation to new staff and left for independent practice before one become confident.

Managing the Challenges

Nurses used diverse coping mechanisms such as discussion with those involved, self control, reporting matter to the higher

authority, feeling guilty, prayer and seeking forgiveness, when they confront with problem. Nurses with more experience were applied coping mechanism more effectively. A participant narrated her experience as follows:

It is true patient's were sufferer. So I listened to the patient with calm, tried to convince the involved personnel.....During mymistake, I tried to be water in fire, informed to authority immediately, prayed to god.....I could not sleep whole night....

Nurses first tried to solve the problem by themselves. During solving the problem they focused on the nature of problem and applied previous experiences. Another participant expressed:

According to the nature of problem I inform to seniors, coworkers and doctors. Most frequently I try to solve the problem base on my previous experience.

Nurses expected quality nursing product, which devote themselves for patient care. They expected to control of mushrooming nursing colleges by nursing council. They expected their voice to be raised by professional organization. They expected action taken by superiors in blunder of them.

As narrated by a participant:

We are lacking effective monitoring and supervision, there must be.... Supervisors do not evaluate our care.....I'm disappointed.....we must be evaluated. have to see and respect our hard working and dedication to duty. There must be equal opportunity of in-service education to nursing personnel.

DISCUSSION

This qualitative study showed that nurses experience different ethical problems in their clinical duty from a wide range of causes. Negligence in patient care, care errors and ambiguity of nurses' role and work load were especially the outcome of

inadequate human resources and materials. Consistent to this study, ICU nurses of Iran experience moral distress form a wide range of causes. ⁽²³⁾ In this study, nurses experienced sometime unfortunate negligence in patient care, and sometimes it happened due to careless practice of health care providers, that contribute for greater morbidity and mortality. However, Lillemon and Pedersen identified that the nurses of primary health care in Norway experienced ethical challenges associated with inadequate attention to the patient's need, use of coercion, and confidentiality. ⁽⁵⁾ Whereas, nurses of government hospital of Malaysia experienced ethical issues of protecting patients' right, respecting informed consent, and quality of care. ⁽²⁴⁾ Despite constraints, nurses were aware about maintaining confidentiality and privacy of their patient, on the other hand, lack of resources played role for breaking those ethical principles. In the same way, nurses of Portugal expressed that in ICU, there is chance of confidentiality breach. ⁽¹⁰⁾ In this study, respondents expressed there is culture of explaining patient's disease condition to his/her family without taking consent of patient, which they perceived as a good practice. This is because, in the culture of Nepal, irrespective of patients' age, their family takes responsibility of them and acts as a guardian. At the same time, they felt disrespect of patient's autonomy when some procedures were performed to the patient without informing properly and given choices to the patient. Similar results were reached by Cobanoglu and Algier (2004) and Halvorsen et al (2008). These authors concluded that there is not done a broad discussion on decision of patient management involving other health professionals and family members. In this study, nurses expressed that they felt stress and extra burden when they have to work with less experienced and unskilled staff. In

our study, it is revealed that, because of high staff turnover and transfer from unit to unit; nurses had to work with less experienced staff, that gives them extra burden, similarly this situation contributed for compromised quality in patient care. Consistent to this, Bruston and Tuckett (2012) said that working with unsafe staffing level contributed to the highest intensity and frequency of moral distress(14)(Burston & Tuckett, 2012) (14)(Burston & Tuckett, 2012)(14). Nurses expressed that health workers' inappropriate way of communication especially with patient and family contributed for conflict and sometimes the situation become out of control. Nurses working in critical care unit of Turkey also expressed communication problem with physicians, patient, and patient's relatives. ⁽⁹⁾

Nurses tried to provide care for their patients, but lack of facilities and inadequate power of nurses' cause reduced their quality of care as well as conflict between patient and the care provider. They also felt distress when patient cannot afford treatment cost, especially life saving drugs during critical illness; they try to save patient's life by their charity. Due to lack of human resources and essential equipment of patient care, nurses were overloaded; therefore, according to them, care for patient was compromised. Due to inadequate resources, sometimes they had to work with increasing risk of cross infection including to their own health. Consistent finding of Malawi showed that shortage of drugs, safe water, medical equipment and essential supplies mean that nurses cannot provide quality care thereby leading to frustration and demoralization. ⁽²⁵⁾ Nurses expressed that, in this situation, they tried to involve only in routine work such as taking vital signs and giving medication of the patient, thus insufficient care for the patient. Understaffing forces nurses to abandon opportunities to sit with patients

listen to their problem and provide all required nursing care. This situation contributed to work stress and job dissatisfaction for nurses. Consistent to our finding, Abrahamson concluded that when nurses are in stress, they fail to deliver the optimum standard of care, try to compensate by caring tasks to a minimum, resulting in low quality care. ^(16,17) In understaffing situation, to maximize patient care, nurses suggested that if the task that can be done by non-nursing personnel such as, sending investigations to the laboratory, administrative work, and even ward management, could be delegated to other non-nursing personnel for instance, so they can provide actual nursing care to their patients. Because of work overload, nurses become irritable, frustrated and their stress can be sometime directed toward the patient and contributed for compromise nurse-patient relationship. If there is no connection between care provider and the care recipient, there will not be therapeutic relationship. Similar to this, nurses of Malawi felt a sense of being unappreciated or mistreated by patients, colleagues and supervisors. ⁽²⁵⁾

On the other hand, nurses expressed that some health personnel have not professional behavior toward patient. They felt that they do not even talk politely to their patients; do not complete their task, which cause stress for their colleagues. Sometimes, nurses felt confusion in their task because they do not have a clear cut job description, for example whether they were allowed for pricking intravenous line or not, in emergency situation, when there is not presence of doctor, whether they are allowed to injecting emergency drugs or not. But in practice, they said that they are doing so with feeling of stress because they cannot leave their patient alone in emergency situation, although they don't know who is behind them to protect if problem occur. Similar result was identified by Maluwa et

al. (2007). According to him, nurses violate regulations e.g. prescribing drugs in emergency conditions if there is absence of clinician, in order to protect patients, though they have guilty conscious.

Nurses try to manage stressful situation by using of their coping mechanism. They had guilty conscious, prayed to god and seek forgiveness in their mistakes. Furthermore, they discuss the situation with those involved, self control in conflicting situation, and reporting matter to the higher authority. Whenever possible, firstly nurses themselves tried to solve the problem by applying their previous experience, and sharing with the coworkers. Interestingly, Cobanoglu and Algier (2004) identified that nurses ask the physicians to solve the problem. While, Fernandes and Morea (2013) also noted that in general, problems are shared with family or within the group of friends. Consistent to our findings, Maluwa et al. (2007) concluded that nurses use diverse coping mechanisms such as reporting the matter to higher authority, sharing with colleagues, ignoring the situation, feeling guilty, prayer and seeking forgiveness. ⁽²⁵⁾

CONCLUSION

Nurses of Nepal, in their clinical duty also experienced ethical problems such as neglected patient's autonomy, confidentiality, and privacy and negligence in patient management due to inadequate number of nurses, inadequate resources for patient care, unskilled and less experienced staff, institutional constrain, lack of public awareness and education, and ambiguity of their role and high work load. When they experience problem, they use different coping mechanisms such as feeling guilty, praying for patient's good. They desire to control of mushrooming nursing colleges that have product of inadequate quality. Although further quantitative study to

support this qualitative finding is recommended, there is a need for awareness creation among all stakeholders in Nepal including Nepal government in order to prevent and control ethical problem among nurses in clinical setting.

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