THE EXPERIENCES OF PROFESSIONAL NURSES WITH ETHICAL DILEMMAS IN NURSING PRACTICE AT WITBANK HOSPITAL, NKANGALA DISTRICT MPUMALANGA PROVINCE

BY

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DECLARATION

I, Thembeka Monica Mbangula declare that this mini-dissertation, "The experiences of professional nurses with ethical dilemmas at Witbank Hospital, Nkangala district Mpumalanga province," hereby submitted to the University of Limpopo for the degree Masters of Curationis has not been previously presented by me for the degree at this or any other university or institution, that it is my own work in design and in execution and that all material contained herein has been duly acknowledged.

T.M Mbangula :_____

Date Signed :_____

DEDICATION

This mini-dissertation is dedicated to my late father Mr. John Bothar Mbangula who has taught me to be humble no matter my accomplishments and provided for my education yet, never lived to see my graduation and my late mother, Mrs Sdudla Annah Mbangula whom even in her sickness encouraged me to continue with my education and to finish writing this dissertation leading to the Masters in Curationis. I will forever remain grateful to my parents who will continue to be my pillar of strength even though they are now in the world hereafter. This mini-dissertation is also dedicated to the professional nurses at Witbank hospital who participated in the success of this dissertation

ABSTRACT

The purpose of the study was to determine the experiences of professional nurses with ethical dilemmas at the Witbank hospital Nkangala district Mpumalanga province. The objectives of the study were to describe the experiences of professional nurses with ethical dilemmas in nursing practice and to determine supportive measures to help professional nurses to deal with ethical dilemmas encountered in nursing practice. The research question was: what are the ethical dilemmas that professional nurses experience in nursing practice? Kohlberg theory of moral development was used as a theoretical framework. A qualitative exploratory, descriptive and contextual research design was used to describe the experiences of professional nurses with ethical dilemmas in nursing practice. Purposive sampling was used to sample fourteen (14) professional nurses. Data was collected using semi-structured interviews. Open-coding method of data analysis was used and four themes and sub-themes emerged. The study found that professional nurses experience ethical dilemmas related to death and dying, distribution of both human and material resources, respect of patients' autonomy and the nurses' rights. The study recommends continuous ethics education and the inclusion of ethics in nursing curricula, creation of a supportive working environment, knowledge and understanding of the pledge of service, Inter- disciplinary teams to discuss ethical issues, availability of ethics experts and ethics mentors in the wards.

Keywords: Ethical dilemma, experiences, professional nurse

DEFINITION OF CONCEPTS

An ethical dilemma is a situation requiring a choice between conflicting moral claims which results in equally unsatisfactory alternatives (Davis and Aroskar1983). In this study an ethical dilemma refers to ethical issues with conflicting moral claims as experienced by professional nurses at the Witbank Hospital.

A Professional nurse according to the South African Nursing Council Act 33 of 2005 is a person registered as a professional nurse in terms of section 31 of the Nursing Act. In this study a professional nurse refers to a nurse registered with the South African Nursing Council as a professional nurse who is working at the Witbank hospital.

Experiences are events or knowledge refers to all the members of a particular group in society, which influences the way they think and behave (Wehmeier, McIntosh and Turnbull, 2005). In this study experiences refer to the experiences of professional nurses with ethical dilemmas in nursing practice.

LIST OF ABBREVIATIONS

AIDS   Acquired Immunodeficiency Syndrome

CEO   Chief Executive Officer

DENOSA   Democratic Nurses Association

HIV   Human Immunodeficiency Virus

MREC   Medunsa Research Ethics Committee

NLN   National League for Nursing

SANC   South African Nursing Council

U.S.A   United States of America

WHO   World Health Organisation

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CHAPTER1

Overview of the Study

1.1   Introduction and Background

Ethical dilemmas in nursing are not new, but new scientific developments affect the nature and the substance of these dilemmas (Davis and Aroskar, 1983). Moodley's (2011) views in this regard are equally succinct as healthcare professionals, in general, are confronted with many ethical dilemmas that require them to make clinical decisions, especially in the age of the HIV/AIDS epidemic. For example, professional nurses are confronted with ethical dilemmas relating to quality versus quantity of life, pro-choice versus pro-life, truth telling versus deception and allocation of limited resources—both human and material. Moodley (2011) also states that clinical decision-making in the 21st century is congested with ethical complexities and that everyday clinicians, professional nurses especially and researchers around the world are faced with ethical dilemmas that must be resolved as compassionately and as quickly as possible.

Searle (2005) indicates that the complexity of modern medicine, are more demanding health care technology, social change and the increase in the number of persons needing healthcare are exerting more and more pressure on the professional nurse. Radzin (2011) asserts that professional nurses are frequently confronted with ethical dilemmas in their nursing practice and, as a consequence of their decisions, report to be experiencing moral distress. The Canadian Nurses Associations Code of Ethics (2003)for registered nurses defines ethical distress as situations in which nurses cannot fulfill their ethical obligations and commitments, or failure to pursue what they believe to be the right course of action, or failure to live up to their own expectations of ethical practice.

Maizura Rashid and Sakamoto (2011) state that 95% of nurses experience ethical dilemmas and 47.2% of these nurses experience them on a weekly to daily basis. Maizura, et al (2011) further state that in 1994 the American Centre for Ethics and Human Rights reported that as high as 79% of their members were confronted with ethical dilemmas on a daily to weekly basis.

Brosnan and Roper (1997) emphasize that in order to prepare nurses to deal with ethical dilemmas, the first step is to realize what these ethical dilemmas are that professional nurses experience daily in nursing practice. Jali (1984) indicates that in order to improve the quality of patient care, professional nurses should be able to identify and resolve ethical dilemmas that confront them. Bosek (2009) emphasizes that despite the awareness of complex ethical dilemmas that nurses at all levels of patient care experience, there has been limited research focusing on describing the ethical dilemmas experienced by professional nurses in nursing practice.

1.2 Problem Statement

Heaget, cited in Mogodi, Jooste and Botes (2003) define caring as a natural capacity essential for members of a caring profession. Caring is the frame within which all nursing that is moral is based and places the patient at the centre of nursing practice. As nurses endeavour to provide quality patient care they are confronted with ethical dilemmas. Pera and van Tonder (2011) underscore that a nurse needs to know what s /he believes in and what s/he values. This knowledge of self contributes to ethical decision making in nursing practice. Dhai and McQuiod-Mason (2011) stress that trust is critical to successful care, and where patients cannot trust their healthcare providers, the quality of care is seriously jeopardised. Dhai and McQuiod-Mason (2011) corroborated this notion by referring to a longitudinal survey which revealed that the level of confidence and trust that was accorded to the profession several decades ago has been substantially eroded. Bezuidenhout (2009) also states that responsible healthcare had degenerated as a result of the loss of trust in the care that nurses give to patients.

Bosek (2009) notes that few studies have been done that indicate the ethical dilemmas experienced by nurses. Furthermore Maizura et al (2011) recommended that further studies, including qualitative studies should be conducted nationwide among nurses of different levels in order to gain wider perspective on professional nurses' experiences of ethical dilemmas in nursing practice. In view of the increasing emphasis on ethical dilemmas in health care and in nursing practice, a need to describe the experiences of professional nurses with ethical dilemmas in nursing practice is crucial in this era.

1.3 Research Question

The following question guided the study: ***What are the ethical dilemmas that professional nurses experience in nursing practice?***

1.4 Purpose of the Study

The purpose of this study was to determine ethical dilemmas that professional nurses experience in nursing practice at the Witbank Hospital in the Nkangala District of the Mpumalanga Province.

1.5 Objectives of the Study

The objectives of this study were to:
- Describe the experiences of professional nurses with ethical dilemmas in nursing practice.
- Determine supportive measures to help professional nurses to deal better with ethical dilemmas encountered in nursing practice.

1.6 Theoretical Framework

In this study, Kohlberg's theory of moral development was used as a conceptual framework to analyse the experiences of professional nurses with ethical dilemmas in nursing practice. The theory was applied in Chapter 4 of this study. Professional nurses are constantly confronted with ethical dilemmas and are required to make moral decisions on a daily basis. The applications of Kohlberg's theory of moral development in nursing could enhance moral judgment that reflects an inner respect of the individual's thinking. Progress through Kohlberg's stages of moral development happens as a result of the individual's increasing competence, both psychologically and in balancing conflicting social-value claims (Barger 2000; Khouanphet 2010; McLeod 2011).

Kohlberg demonstrates that people progress in their moral reasoning through three levels that are classified into six identifiable stages (Figure1.1). Human beings progress consecutively from one stage to the next in an invariant sequence, not skipping any stage or going back to any previous stage. The stages are also hierarchical and each successive stage is more highly developed than the previous one because it incorporates aspects of all earlier stages (Barger2000; Khouanphet 2010; McLeod2011).
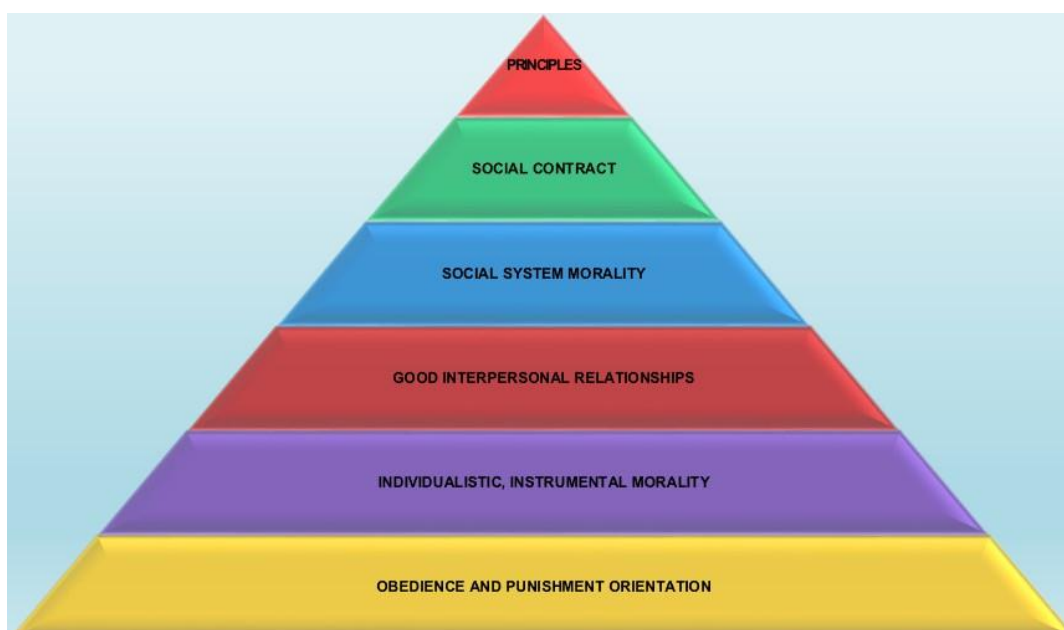
Figure1.1: Kohlberg's stages of moral development

1.6.1 Level 1: Pre-Conventional Morality

The pre-conventional level is generally found at the elementary school level. At this level individuals are judged by direct consequences and their perspective is on their own needs. Their reasoning is based on the physical consequences of actions. At this level an individual is responsive to cultural rules and labels of good and bad, right and wrong (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.1.1 Stage 1: Obedience and Punishment Orientation

At the obedience and punishment orientation stage, individuals avoid punishment and respect authority as the basis of moral reasoning. They behave according to socially acceptable norms because they are told to do so by some authority figure, for example, parent or teacher. The obedience is compelled by the threat or application of punishment. At this stage the individual makes a moral decision to avoid punishment. S/he is obedient in order to avoid punishment. Small children function at this stage of moral development (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.1.2 Stage 2: Individualistic, Instrumental Morality

Individuals functioning at stage two of Kohlberg's theory of moral development follow rules in their own interest. Children recognize that there is no just one right view that is handed down by authorities. Different individuals have different views. The right behavior is defined by whatever the individual believes to be in his/her best interest. This stage is therefore, characterized by motives to satisfy personal needs and school children are at this stage of moral development (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.2   Level 2: Conventional Morality

The conventional morality level is generally found in society. It is characterized by an acceptance of societal norms of what is right and wrong, even where there are no consequences for obedience or disobedience. Authority is internalized, but not questioned and reasoning is based on the norms of the group to which the person belongs (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.2.1   Stage 3: Good Interpersonal Relationships

The good interpersonal relationships stage is characterized by an attitude that seeks to do what will gain the approval of others. What is approved by conventional norms forms the basis for moral decisions. Explained differently, the individual is good in order to be seen as being a good person by others. Early teenagers are at this stage of moral development (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.2.2   Stage 4: Social System Morality

Individuals functioning at the social system morality stage make moral decisions based on the perspective of society as a whole. The individual becomes aware of the wider rules of society and judgment concerns—obeying rules in order to uphold the law and to avoid guilt. Late teenagers are at this stage of moral development (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.3   Level 3: Post-Conventional Morality

Kohlberg indicates that the third level of moral development is not reached by the majority of adults. At this level individual judgment is based on self-chosen principles and moral reasoning is based on individual rights and justice. Post-conventional moralists live by their own ethical principles that include principles such as basic human rights, liberty, and justice. People who exhibit post-conventional morality view rules as useful, but changeable. Rules are not absolute dictates that must be obeyed without question (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.3.1 Stage 5: Social Contract and Human Rights

At this stage of moral development, principles and values that emphasize basic rights become familiar. An individual at this stage has more completely developed moral behavior and has a genuine interest in the welfare of others. There are no legal absolutes and therefore, changes in law can be made. Personal values and opinions are regarded as the basis for moral decisions. Those in their middle twenties or later years of development are at this stage of moral development (Barger 2000; Khouanphet 2010; McLeod 2011). Laws are regarded as social contracts rather than rigid edicts. Those that do not promote the general welfare should be changed when necessary to meet the "Greatest good for the greatest number of people". This is achieved through majority decision, and inevitable compromise. Democratic governments are based on stage five of moral reasoning (Barger 2000; Khouanphet 2010; McLeod 2011).

1.6.3.2 Stage 6: Universal Ethical Principles

An individual functioning at stage six of moral development follows self-chosen ethical principles which may or may not fit the law and the demands of individual conscience. The principles apply to everyone, for example, human rights, justice and equality. The person will be prepared to defend these principles even if it means going against the rest of society in the process and having to pay the consequences of disproval and/or imprisonment. Individuals who function at this stage of moral development are rare. They often value their principles more than their own life, often seen as incarnating the highest human potential. Individuals who functioned at this stage included Mahatma Gandhi, Martin Luther King, Jr, and Mother Theresa (Barger 2000; Khouanphet 2010; McLeod 2 011).

1.7 Summary of the Research Method

In this study a qualitative research method and an exploratory, descriptive and contextual research design were used to describe the experiences of professional nurses with ethical dilemmas in nursing practice. The descriptive research design enabled the researcher to describe in depth the experiences of professional nurses with ethical dilemmas in nursing practice. Purposive sampling was used to sample fourteen (14) participants and ethical considerations of informed consent, confidentiality and anonymity were observed. Data were collected from participants by means of one-to-one interview sessions. Tesch's open-coding method of data analysis was used to analyze data. Measures to ensure trustworthiness included credibility, transferability, conformability and dependability. Details of the research methodology are discussed in Chapter 3.

1.8 Significance of the study

The study will offer some insights into the ethical dilemmas that professional nurses experience at the Witbank hospital. Contributory factors to the ethical dilemmas may also be identified and measures to assist professional nurses to deal with the dilemmas can also be identified. The stud may also form a basis for further research on ethical dilemmas that professional nurses experience in nursing practice

1.9 Conclusion

This chapter described the introduction and background, problem statement, purpose and objectives of the study, the theoretical framework and a summary of the research method.

CHAPTER2

Literature Review

2.1 Introduction

This chapter encompasses a literature review on the experiences of professional nurses with ethical dilemmas in nursing practice. The literature review enabled the researcher to gain a wider perspective on what is already known and also to identify gaps about the phenomenon under study.

2.2 Nursing Practice

Ulrich, Taylor, Soeken, O'Donnell, Farrar, Danis and Grady (2010) state that *Florence Nightingale* in her *Notes on Nursing* discussed ethical dilemmas relating to confidentiality, communication and the importance of meeting patients' needs. Similarly, nurses in today's health care environment continue to be faced with ethical dilemmas on a daily basis regardless of where they function in their roles in nursing practice. These ethical dilemmas include quality versus quantity of life, pro-choice versus pro-life, freedom versus control, truth-telling versus deception, distribution of resources and empirical knowledge versus personal beliefs (Moodley2011). Wood (2014) also indicates that ethical conflicts have become part of today's healthcare environment that is characterized by a shortage of both material and human resources.

Cannaerts, Gastmans, and de Casterlé (2014) contend that nurses are continuously being challenged to make decisions with the view of providing quality care. The delivery of healthcare has also become more complex and ethics has become a required component of clinical practice (Kälvemark, Höglund, Hansson, Westerholm and Arnetz, 2003).

Despite the increasing demands for health professionals who are well qualified to make ethical judgments, there is often lack of standardized policies for guidelines and education in ethics and structures that provide ethical support for all health professionals who carry out the decisions (Kälvemark et al, 2003). Ayers (1998) found that ethical issues were not understood by the majority of surveyed respondents. Less than 30% of health personnel grasped the principles of non-malefencence and beneficence (Ayers 1998).

Technological and medical advancement and the complexity of healthcare require nurse's to be constantly and critically reflecting on how they can contribute to the patient's well-being and this requires them to be highly competent and to have ethical maturity. Raines (2000) cited by de Casterlé, Izumi, Godfrey and Denhaerynck (2008) found that oncology nurses experience an average of 32 different types of ethical dilemmas over a one year period, with many of these ethical dilemmas taking place daily. Most frequently cited ethical dilemmas dealt with pain management, cost containment issues and quality of life, and other decisions relating to a patient's best interest (Raines, cited in de Casterlé et al, 2008).

Johnstone, Da Costa and Turale (2004) indicate that nurses at all levels and areas of practice, experience a range of ethical dilemmas during their day-to-day work. The findings of their study also suggest that issues that concern nurses the most are not confined to bio-ethics related to abortion, euthanasia, organ transplantation and reproductive technology.

Probably the most pressing concerns that cause nurses the most distress are the frequently occurring issues of protecting patients' rights and human dignity, caring for patients in under-resourced health care services including staffing patterns that limit patient access to nursing care and policies that threaten quality patient care, informed consent including patient autonomy and family involvement in decision making, ethical issues at the end of life such as prolonging the dying process using

inappropriate means, not considering the patient's quality of life, working with unethical and in competent colleagues, and using physical or chemical restraints(Johnstone et al, 2004).

Ulrich et al (2010) in their study conducted in four regions in the United States of America (U.S.A.) found that ethical issues that nurses frequently experience were stratified across a number of clinical practices and caused a lot of stress to the nurses. These nurses identified shortage of staff as the most stressful issue. Without adequate staff, it becomes very difficult to provide quality patient care as expected. Ulrich et al (2010) indicate that the present health care environment is driven by the provision of high quality care and to manage costs with limited resources. The second ethical dilemma that nurses in the U.S.A. identified was concerned with protecting patients' rights. Nurses' codes of ethics, both nationally and internationally, emphasize the importance of beneficence, advocacy and serving patients' best interests. However, when nurses attempt to advocate for the patient, they are discouraged to do so (Ulrich et al 2010). The authors also observed that nurses identified ethical dilemmas related to informed consent, advance care planning, and surrogate decision-making and end-of-life issues. The study also revealed that nurses with less experience reported experiencing greater stress and were more uncomfortable and had little training in resolving end-of-life ethical dilemmas. Those nurses with more experience and who had received in-service education in ethics also reported high levels of stress related to the allocation of resources (Ulrich et al, 2010).

Ulrich et al (2010) also reported that the majority of nurses were confident in justifying their decisions about ethical issues and felt well-prepared educationally to resolve these ethical issues. Paradoxically, many nurses also reported fatigue and a sense of powerlessness that was classified as moral distress.

Stress related to ethical dilemmas is referred to as moral distress and is defined as stress that occurs when one knows the right thing to do, but institutional or other constraints make it difficult to follow the desired course of action (Ulrich et al, 2010).

Moreover, Jameton (1984) cited by Kälvermark et al (2003) define moral distress as painful feelings that occur when institutional constraints prohibit the nurse not to follow through what s/ he perceives as morally correct and necessary. Such distress is caused by the perception of being morally responsible, but restricted by circumstances. Moral distress can leave a person with emotional scars and often hesitant to speak out against what is perceived as an impenetrable hierarchical system of health care.

Wood (2014) indicates that when nurses and other members of the health team are unable to do what they consider to be the correct action, they may experience moral distress. She further states that since ethical conflicts have become part of today's health care environment, the goal has become to learn how to recognize and address them effectively. Finding ways to deal successfully with ethical conflicts is critical not only to the distressed nurse, but also to the organization as a whole because moral distress affects the nurse, resulting in poor nursing care. Moral distress also leads to employee turnover (Wood 2014). The Canadian Nurses Association (2003) asserts that the experience of ethical distress maybe an expression of the nurse's sensitivity to the moral aspects of practice, including their appreciation of patients' vulnerability.

Jameton (1984) cited by Kälvermark et al (2003) classified moral distress as follows:
- *Moral uncertainty* arises when one is not sure whether there is an ethical dilemma, or when one assumes that there is an ethical dilemma, but is not sure what principles or values apply in the ethical conflict.
- *Moral dilemmas* occur when two or more principles or values conflict and there are good reasons to support mutually inconsistent courses of action.

- *Moral distress* occurs when one believes one knows an ethical dilemma is at stake and also the morally right thing to do, but institutional constraints make it difficult to follow the desired course of action.

Ulrich et al (2010) found that less experienced nurses were confronted with end-of-life issues more frequently than those nurses with more experience and that less experienced doctors and nurses were reluctant to withdraw life-sustaining treatment for critically ill patients. These authors further noted that even though the majority of nurses believed that patients had rights to determine their course of health care, doctors and nurses had poor understanding of advance directives, namely, a living will.

de Casterlé et al (2008), in a study conducted among nurses in the U.S.A, Belgium and Switzerland, provided evidence that nurses, in general, could be located at stage four of Kohlberg's theory of moral development. The study also revealed that there were differences between newly qualified and more experienced nurses with regard to resolving ethical dilemmas. The experienced nurses demonstrated ethical reasoning proficiency that approaches the post conventional level of Kohlberg's theory of moral development. However, newly qualified nurses based their nursing actions on ethical codes and gradually succumbed to environmental pressures to conform to rules such as a doctor's prescriptions, and rules and norms of care that are found in the unit. This suggests that nurses are functioning at the conventional level (stages 3 and 4) of Kohlberg's theory of moral development.

Conformist nurses follow rules, norms and expectations of society just because these are societal rules even though the rules provide them with a framework for daily nursing practice and also save time. Such nurses, however, lack creativity and critical thinking (de Casterlé et al, 2008).

Jali (1984), in a comparative study of ethical dilemmas faced by registered nurses in South Africa and the U.S.A., corroborated that South African nurses also experienced various ethical dilemmas relating to informed consent, overcrowding in the wards and shortage of human resources, which led to discontentment and burnout. Correspondingly, Botes (2000) found that nurses in South Africa were narrow-minded in viewing abortion as an ethical issue and they lacked critical thinking skills to make ethical decisions.

Botes (2000) further indicates that nurses who think in a rational manner make a thorough assessment and ensure that they are well informed before making any logical decision. Critical thinkers take time to collect data, weigh the facts and think through the scenario. They do not accept or reject an idea unless they understand it. Reflective practitioners are honest about their own biases and they are empathic (Botes 2000)

2.3   Nursing Education

The provision of quality nursing care requires more than simply applying knowledge and skills. It requires nurses to demonstrate ethical competence which involves more than a mere understanding of ethical theories. Gallagher cited by Cannaerts, Gastmans and de Casterlé (2014) define ethical competence as the possession of ethical knowledge that gives one the ability to see what a situation presents, ethical perception to reflect critically on what the nurse knows and does and ethical reflection to bring out ethical behavior and practice. Callister, Luthy, Thompson and Memmott (2009) indicate that in the U.S.A, the National League for Nursing (NLN) has mandated nurse educators to create learning environments that facilitate learner nurses' reflection. Thus, the inclusion of ethics education in the curriculum will provide nursing students with the opportunity to develop skills in critical thinking that will enable them to deal with ethical dilemmas that they may encounter as students and when they enter nursing practice.

The teaching of ethics has received considerable attention in nursing education, but nurses do not demonstrate the necessary competence that allows them to engage in ethical reflection, ethical decision making and ethical behaviour. Student nurses are exposed to ethical theories in nursing education, but they find it difficult to apply these ethical theories in nursing practice.

This perceived disconnection between ethical theories and nursing practice maybe explained as the reason why nurses demonstrate inconsistency in ethical decision making (Cannaerts et al, 2014; Callister et al, 2009). Johnstone et al (2004) state that 80% of the nurses surveyed reported that ethics education was integrated into their regular nursing curricula and almost 74% of the nurses believed they had a need for more education on ethical dilemmas while only 7% felt there is little need for such education.

Bilajac, Bazdaric, Brozovic and Agich (2008) indicate that a systematic approach to continuous, life-long education on ethics is needed for both nurses and doctors as this might improve knowledge in ethics for both groups. Johnstone et al (2004) also reported that the level of ethics education among nurses was often higher than that taken by allied workers. This means that nurses may identify ethical issues in nursing practice better than other health professional who lacks the moral knowledge and skill in dealing with ethical dilemmas.

According to Russo (2011), members of the multi disciplinary health care team and patients are not well-equipped to deal with ethical dilemmas. Pacsi (2008) states that nursing education has an ethical responsibility to prepare competent nurses and facilitate continuing education that will help nurses recognize ethical dilemmas in practice and apply ethical principles in trying to resolve them. She further states that the focus in practice education and research must be on providing care that respects patients' cultural beliefs and autonomy.

Cannaerts et al (2014) draw attention to the growing debate concerning the best ways to teach ethics to nurses so that they can respond appropriately to ethical dilemmas that arise in clinical practice. Nursing education has an important role to play in stimulating nurses to reflect critically and creatively on their work regarding a patient's well-being. Nurses should be empowered to implement difficult personal ethical decisions in nursing practice (de Casterlé et al, 2008).

2.4　Contribution of Ethics Education

Cannaerts et al (2014), in a study conducted among nursing students and nurse educators in the United Kingdom (UK),Turkey, Taiwan and Australia universities and nursing colleges, found that ethics education increased the students' awareness of the importance of ethics in nursing and they became cognisant of the many and complex ethical issues that a bound in nursing practice.

Students mentioned that they have learned to challenge their practices. They also argued that ethics education contributed to their ethical reflection and ethical competence. They became aware of their personal qualities and limitations and also discovered professional and personal values. Through ethics education, students were able to state their thoughts positively and they could listen to arguments.

Students and educators further indicated that ethics education enabled them to identify and describe ethical issues, and to understand, explain and to justify ethical issues. It also influenced their analytical and problem-solving skills. At the same time, students mentioned that the increased awareness and reflective attitude created uncertainty (Cannaerts et al, 2014). Callister et al (2009) conducted four studies that focused on ethical reasoning in Greek, Korean, British and American students and found that students developed a high level of critical thinking, namely, discrimination and judgmental levels of reflection and commitment to ethical nursing practice.

2.5   Contribution of Teaching Methods

Cannaerts et al (2014), in a study of student nurses and nurse educators, reported that students regarded the lecture method as dull, impractical, not motivating and teacher-centered, but recognized that it was needed in the teaching of ethical theories because students require a certain amount of ethical knowledge before they can apply it in practice. Both nurse educators and students regarded the case study method as the most meaningful and appropriate method of teaching ethics.

The analysis of case studies enabled students to better understand ethical conflicts, develop a deeper understanding of concepts used in ethics, their applications and to develop ethical-decision making skills. However, students identified the disadvantage of the case study method in teaching—the case study method was too vague or obvious and there was limited time to discuss the cases. Students also recognized the discussion method as an appropriate strategy in the teaching of ethics. They indicated that group discussion of ethical dilemmas facilitated learning.

Group discussion facilitated students' listening skills, affirmed their own thoughts positively and also enabled them to express their thoughts carefully and clearly (Cannaerts et al, 2014). Students identified the usefulness of the problem-solving paradigm in the teaching of ethics. According to the students, the problem-solving approach promoted self-motivated learning, moral self-cultivation and understanding of nursing ethics (Canaerts et al, 2014).

The use of reflective journals, together with group discussion, was also considered as an effective method for teaching ethics. Students indicated that the discussion of the reflective diary helped them to think about their experiences and to question their convictions and attitudes (Cannaerts et al, 2014). Callister et al (2014) emphasized that the use of a reflective journal has both a developmental purpose and a learning enhancement objective. It also provides students with the opportunity to share their experiences with other students.

2.6 Conclusion

The literature review covered several ethical dilemmas that confront professional nurses in nursing practice and enunciated the formative roles of ethics education using various teaching methods in the nursing curriculum. Thus, the value of ethics eduction in developing ethical-decision making skills in nurses should be realized and implemented in the theoretical and practical/in-service components of nurse training.

CHAPTER3

Research Methodology

3.1 Introduction

This chapter described in details the research design and the methods that were used in the study. These included the research setting, research design, population, sampling method, data collection, data analysis and ethical considerations.

3.2 Research Setting

The research study was conducted at Witbank Hospital which is situated at the Nkangala District of the Mpumalanga Province. The Nkangala District has at least 22 coal mines and a maximum number of power stations. Witbank is a small town situated along the N4 road and is 95.2 kilometers away from Pretoria and 190 kilometers away from Nelspruit, the capital of the Mpumalanga Province. The Witbank Hospital is a level 2 hospital with 15 wards, namely, maternity, postnatal, orthopedic, pediatrics, female medical, male medical, female surgical, male surgical, theatre, adult intensive care, casualty, wellness, kangaroo mother and child, neonatal intensive care unit, and pediatrics short stay wards. It is also a referral hospital for several smaller hospitals in the Mpumalanga Province, including Amajuba Memorial, Barberton, Bernice Samuel, Bethal, Carolina, Elsie Ballot, Embhuleni, Ermelo, Evander, KwaMhlanga, Lyndenburg, Itshelejuba, Middelburg, Mmametlake, Piet Retief, Sabie, Shongwe, Standerton and Themba hospitals.

3.3   Research Design and Methods

A qualitative research method was used to describe the experiences of professional nurses with ethical dilemmas in nursing practice. Jooste (2010) describes a qualitative research method as a systematic, interactive and subjective approach that describes the experiences of participants and the meaning they ascribe to their experiences. Qualitative research emphasizes the dynamic, holistic and individual experiences and attempts to capture those experiences in their entirety within the context of those experiencing them (Polit and Beck, 2004).

3.4   Research Design

A qualitative exploratory, descriptive and contextual research design was used to describe in-depth the experiences of professional nurses with ethical dilemmas in nursing practice at the Witbank hospital.

3.4.1   Exploratory Research Design

An exploratory research design was used to describe the experiences of professional nurses with ethical dilemmas in nursing practice in one hospital at Nkangala District of the Mpumalanga Province. The few studies that have been conducted with regard to experiences of professional nurses with ethical dilemmas in nursing practice necessitated an explorative approach to be conducted. Burns and Grove (2001) state that explorative research is conducted to gain new insights, discover new ideas and increase knowledge of the phenomenon being studied.

3.4.2   Descriptive Research Design

The descriptive research design enabled the researcher to provide a thick and detailed description of the experiences of professional nurses with ethical dilemmas in nursing practice at the Witbank Hospital.

The descriptive research design facilitated as well the process of the researcher giving participants an opportunity to describe in detail their experiences of ethical dilemmas in nursing practice. Descriptive research refers to a more intensive examination of phenomena and their deeper meaning, thus leading to thicker description (de Vos, Strydom, Fouchè and Delport 2011). The richness and depth of the description gained from a qualitative approach provides a unique appreciation of the reality of the experience (Munhall, 2001).

3.4.3 Contextual Research Design

The contextual research design was deemed appropriate because of its emphasis on the natural setting. The researcher was able to immerse herself in the natural setting and social dimension where ethical dilemmas occur in order to describe the experiences of professional nurses with ethical dilemmas as accurately as possible as they occurred in nursing practice (Babbie and Mouton, 2001). A thick and detailed description of lived experiences with selected anecdotes and comments from the participants were provided. Babbie and Mouton (2001) describe the contextual research method as a procedure conducted with the aim of understanding events within the concrete, natural context in which they occur.

3.5 Population

The population of the study included 203 professional nurses employed at Witbank Hospital during the time of the study. Polit and Hungler (1997) define a population as the entire aggregation of cases that meets a designated set of criteria for inclusion in a study.

3.6 Sampling

A non-probability purposive sampling technique was used to obtain a sample size of fourteen (14) participants who had three or more years of experience as professional nurses at the Witbank Hospital. Sampling was done using the monthly change list at the hospital. Under each ward in the change list, nurses are listed hierarchically according to their years of experience as professional nurses. Those with three and above years of experience were purposively sampled.   Sampling was continued until saturation was reached.

de Vos et al (2011) define sampling as a small portion of the total set of objects or persons from whom a representative sample of participants is made. They further indicate that purposive sampling is entirely based on the judgment of the researcher, in that a sample is composed of participants that contain the most characteristics representative or typical of the population that best serve the purpose of the study.

3.6.1 Inclusion Criteria

This study included all professional nurses employed at Witbank Hospital who had three or more years of experience as professional nurses.

3.6.2 Exclusion Criteria

All professional nurses with less than three years of experience as professional nurses at the Witbank Hospital were excluded from this study.

3.7 Data Collection

The researcher made an appointment by means of a written letter to the unit managers and participants at Witbank Hospital and the purpose of the study was explained with the aim of establishing a trusting relationship with the participants. Semi-structured in-depth interviews were conducted using an interview guide to determine the experiences of professional nurses with ethical dilemmas in nursing practice at the study setting. Interviews were conducted when the participants were free so as not to disturb patient care. These interviews were conducted in a private doctor's room away from the noise and disruptions at the hospital. Each interview lasted for about 30-60 minutes

 Open-ended questions that allowed participants to speak freely were used to enable participants to describe in detail the ethical dilemmas that they experienced in nursing practice. *The central question that was asked to each participant was:* **What are the ethical dilemmas that professional nurses experience in nursing practice?**

Open-ended questions do not necessarily need a one word answer, but provide interviewees with ample opportunity to express their feelings (de Vos et al, 2011).

A full record of all the data collected from participants was secured on a tape recorder. Probing was used to obtain clarity of critical issues during the interviews. According to Creswell (1998), probing is done to follow up and ask individuals to explain their ideas in more detail or to elaborate on what they have said. In this study, the searcher took observational, theoretical and personal field notes. Observational notes are events experienced through watching and listening during an interview. Theoretical field notes are purposeful attempts to derive meaning from the observation notes.

Triangulation of data collection tools was achieved by using field notes and a voice recorder to complement each other, thus, maximizing the quality of data and reducing the chance of bias.

3.8 Bias

In this study bias was minimized as follows:

- The researcher suspended all her preconceived ideas about the experiences of professional nurses with ethical dilemmas in nursing practice.
- Purposive sampling was used to sample participants who had 3 or more years of experience as professional nurses.
- No leading questions were asked during data collection, but probing was also done for clarification of vague answers.
- During data collection, field notes that helped the researcher to reflect on the research process and verbatim reports from the participants were written.
- Observation of the participants was done to register any important reaction during data collection. An audio tape was also used during data collection.
- During data analysis, transcripts were carefully read and coded using themes and sub-themes, and an independent coder verified the themes and sub-themes that emerged from the data.

Bracketing is a technique that is used in qualitative research and it enables the researcher to suspend pre-conceived ideas with the view of approaching the phenomena being studied without any biases (Burns and Grove, 2001).

3.9 Data Analysis

Data were analyzed using the Tesch's open-coding method (Creswell, 1998):

- The researcher read carefully all transcripts to obtain a sense of the whole interview and jotted down any ideas that came to mind.

- The researcher randomly selected one interview, read through it, and asked herself the following questions: *What is it about? What is the underlying meaning?*

- The researcher rationalized the coding for the existence or frequency of concepts; when this was completed, a list was made of all topics covered with the participants. Similar topics were grouped and those that did not have association were clustered separately.

- The topics were then abbreviated as codes and the codes were written next to the appropriate segment of text. Interview schedules and field notes were colour coded appropriately and written in separate note books.

- Themes and sub-themes were then developed from coding or associated text and topics related to each other were grouped to reduce the total list to categories. Lines were drawn between categories to show interrelationships.

- The researcher made the final decision on the abbreviations for each category and arranged the codes alphabetically. Privacy and confidentiality of irrelevant information was ensured throughout the study.

- The researcher explored the preliminary organizing scheme for any new or emerging categories and codes.

- The researcher collated and analyzed data which belonged to each theme.

- The researcher then summarized the themes and sub-themes identified, and sent the data to an independent coder. Once the co-coder had completed the independent coding, common themes and sub-themes of the independent coder and the researcher were identified.

3.10 Ethical Considerations

The researcher adhered to the following ethical standards in order to fulfill the aim of the study:

3.10.1 Permission

Ethical clearance was obtained from the University of Limpopo- Medunsa Campus Research Ethics Committee (MREC). Permission to conduct the study was obtained from the Mpumalanga Department of Health and Social Development Ethics Committee and the Chief Executive Officer of Witbank Hospital because participants were professional nurses employed at the study site.

3.10.2 Informed Consent

Informed consent was obtained from the participants after a thorough explanation of the purpose and the objectives of the study. Participation to the study was voluntary and participants had the right to withdraw from the study at any-time without any risk of penalty or prejudicial treatment. Permission to use a tape recorder and field notes during the semi-structured interviews was obtained from the participants.

3.10.3 Confidentiality and Anonymity

According to the *Democratic Nurses Association of South Africa (1998)* (DENOSA) ethical standards for nurse researchers, confidentiality and anonymity were ensured in accordance with the following criteria: protection of participants' identity ensured that research data could not be linked to the individual's identity or organization.
In ensuring such anonymity, the researcher guaranteed that the participants would not be identified by the reader at anytime. The participants were given code names that were used instead of their real names.

3.11 Measures to Ensure Trustworthiness

According to Babbie and Mouton (2001), criteria to ensure trustworthiness are credibility, transferability, dependability, and confirmability.

3.11.1 Credibility

In this study, credibility was ensured through prolonged engagement wherein the researcher stayed in the field until data saturation was achieved. The researcher conducted the interviews for a period of a month. Triangulation of data collections tools was achieved during the interview sessions by writing field notes, observation and recording of all the interview sessions in a voice recorder. Credibility refers to the compatibility between the constructed realities that exist in the minds of the participants and those that are attributed to them (Babbie and Mouton, 2001). Jooste (2010) further states that triangulation is a combination of multiple methods to portray data collected more accurately.

3.11.2 Transferability

In this study, transferability was ensured by providing a thick description of the methodology and by purposive sampling of participants. Transferability refers to the extent to which the findings of the study can be transferred to another context or with other participants (de Vos et al 2011)

3.11.3 Dependability

In this study, dependability was ensured by a dense description of the research method that was used. Verbatim capturing of the interviews on audiotape was done to enhance dependability.

Babbie and Mouton (2001) state that dependability implies that if the study was to be repeated with similar participants in the same context, its findings would be the same.

3.11.4 Confirmability

In this study, confirmability was ensured through the use of a tape recorder and field notes to support the semi-structured interviews as a point of reference (de Vos et al, 2011). Transcribed data and field notes were sent to an independent coder who specialised in qualitative research to ensure confirmability. Babbie and Mouton (2001) indicate that confirmability refers to the degree to which the findings of the study are a product of the inquiry and not the biases of the researcher.

3.12 Conclusion

This chapter described in details the qualitative, exploratory, descriptive and contextual research design that was used in this study. Semi-structured, in-depth interviews with an interview guide were used to collect data until data saturation was reached. Field notes and a voice recorder were also used during data collection. Data were analysed according to Tesch's open coding method as outlined by de Vos et al (2011).

CHAPTER 4

Results and Discussion

4.1 Introduction

This chapter presents the analysis of data collected from fourteen (14) participants who were purposively selected to describe their experiences with regard to ethical dilemmas in nursing practice at the Witbank Hospital. Four main themes and associated sub-themes emerged during data analysis as summarized in Table 4.1. The themes and sub-themes are supported by a literature control that reinforces the study results and participants' verbatim statements that are presented in italics.

4.2 Themes and Sub-Themes Identified

Four themes and related sub-themes emerged from the findings of the study as depicted in Table 4.1. The themes were: death and dying, distribution of resources, respect of patients' autonomy and nurses' rights. These themes and sub-themes are discussed below

4.2.1 Theme 1: Death and Dying

The study found that some of the participants stated that they experienced ethical dilemmas related to death and dying. They experienced moral conflict when they were required not to resuscitate a patient and this is described in the following sub-themes:

Table4.1: Themes and sub-themes identified through data analysis

Themes	Sub-Themes
1.Death and dying	1.1 Passive euthanasia
2.Distribution of resources	2.1 Shortage of material resources
	2.2 Shortage of human resources
	2.3 Provision of nursing care at nurses' health risk
3.Respect of patients' autonomy	3.1 Patients' right to refuse treatment
	3.2 Patients' confidentiality
	3.3 Patients' cultural beliefs
4.Nurses' rights	4.1 Nurses 'rights to strike actions
	4.2 Performing nursing actions that are above the nurses' scope of practice

4.2.1.1   Sub-Theme1.1: Passive Euthanasia

Four (4) participants indicated that the "*do not resuscitate order*" from doctors posed an ethical dilemma because they have taken an oath to preserve life as indicated in the Nurses' *Pledge of Service.* They, therefore, experience moral distress when they are required not to resuscitate a patient. Participants further explained that they know that minimizing the ventilator settings and progressive administration of dormicum (sedative) and morphine (analgesia) do not only alleviate pain, but also accelerates death. They also expressed moral distress when they have to give nursing care to a newborn baby who has an *Apgar* score of 1 on *Continuous Positive Airway Pressure (*CPAP) or to put the baby on nasal prongs. They stated that the hospital protocol states that such babies should not be intubated. The following excerpts from the interviews qualify this sub-theme. Participants 9 said:

A newborn baby with severe birth asphyxia was brought to the hospital from the clinic where the baby was managed and the woman had a prolonged 2nd stage of labour. In the hospital the woman was delayed to be taken for Caesarean section. When the baby was delivered, she was hypoxic and the Apgar score was 1 and the intern intubated the newborn baby and transferred her to neonatal ICU. During ward rounds the baby was found to be brain dead. After the parents were informed of the baby's poor prognosis, the father decided that the machine should be switched off to let the baby to die peacefully.

Participant 11 also concurred:

We had a child who was diagnosed with cancer and his prognosis was poor because of metastasis. After the parents had been counseled about the child's prognosis, members of the multidisciplinary team decided that treatment for the child should be minimal (weaned off to minimal ventilator settings). As I was delegated to take care of the patient ,I had to administer the medication slowly, hourly, and keep on weaning the patient from the ventilator. I was much traumatized the whole month and as a male I was not supposed to cry, but I went to the toilet to cry. I nearly resigned, but did not because I like the profession.

Participant 14 added:

In the Intensive Care Unit (ICU), critically ill patients or terminally ill patients come to the hospital for help and after they have been examined— then the doctor tells you not to resuscitate the patient. We are here for patients; we are here to preserve life, so that is really a dilemma.

Participant 11 continued:

The only thing to do was to put the child to sleep; to die peacefully—and now because of my religion, I am a Christian, and my profession does not allow us to kill. I was just in between my religion and my profession.

The findings of this study are supported by Ulrich et al (2010) who also found that nurses with less experience encountered end-of-life and surrogate decision-making issues more frequently than those with more experience. Less experienced doctors and nurses are reluctant to withdraw life-saving treatment for critically ill patients and they also have difficulties associated with providing analgesics or sedative relief during treatment withdrawal (Ulrich et al, 2010).

Dhai and McQuoid-Mason (2011) also assert that practitioners often express concerns about increasing sedation and pain relief which result in secondary effect complications that can accelerate death. They further state that where the intention is to relieve suffering and not to accelerate death, this treatment would be both legally and ethically acceptable and this scenario is referred to as the doctrine of double effect. McQuoid-Mason (2013) further states that in South Africa active euthanasia is illegal, but passive euthanasia is legal under certain conditions. The South African common law indicates that it is unlawful to terminate a person's life in order to relieve him/her from unbearable pain, even if death is eminent.

Chidoori (2009), in a study conducted in 2005, found that 70% of adult South Africans were in favour of passive euthanasia of a brain dead person. Landman (2001) also states that a number of doctors in South Africa would be willing to perform euthanasia at the request of their patients once it was legalized in the country. Forty (40%) of all deaths and of all non-acute deaths are results of medical end-of-life decisions. This indicates that South African doctors are performing euthanasia albeit secretly for fear of exposure to civil claims, criminal prosecution or professional censure (Chidoori,2009).

The findings of this study demonstrated that participants function at stage 4 of Kohlberg's theory of moral development. Obeying rules took precedence over what they believe in as individuals. Botes (2000) indicates that nurses in South Africa are narrow-minded and lack critical thinking skills when making ethical decisions. A nurse who thinks in a rational manner use logical reasoning in her/his decision-making (Botes, 2000).

4.2.2 Theme 2:   Distribution of Resources

The study found that all fourteen (14) participants experienced ethical dilemmas relating to the shortage of both material and human resources and these are discussed in the following sub-themes:

4.2.2.1   Sub-Theme 2.1: Shortage of Material Resources

Eight (8) participants indicated shortage of material resources as predisposing them to ethical dilemmas. They expressed that poor patients or less educated patients have little autonomy regarding their access to material resources, while the opposite is true for well-educated patients with good social standing. Participants also indicated that they have taken an oath not discriminate patients based on their social standing and religion and they then find themselves in conflict when in practice they have to treat patients differently based on their economic and/or social standing. Participants also indicated that there was a shortage of material resources such as medication and oxygen gauges in the hospital and they found it very difficult to tell patients that there was no medication such as paracetamol. They were also afraid of publicity in the newspapers should they advise patients or relatives to buy the medication for themselves. These sentiments are aptly expressed in the following excerpts:

Participant 9 said:

I am in ICU and when an educated woman delivers a premature baby weighing less than one kilogram, protocol is not followed and the premature baby will be put on the ventilator regardless of the weight of the baby simply because the woman is from a rich family or is educated. That actually creates a dilemma for me because everybody has a right to healthcare and the right to life regardless of one's social standing. When I took the oath in the Nurses' Pledge of Service I have indicated that I will not allow any social standing to interfere with my profession. But in practice somewhere, somehow I fail.

Participant 8 added:

Usually in the medical ward all patients need oxygen points but, there is a shortage of oxygen gauges. So you don't know who to give the oxygen and who must not get it and you end up feeling guilty because some of the patient s might even die due to lack of oxygen.

Participant 7 also added:

Like in our department, we have ten beds and there are three beds with CPAPs that have biphasics modes. We have a challenge of having four kids who need the biphasics CPAPs, we end up not knowing who is to be recommended first, you know! And because of that we end up not giving them the quality nursing care that we want to give to our patients. May be or otherwise if they can give us some more equipment we will have to sort out the problem of ventilators and CPAP shortage.

The findings of this study confirm the statement by WHO (2008) that access to health-care and the benefits that people gain are closely related to other social determinants of health like income, gender, education, ethnicity, and occupation. Inequalities in health are also determined by these socio-economic and cultural factors.

Healthcare is inequitably distributed globally, with pronounced inequality for the poor in low and middle-income countries. The distribution of healthcare resources should be fair and just regardless of race, colour or creed. In reality, the distribution of scarce resources is based on the ability of the individual patient to pay directly or indirectly through health insurances. Thus, the poorly insured and the uninsured often cannot have access to adequate healthcare services (Beauchamp and Childress, 1994).

4.2.2.2 Sub-Theme 2.2: Shortage of Human Resources

Six (6) participants expressed that shortage of human resources expose them to ethical dilemmas. They further explained that patients have become more aware of their rights and therefore demand quality patient care. They indicated as well that the shortage of nurses at the hospital leads to burnout and poor nursing care because they are unable to complete their delegated tasks. They also expressed that they have chosen a wrong career in nursing. These sentiments were expressed as follows by participant 8:

> *We do have standards and the staff-patient ratio is stipulated, but that does not happen. And you find that as a nurse you are expected to do wonders, both day and night. It is worse during the night because people think that there is less work during the night—whereas it is totally wrong. So you find that as a nurse you pull until you feel you cannot pull any more and as long as you executing your task you end up deciding what is it that I can do first and what is it that I consider important and other duties become less important and that does not mean that these duties are truly not important. We are short-staffed, you find that in a ward you have to nurse 40 patients, you have five (5) personnel on duty of which it becomes difficult to give quality nursing care to patients. The dilemma that we are facing is whom do you attend first, who are you not supposed to attend because all of them need your attention as a nurse.*

Participant 12 concurred:

You find that we need to have side wards for putting patients that are critically ill, terminally ill or patients that have sepsis. Patients with special needs like sepsis, and patients with offensive discharge need to be separated from the other patients, but because of shortage of space you are left with no choice but to place these patients in the general ward and by so doing you are not doing justice to other patients. For example, if you put aseptic patient in the general ward you are actually exposing the other patients to the risk of cross-infection, but as a nurse you cannot deny a patient a bed based on those grounds—instead, you look at the patient in the eye and .what do you say? Some of these patients feel they don't need to be mixed with other patients because of their condition, but because of resources.

Stellenberg and Dorse (2014),in a study conducted in private hospitals in the Western Cape, reported similar findings of adverse conditions that existed in the work environment with some of the respondents stating that they were exploited and not happy in their area of work. The findings of this study are also congruent with those of Landman, Mouton and Nevhutalu (2001) who, in a survey of hospitals in South Africa, found that unsatisfactory working conditions at public health facilities contributed to the increased shortage of health professionals. They are expected to provide healthcare to increased numbers of patients amidst insufficient resources, poor maintenance, outdated or faulty equipment and a lack of property or incentives. Erlen (2004) also asserts that the persistent nursing shortages is challenging the values and beliefs of the nursing profession and causing nurses to ask how can they fulfill their ethical responsibilities to patients when there are an insufficient number and mal-distribution of nurses. She further states that nurses are expressing job dissatisfaction, experiencing moral distress and wondering about their ability to provide quality care.

Several authors have expressed the negative impact of unsafe staffing on the safety and the quality of patient care (Aiken, Clarke, Sloane, Sochalski and Silber, 2002; Curtin 2003; Needleman, Buerhaus, Stewart, Zelevinsky and Mattke, 2006;Sovie and Jaward, 2001). Safe patient care ,regardless of the practice setting, is predicated on having an adequate number of registered nurses with the appropriate skill mix providing nursing care. According to the New York Nurses Association (2005), an unsafe practice situation can arise from a number of circumstances, including inadequate or inappropriate staffing mixes, improper policies and procedures or a lack of supplies or equipment with such circumstances leading to a situation where the registered nurses' obligations to provide safe, competent and ethical care cannot be fulfilled.

The American Nurses Association (2001) upholds that registered nurses, based on their professional and ethical responsibilities, have the professional right to accept, reject or object in writing to any patient assignment that puts patients or themselves at serious risk for harm. It further indicates that registered nurses have the professional obligation to raise concerns regarding any patient assignment that puts patients and themselves at risk of harm. Dhai and McQuiod-Mason (2011) concur that ethical dilemmas relating to the shortage of both human and material resources occur frequently in South Africa where there is shortage of both human and material resources, unmanageable patient load and the burden of diseases such as HIV/AIDS and tuberculosis (TB).

4.2.2.3 Sub-Theme 2.3: Provision of Nursing Care at Nurse's Health Risk

Five (5) participants indicated that they were at risk of being infected with communicable diseases such as TB due to the shortage of material resources and that they were performing non-nursing duties. Participant 8 said to express these sentiments:

Some of the patients with TB and especially those that are diagnosed with multi-drug resistant (MDR) T.B and you find that we don't have protective garments such as masks because they are out of stock. So as professional nurses our health is at risk because we are expected to nurse these patients and expose ourselves to infectious diseases.

Participant 13 added:

There are patients with unknown diagnoses or undiagnosed patients and you also find that the nurse is also ill with probably low resistance and the nurse actually becomes infected as well.

Participant 12 concurred:

As a nurse you are a messenger, blood is ordered, and you have to move from your department to collect blood at the blood bank at night. There are three staff members and one staff member has to accompany you to the blood bank at night because the corridors are dark with no lights at all and with no security. So this brings our safety at risk, but because of patient care, you are bound to risk your own life and nobody cares for you in return. If you call the security people to accompany you to the blood bank,   they tell you it's not my job, but as a nurse it is your job, you then leave patients behind and go fetch blood from the blood bank. When the porters are not available the nurse becomes a porter. You are expected to push the trolley and there is nowhere where you are trained as a porter, but you have to do it because of patient care.

The findings of this study are congruent with those of Ayer's (1998) in that medical staff, orderlies, housekeepers, emergency care providers and others are at risk of becoming infected with and other infectious diseases.

4.2.3　Theme 3: Respect for Patients' Autonomy

Ten (10) participants indicated that they were often confronted with ethical dilemmas related to a patient's right to refuse treatment, confidentiality and cultural beliefs. These are described in the following sub-themes:

4.2.3.1　Sub-Theme 3.1: Patients' Right to Refuse Treatment

Ten (10) participants indicated that patients' rights to refuse treatment based on their religious belief, in particular those patients who are Jehovah's Witnesses, made them to compromise their primary objective of providing quality nursing care.

They also indicated that patients' religious beliefs of not accepting blood transfusion often exposed them to an ethical dilemma because they have to witness a patient's death while life-saving measures such as blood transfusion were available at the hospital. They also stated that senior medical and nursing personnel undermined the patients' right to self-determination. Patients were often coerced and threatened and given blood transfusion against their religious beliefs. Participants felt that such behaviours by other members of the health team undermined patients' right to autonomy to make their own choices and decisions. Participants experienced moral distress because they could not advocate for the patients' right to autonomy. When a patient who refused blood transfusion died, participants also found themselves in a dilemma because they could not help the patient. These sentiments were expressed in the following excerpt by participant 4 who said:

> *You know that Jehovah's Witness patients don't accept blood or blood products and the patient had a medical disc alert written Jehovah's Witnesses and had signed refusing blood transfusion. The patient was bleeding post-operatively after a Caesarean section and her Hb (haemoglobin level) was 4. Her husband also refused to sign the consent form. The woman eventually died leaving a three-day old baby.*

Participant 12 added:

A woman who belonged to the Jehovah's Witnesses church needed blood transfusion. The Chief Executive Officer (CEO)and the nursing service manager were threatening the patient telling her that she was going to die, but the patient refused the blood transfusion. The doctor also came to convince the patient. Eventually the patient covered herself with a blanket and the doctors and the management gave a go ahead and the patient was given the blood transfusion. I was traumatized because the patient understood fully the consequences of her action, but the patient's right to make informed decision was not honoured. I felt that I had failed to advocate for the patient.

Participant 7 concurred:

The dilemma that we come across is that of a Jehovah's Witness patient who had an abortion and was in hypovolaemic shock because of excessive bleeding. She needed blood transfusion, but the patient refused the blood transfusion. We ultimately lost that patient and there was no way that we could help the patient. As nurses we know that we are here to preserve life, so it's very much difficult for us to stand and do nothing whereas there is help.

McQuoid-Mason (2013) states that patients have the right to refuse treatment even if it is not in their best interest. Pera and van Tonder (2011) also indicate that health professionals should respect the patients' autonomy by giving the patient all the information that will enable them to make informed decisions. However, Moodley (2011) indicates that a patient's refusal of treatment conflicts with a doctor's need to do good. He further asserts that the principle of respect of autonomy is not absolute, but rather *prima facie*. This means that a principle can be fulfilled unless it conflicts with an equal or a more compelling principle. In the case of the Jehovah Witnesses' patient, the right to refuse treatment was overridden by the patient's right to life.

4.2.3.2 Sub-Theme 3.2: Patients' Confidentiality

Four (4) participants stated that they were confronted with ethical dilemma of confidentiality. Patients' visitors exposed themselves to cross-infection because they do not know the patient's diagnosis and they also have poor knowledge about HIV/AIDS. These sentiments are summarized as follows by participant 14 who said:

> *You find that patients' relatives visit the hospital and they handle the HIV-positive patients' discharges and secretions with their bare hands .When you advise them to wear gloves they feel bad because it is their beloved one and they want to take care of him/her. So it's difficult to tell them the diagnosis of the patient. So we tell them that we treat each and every patient like they are HIV-positive, but they want to know more, so it becomes a dilemma because the patient's diagnosis should be kept confidential.*

The findings of this study are similar to Stellenberg and Dorse's findings (2014) that some nurses did not acknowledge patients' autonomy, confidentiality, privacy and honesty. Hall (2004) also found that nurses are at times confronted with ethical dilemmas such as to balance the rights of people with HIV/AIDS with the rights of relatives and sometimes children who act as caregivers, but who may not be aware of a person's HIV status. Hall (2004) further states that the secrecy surrounding the disease seems to reduce the nurses' productivity and also hinders nurses in their efforts to prevent further spread of the disease.

4.2.3.3 Sub-Theme 3.3: Patients' Cultural Beliefs

Ten (10) participants indicated that patients' rights to practice their cultural beliefs were in conflict with nurses' rights to perform their nursing duties within the legal parameters. Participants also stated that at times the patient's right to perform his/her culture was in conflict with the rights of other patients in the ward. These sentiments were expressed as follows:

Participant 12 said:

> *We had a patient that was four (4) weeks pregnant and she aborted clots and she wanted to take the clots home to perform cultural rituals. I don't know how far we can go around that when you think of the patient's culture and the Human Tissue Act. When you refuse it's like your interfering with the patient's culture and when you agree to the patient's request, you are interfering with the Human Tissue Act.*

Participant 8 added:

> *When a person is deceased, the relatives come to the ward to perform a ritual of taking the soul of the deceased person home from the ward. They also use traditional medicine. Sometimes they find that there is already a patient on that bed where the deceased patient was sleeping. Patients in the ward feel threatened because they feel that they might also die. It becomes a dilemma for me as a professional nurse because there are complaints from patients who are still in the cubicle. At the same time you feel that those ones also have a right to perform their rituals.*

The findings of this study are congruent with those of Chua and Tham (2006) who found that the major ethical dilemma is that by honouring the patient's autonomy and religious beliefs, the physicians and interdisciplinary team members are faced with compromising their moral duty to administer professional care in accordance with established standards.

4.2.4 Theme 4: Nurses' Rights

Twelve (12) participants stated that they were confronted with ethical dilemmas when there was a strike at the hospital because as professional nurses, they strongly wanted to provide patient care because they have taken an oath and they have pledged to serve humanity and that the health of the patient will be their first consideration. At the same time, they were afraid to risk their own lives during the strike action. These sentiments were expressed in the following sub-themes:

4.2.4.1 Sub-Theme 4.1: Nurses' Right to Strike Actions

Nine (9) participants stated that they found themselves confronted with ethical dilemmas because they have taken a pledge to serve humanity and to endeavour to practice their profession with conscience and dignity; that the total health of their patients will be their first consideration and that they will maintain the utmost respect for human life. These notions were expressed as follows by participant 11 who said:

> We as employees have joined unions and sometimes when they take decisions to go on strike, we have to go on strike. We as nurses are faced with a dilemma because we can't leave patients unattended in ICU, it is very, very wrong. To us nurses, the patient's life is important. Yes we can get money, but once someone losses his/her life there is nothing one can do. But because we fear for our lives; they will kill us and so you have to go on strike against your will. That is a very harsh decision that you're taking because remember we took an oath.

Participant 5 concurred:

> We do have the legal right to strike, but as we know we have taken an oath and we have our rules and regulations, our acts and omissions and this leads to an ethical dilemma because when we strike, our aim to promote health is compromised. Patients become affected and some of them are mismanaged, while others die as a consequence of our strike actions.

Participant 11 added:

> You know that when there is a strike, there's also a dilemma because you don't want to go on strike and at the same time you think about the patients because they need you. You are also committed to your job and when now there is a strike your life is in danger, you think about the patients, you don' t know actually whether to go. As I said you're in a dilemma.

In the Republic of South Africa, nurses have a right to strike as supported by the *Constitution of the Republic of South Africa Act* 108 of 1996 and the *Labour Relations Act* 66 of 1995. However, a dilemma exists because the nurses' right to strike is in conflict with the patients' right to nursing care. The patients' right to health care overrides the nurses' right to strike. Nurses have a moral obligation to provide healthcare. However, from a legal point of view, nurses have a right to strike. When nurses embark on a strike, they are violating the patients' right to healthcare.

4.2.4.2 Sub-Theme 4.2: Performing Nursing Actions that Are Above the Nurses' Scope of Practice

Eight (8) participants indicated that quite often they performed duties that were above the nurses' scope of practice and this posed ethical dilemmas to them. They expressed these sentiments a r e e x p r e s s e d as follows:

Participant 7 said:

> *When doctors don't come to review the patients' prescriptions on time and to us it's difficult because as a professional nurse I'm supposed to give medication at the correct time so that the patient doesn't develop resistance to the medication. So it's a dilemma because now I'm stuck, I have to give medication and if it's not prescribed again it's not legal, so then what do you do in that situation? So it's a dilemma.*

Participant 12 also said:

> *Remember we are guided by the scope of practice which does not allow me as a professional nurse to put up a drip under normal circumstances. You are only to put up a drip in a case of an emergency and there is no clause that explains what an emergency is. So the ethical dilemma that I experience is should I leave or should I put up the drip, the patient needs that antibiotic—at the end of the day you feel like you haven't done as expected. You don't get joy in what you have come to do.*

Participant 8 added:

> *It is not in our scope of practice as professional nurses to complete death certificates, but because we are working in an environment where you find that relatives of deceased patients are waiting in queues for death certificates and you end up leaving your nursing routine and attending to relatives' needs. You have to complete the death certificate so that the relatives can go and prepare for the burial. It becomes an ethical dilemma for me as a professional nurse because I'm neglecting the patients that I am supposed to be giving proper nursing care and on the other hand I had to help the people who are grieving on behalf of their deceased loved one.*

4.3 Conclusion

The findings of this study indicated that professional nurses were experiencing ethical dilemmas relating to passive euthanasia, shortage of both human and material resources, respect of patients' autonomy, nurses' rights to be involved in strike actions and that professional nurses perform nursing actions that were above the nurses.' scope of practice. These ethical dilemmas had a negative impact on the professional nurses' ability to provide quality patient care.

CHAPTER 5

Summary of the Findings, Limitations, Conclusion and Recommendations

5.1 Introduction

This chapter presents the summary of the findings of the study on the experiences of professional nurses with ethical dilemmas in nursing practice. It also presents the extent to which the objectives of the study have been achieved and the limitations of the study. Recommendations were drawn from the findings of the study as presented in Chapter 4.

5.2 Purpose of the Study

The purpose of this study was to determine the experiences of professional nurses with ethical dilemmas at the Witbank Hospital, Mpumalanga Province.

5.3 Objectives of the Study

The objectives of the study as stated in Chapter 1 were achieved and are evaluated as follows:

Objective 1:
To describe the experiences of professional nurses with ethical dilemmas in nursing practice.

This   objective was achieved as outlined in the summary of the findings (section 5.4).

Objective 2:

To determine supportive measures to help professional nurses to deal better with ethical dilemmas encountered in nursing practice.

This objective was achieved as indicated in the recommendations (section 5.5).

5.4   Summary of the Findings of the Study

Participants expressed clearly the ethical dilemmas they experienced in nursing practice as identified in the four major themes and sub-themes that emerged from data analysis.

5.4.1   Death and Dying

5.4.1.1   Passive Euthanasia

Participants stated that they experienced moral distress regarding passive euthanasia that was practiced at the hospital. They indicated that as nurses they have taken an oath as stated in the *Nurses' Pledge of Service* that they will save lives. They therefore, find it very difficult not to resuscitate a patient when the *Do Not Resuscitate* order has been mandated.

5.4.2   Distribution of Resources

5.4.2.1   Shortage of Both Human and Material Resources

The study found that professional nurses experienced ethical dilemmas related to shortage of both human and material resources. They indicated that there was unfair distribution of material resources in the hospital with the poor and uneducated patients not receiving quality nursing care, while the educated and rich patients received quality patient care. Professional nurses believed that such skewed nursing actions undermined the patients' autonomy and impacts negatively on quality health care.

They further referred to the *Nurses' Pledge of Service* which states that nurses should treat all patients equally regardless of the patients' social standing, education and religious affiliation, and that they should consider the total health needs of the patient. Professional nurses also stated clearly that the shortage of protective garments such as masks and gowns exposed them to the risk of becoming infected with infectious diseases such as TB.

Professional nurses frequently referred to the Nurses' Pledge of Service because it assisted them to identify the ethical dilemmas and also provided them with a framework that enabled them to make informed decisions to deal with the ethical dilemmas. The *Nurses' Pledge* of Service contains those shared norms and values that members of the profession cherish and it offers professional nurses with moral standards that they follow as they carry out their professional duties. Maraldo (1992) indicates that standards for ethical conduct are necessary in order to provide morally responsible care.

Participants indicated that the shortage of staff in the wards led to moral distress because they were unable to render quality nursing care with the available material resources. Jali (2010) in the analysis of the *Nurses' Pledge of Service* states that when nurses make their services available, they are also accepting the responsibility to observe the moral standards of due care. She further indicates that if the nurses' conduct falls below the moral standard of due care, nurses will be acting negligently.

The shortage of both material and human resources, the lack of support and appreciation from senior management of nurses' efforts to do their best for their patients with limited resources and other issues contribute to moral distress for professional nurses. It is evident that nurses are dissatisfied and experience burnout. They expressed that they have made wrong career choices and are considering leaving the nursing profession.

5.4.3   Respect of Patients' Autonomy

5.4.3.1   Patients' Right to Refuse Treatment

Participants were confronted with ethical dilemmas relating to the respect of patients' autonomy. They expressed that the patients' right to self-determination was undermined in the hospital because the patients' religious beliefs were not respected. This referred in particular to the patients who belonged to the *Jehovah's Witness* denomination.

Nursing management and the medical staff coerced the patients to receive blood transfusion against their religious beliefs. At the same time participants realized that blood transfusion could save patients' lives. In this case the Principle of Autonomy was in conflict with the Value of Life Principle. As such, they experienced moral distress if they had to let the patient die when blood transfusion was available to save life. Nurses also experienced moral distress because they are committed to the principle of beneficence which is a moral obligation to act for the benefit of others. This principle, therefore, obligates them to do good for the benefit of others (Jali 2010). It should be borne in mind that the respect of autonomy is not absolute and can be overridden by competing moral considerations. For example, life is more important than the respect of one's autonomy.

5.4.4   Nurses' Rights

5.4.4.1   Nurses' Rights to Strike Actions

Participants indicated that they experienced ethical dilemmas during nurses' strike actions because they have an obligation to provide patient care. They again referred to the *Nurses' Pledge of Service* that they have taken an oath to serve humanity and that the total health of the patient will be their first consideration. At the same time they were afraid to risk their own lives during the strike action.

It should be taken into account that nurses have a moral obligation to provide nursing care and that the patients' right to health care is more important than the nurses' right to engage in strike action.

5.5 Recommendations

Based on the findings of this study, the researcher wishes to make the following recommendations that will offer professional nurses with supportive measures to resolve some of the ethical dilemmas that they are confronted with in nursing practice:

5.5.1 Support for the Nurses' Code of Ethics

The Nurses' Pledge of Service provides nurses with a framework that helps them to resolve ethical dilemmas. Therefore, nurses should be familiar with the Nurses' Pledge of Service and use it on a daily basis. Hospitals should also incorporate behavior that is congruent with the code into their nursing actions.

5.5.2 Provision of Continuing Education

One way to support professional nurses in handling ethical dilemmas is through education and training in ethics. Professional competence is a prerequisite for providing morally responsible care.

Book or journal clubs could be sponsored as these could offer an opportunity to focus on ethics practices and procedures. Through this, members of the multi-disciplinary health team can also obtain continuing education that will enhance their formative experience.

Professional associations should provide resources to initiate and sustain health promotion and education programmes aimed at imparting knowledge and proficiency skills to nurses and healthcare professionals so that they can deal with ethical issues more effectively and efficiently.

5.5.3 Creation of a Supportive Environment

The nursing environment should be supportive to all members of the health team who are raising ethical questions. It should also be empowering to them to address their concerns. Hospitals should provide an enabling environment that has all the necessary material resources.

Employees who have access to information, receive support from organizational leadership, subordinates and peers, should be given adequate resources to do their work and have opportunities for personal and professional development and are empowered to contribute to achieving organizational goals. More professional nurses should be employed to ease the pressure of work for the professional nurses. Hospitals should establish Hospital Ethics Committees to facilitate debriefing sessions for employees.

Hospitals should have on-site nurse ethicists or other ethics professionals who can be confidentially consulted by other members of the multidisciplinary team. A nurse ethicist can help people to look at the situation from another perspective.

Hospitals should have unit-based ethics mentors who could help their colleagues with such day- to-day concerns. If there is someone based in the unit, ethical issues can be addressed earlier and can thus be readily resolved and not lead to further conflict.

Nurses experiencing moral distress should be provided with individual counseling sessions with a counsellor who is readily available in the wards

5.5.4 Inter-Disciplinary Team

Both doctors and nurses experience ethical dilemmas on a daily basis—more than other members of the multidisciplinary team. Working together in the education and discourse of ethical dilemmas could therefore be beneficial to both groups.

5.5.5   Further Research

It is recommended that a nationwide study should be conducted on the experiences of professional nurses with ethical dilemmas in nursing practice. This will assist in getting a clearer picture of the extent of the challenges that professional nurses are experiencing when faced with ethical dilemmas. Job satisfaction studies are also recommended for correlation with the ethical dilemmas that were identified by professional nurses in this study.

5.5.6   Establishment of Institutional Policies

Hospitals should establish institutional policies which address ethical issues for example, a *Living Will*, *Individual Choices Related to Euthanasia*, *Blood Transfusions*, and *Care of HIV-and TB-Infected Patients*.

5.6   Limitations of the Study

The study was conducted in one hospital with a purposive sample of 14 professional nurses. Therefore, the findings of this study cannot be generalized to other hospitals. Despite the limitations, the overall study does offer some valuable insight into the ethical dilemmas that professional nurses experience in nursing practice.

5.7   Conclusion

The study concluded that professional nurses at the Witbank Hospital, Nkangala District Mpumalanga Province were experiencing ethical dilemmas relating to passive euthanasia, shortage of human and material resources, provision of nursing care at nurses' health risk, patients' rights to refuse treatment, patient confidentiality, patients' cultural beliefs, nurses' right to strike actions and performing nursing actions that were above their scope of practice.

The most stressful ethical dilemmas were related to end-of-life and the shortage of both material and human resources. The shortage of staff and material resources made it very difficult to provide ethically competent nursing care as expected.

Participants also regretted their choice of nursing as a career and expressed that they would not encourage anybody to follow nursing as a career path. Several nurses also expressed a wish to resign due to the burden of ethics in health care. They were concerned that senior management at the hospital did not support them. Lack of support from the management led to a sense of powerlessness, burnout and demoralization of professional nurses which compromised the provision of ethically and morally acceptable nursing actions.

The study also found that participants used the Nurses' Pledge of Service as a point of reference to resolve ethical dilemmas in nursing practice. This indicates that it helps them to clarify the ethical concerns that give rise to moral distress. The values that are contained in the Nurses' Pledge of Service and the responsibilities associated with each value serve as a guide for nurses to reflect and to act accordingly. At the same time, it could be concluded that professional nurses are functioning at stage 4 of Kohlberg's theory of moral development. They conform to rules as expected. A conformist nurse lacks critical thinking skills. Such behavior gradually leads the nurse to succumb to environmental pressures to abide by the rules and perpetuating an injudicious status quo.

This study strongly advocates the inclusion of ethics education in nursing curricula and the use of appropriate teaching and learning methods that will provide nursing students with opportunities to develop critical thinking skills to become reflective professional nurses when confronted with ethical dilemmas in nursing practice.

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APPENDIX A: INTERVIEW GUIDE

The following questions were asked:

1. In your experience kindly describe ethical dilemmas encountered in your years of practice as a professional nurse?

2. What do you think influences your experiences of ethical dilemmas encountered in practice?

3. Describe the experience of the resolution process of the ethical dilemmas experienced?

4. How does the experience of ethical dilemmas influence your practice as a professional over the years?

5. What resources do you believe are needed to assist professional nurses (at this hospital) to resolve ethical dilemmas in nursing practice?

Appendix B: Consent Form

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in Clinical Trial/Research Project*.

Name of Project/Study

The experiences of professional nurses with ethical dilemmas in nursing

……………………………………………………………………………………

Practice at Witbank Hospital, Nkangala Mpumalanga province

……………………………………………………………………………………

I have read the information and heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed.

I understand that participation in this Study/Project is completely voluntarily and that I may withdraw from it at any time without supply reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Study/Project has been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Medunsa Campus). I am fully aware that results of this Study/ Project* will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study/ Project.

…………………………..   …..……………………….

Name of patient volunteer   Signature of patient or guardian

_____   _____   _____

Place   Date   Witness

_____

Statement by researcher:

I provided verbal and/ or written information regarding this study

I agree to answer any future questions about the study to the best of my ability.

I will adhere to the approved protocols

_____   _____   _____

Researcher   **Signature**   **Date**

_____
    Place

Appendix C: Ethical

Clearance-MREC

UNIVERSITY OF LIMPOPO-Medunsa Campus

Medunsa Research & Ethics Committee

CLEARANCE CERTIFICATE

Meeting	:	08/2013
Project Number	:	MREC/HS/255/2013
PG Project Title	:	The Experiences of Professional Nurses with Ethical Dilemmas in Nursing Practice at Witbank Hospital, Nkangala District, Mpumalanga Province
Researcher	:	Ms TM Mbangula
Supervisor	:	Prof MN Jali
Co-Supervisor	:	Prof ME Lekhuleni
Department	:	Nursing & Human Nutrition
School	:	Health Sciences
Degree	:	MCur (Nursing Science)
Decision of the Committee	:	MREC approved the project
Date	:	03 October 2013

....

Prof N Ebrahim   MEDUNSA RESEARCH ETHICS COMMITIEE MREC CHAIRPERSON

Deputy Chairperson MREC

The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)

Note: Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

Appendix D: Ethical

Clearance-Mpumalanga Provincial

Government

No. 7 Government Boulevard

Building No. 3

Riverside Park

Extension 2

Nelspruit

1200

MPUMALANGA PROVINCIAL GOVERNMENT

Private Bag X 11341

Nelspruit

1200

Tel: +27 13 766 3429/30/28

Fax: +27 13 766 3458

Enquiries: Themba Mulungo (013) 766 3511
http://www.mpumalanga.gov.za/healthsocserv

23 January 2014

Ms Thembeka Mbangula

No 3753 Tlakula Street

Kwaguqa Ext 5

1039

Dear Ms. Thembeka Mbangula

APPLICATION FOR RESEARCH & ETHICS APPROVAL: THE EXPERIENCES OF PROFESSIONAL NURSES WITH ETHICAL DILEMMAS IN NURSING PRACTICE AT WITBANK HOSPITAL, NKANGALA DISTRICT, MPUMALANGA PROVINCE

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

....

MOLEFE MACHABA
RESEARCH AND EPIDEMIOLOGY

Independent Coder

QUALITATIVE ANALYSIS

Master of Curationis

MBANGULA T. M.

THIS IS TO CERTIFY THAT:

Prof J.C Kgole has coded the following qualitative data: 14 individual interviews and field notes, for the study:

EXPERIENCES OF PROFESSIONAL NURSES WITH ETHICAL DILEMMAS IN NURSING PRACTICE AT WITBANK HOSPITAL NKANGALA DISTRICT, MPUMALANGA PROVINCE.

I declare that the candidate and I have reached consensus about the major themes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Prof J.C KGOLE

APPENDIX F: SEMI – STRUCTURED INTERVIEW

One interview session selected

Date 04.2014

Researcher = R

Participant = p

R: Good morning how are you?

P: I'm fine thank you.

R: I am Sister Mbangula and I am here to collect data with regard to ethical dilemmas you have encountered in nursing practice over the years. I should think most of the things you'll ask clarity where you've got questions. So I am not sure if you are ready for the interview?

P: Yes I am.

R: Ok my first question is. In your experience can you kindly describe the ethical dilemma you have encountered in nursing practice?

P: Mmh there's a lot to quote but a few. I'll start off by staff shortage. I think when you look at the policies around labour, you do have standards how many nurses per patient (that is staff patient ration) but that does not happen- it is there in black and white but it does not happen and you find that as a nurse you are expected to do wonders both day and night. It is worse during the night because people think there is less to do than during the day whereas it is totally wrong and people don't consider the fact that night was not meant to work.

So you find that as a nurse you pull until you feel you cannot pull and along you executing your task, you end up deciding what is it that I can do first and what is it that I consider important and others become non important and that does not mean that those things are not important.

To quote but a few - you find that as a professional nurse- during the night duty- there is one professional nurse and two nursing assistance. In nursing there's no procedure that is done without supervision as a professional nurse. As a professional nurse you push the medication trolley- patients are sick and are in pain are basically here for that medication. So you start pushing your trolley in a 29 or 30 bedded ward- you are the only Sister on duty. So you start in the first cubicle- which is on the far end of the ward and distribution of the patient is remember you have patients that a acutely ill- patients that can change condition at any time, but now you are looking at a trolley- pushing medication you start from bed one- as you go along patients are helpless- you need to assist - 70% of those patients need assistance. As you go along drips have infiltrated, drips have tissued and some of the drips are out. So you end up not knowing - do I reinsert drip or not? It will consume most of my time. I will do it last, by the time you finish your medication, admissions enter, and patients must go to theatre. You have been called for other patients that have changed condition. So the ones that you left with the intention of coming back to put up drips are neglected.

And remember we have intern, medical officers and consultants that are call during the night and the intern (doctor) is responsible for all surgical if it's a surgery unit or orthopaedic or casualty it is a casual unit. So he will be in between all those units and you ask them a drip it is like you committing them and response will be Im busy in theatre, casualty and in another ward. Sister I'm coming and antibiotics have a specific time you break the chain- patient is going to develop resistance, so as a nurse you carry that through. You only give things through only when the shift is over- you say' bazosala babona' at the expense of a patient and I'm not sure you sleep peacefully knowing what was expected of you to do was not done.

R: Ok I hear you very well sister, anything else maybe you left?

P: Ethical dilemmas under the shortage of resources you are expected according to our scope of practise- remember we are guided under the legal framework of our scope of practice that does not allow me as a professional nurse to put up a drip under normal circumstances, you are only to put up drips in case of an emergency because the doctor can be busy at casualty- patients need treatment, you can put up the drip.

So the ethical dilemma should I live or put up the drip? Patient needs that antibiotic obliged for that matter but the patient cannot. You can put up the drip but should anything go wrong, you are held accountable as to why didn't you call the doctor to put up the drip. Blood is a resuscitative agent but the drip is not put up we'll have to wait and at the end of the day you feel like you haven't done as expected, you don't get joy in what you have come to do. If there is no medical officer on duty patients are still in the ward should the situation warrants you to call the doctor, who are you going to call because even the intern they are told that if there's no senior medical officer covering the unit during that night but nobody cares for that nurse on duty. So the least is so much under resources again, I am going to talk about material resources again.

Patients are admitted to be cared for there is no panado for an example and to me what is a dilemma is when I explained to the patients or relative that there is no panado because that you can't get from any other department including the pharmacy. Let me tell you it is out of stock- no alternative - no plan B, at times for the other resources also. So when you tell the relatives to go buy panado thing then first page of the news- Witbank Hospital without panado- relatives asked to buy panado- it is like you committed a sin and in the true sense you were doing this for the benefit of the patients because it does not mean that patients who are coming here at the public sector don't have money to buy.

At times they suffer end up dying because we are scared to say go to clicks you'll find 1,2,3 because should out of anger patient find it acquired and funny for the hospital to run out of such resources then as a nurse you end up caught up in between- you look at them and ask yourself do I tell them to go buy or not. Long slate around the patients that should go to theatre for procedures- the list is long- the list is very long! And at times when you say can you afford to take your mom or child to a private sector, it is like you are exposing the institution whereas you are not. Remember a patient can come in with something that is minor but it can complicate to be major if it is not attended in good time. So as a nurse you are faced with a dilemma. As you say what do I do? Do I leave them knowing very well that whatever they are waiting for is not going to give them joy at the end of the day?

Space under resources, you find that we need to have side wards for putting patients that are critically ill or terminally ill or patients that have sepsis. Patients we special need like sepsis- patients have got discharges that can be very offensive but because of space you are left with no choice but to mix those patients in the general ward and by so doing you are not doing justice to the patients for example, if you put a septic patient in the general ward, you are actually exposing other patients to the risk of getting that very same infection but as a nurse you cannot deny a patient bed based on those grounds instead you look the patient in the eye and ...

Some of these patients feel they cannot be mixed with other patients because of their condition but because of resources you are forced to. You have a patient with TB in a ward because you don't know where to put this particular patient, side wards are full that is structurally, so it is a serious dilemma that can be overlooked by someone and say put her there and we will move her when someone is discharged or passed on but the dilemma is the risk that your exposing other patients which put us into ...

I don't want to talk about risk to own health

R: Please do- let's just explore everything that we can explore, we need to explore all the dilemmas so that at the end of the day we can come up with possible solutions.

P: Risk to own health, as a nurse you are a messenger, blood is ordered, and as a nurse you have to move from your department and go – and don't think of time be it 1 am, 2 am – you go down to blood bank to fetch blood. And as I say there are three people on during the night, so if you take one with, it means you living one in the unit, so it means you're taking this one to accompany you which is risky some of the corridors are dark with no light at all. There are no securities at the corridors as you bypass. So this brings our safety at risk but because you are here for patient care and nobody cares for you in return you are bound to risk your own life. That is not only for the blood bank

Taking patients to theatre, you come back alone and end up not knowing what best to do because the blood bank technician is not going to assist, let me tell you I'm alone sisi where are you coming from? The security, you can't call the security, the security will tell you it's not my job, but as a nurse it is your job – live patients behind and go fetch blood – when the porters are not available- the nurse is a porter. You are expected to take care of these patients, you are expected to push the stretcher and nowhere are you trained to push, but you push because of patient care. And if the patient can fall out, you trying to push alone – remember a patient that warrants a wheelchair or a stretcher is a patient that is not so well conditionally. The patient can be restless and the patient can fall out of the stretcher because as you are pushing, should that patient fall you account and there are so many duties that we do that are none nursing duties.

I am a ward secretary because I don't have a ward secretary. I'm expected to order for example today, I'm expected to order stationery, to order cleaning material, to order medication. All these I feel are none nursing duties because as a unit manager I'm expected to be next to the patient, you are still expected to know each and every ones report and what everyone has written in the file, and should anything go wrong, you are expected to know what everyone has written and you are still expected to be an educator.

As in now you are running a department with somebody who is awaiting registration who cannot work alone but needs a professional nurse at all times, remember supervision and patient care at all times. There are no professional nurses so you stretch become an octopus.

Out patients department does not have enough clerks so they'll be sending patients for files, remember on discharge we need to discharge, files must go back to outpatients department for filing. So these patients were discharged last week – they are coming back today looking for their files so it becomes a nurse responsibility to record those files, take them down – I'm not talking of ten files I'm talking of twenty files per day which is time consuming.

There is so much actually, when I talk of these things it breaks my heart makes me feel I have chosen the wrong career. I'm not even sure I'm in a position to motivate people to take nursing as a career because so much is wrong in this profession or done wrongly in a way that is demoralising people. That is why they say dogs have come to nursing. It isn't like that and it is very little that is done in taking care of the people that are caring for others.

You know there is a paper the BI 1663 – the one that authorizes for death certificate, if it is wrongly filled by a nurse it comes back and that disorganises not only the family but also the nurse because it is time consuming to fill in those details and what is necessary there is the person that has passed on and the information of the relative and I'm not sure if it is difficult for home affairs to send somebody that is trained to do it, to have a little office in the hospital so that if there is a death we know exactly where we can refer the patient for paper work.

R: Ok with regards to the BI 1663 what are your legal requirements in terms of filling is it within your scope of practice or what?

P: It is never within our scope of practice and remember you fill it in based on what somebody else is telling you, you are not sure this person being the relative of the patient or deceased or what. In that very document you are still expected to fill in your details and none nursing you have nursed the patient, the patient has passed on you have filled in the death report form, you have notified the relatives, I personally feel it should end there. The doctor can fill in cause of death and staff like that. Remember people come in here not registered not in their real names and people are money conscious these days so you end up not knowing.

And should anything go wrong is the nurse who accounts for the mistakes that have been done despite the fact that information provided you were given by a person who has claimed to be a family member whom at the time you cannot verify to say she is or not. Patients have got rights and at times these patients' rights become a dilemma. Working in a gynae ward you find a patient coming with incomplete abortion and you find that the foetus is less than 500g. 300 or 200g for arguments sake, they want to bury. Is it not a right?

R: It is a right

P: It is a right and they want to bury, I don't to come to the reason why they want to bury – whatever the reason they want to bury. There is no birth certificate that can be issued for anything that is not viable according to the law, and they can't bury without BI 663 – but they are looking at n you they want to bury, it's their right. You take this up Doctor this patient wants to go and bury – it's their right. Then you find that the doctor is reluctant to write anything around the support around patient's rights. Say we have a 1g baby they want to cremate. I at times feel as a nurse you can't practice your rights over someone else no matter how strong you feel around the issue or incident that has happened but you need to step out, which to me is a serious dilemma to step out of being you and become a statue and listen to somebody telling you about her rights and acknowledge and moving on. We had a patient that was four weeks pregnant and delivered a clots and she wanted those clots for rituals. I don't know how far we can go around that. That's patient culture, human tissue act you say no it's like u you are interfering with patients culture. You say yes, there's the tissue act. You know there are at times guidelines that we make. Remember guidelines at times are made by head of departments and at times they make guidelines without considering the things that affect us mostly, so you end up caught in a situation where you don't know what is the best root to take but as a human being you end up deciding your own way whether to give up the clots for rituals purposes, it is theirs any way or whether not because it feels like your interfering with the patients culture because it is what she or he believes in or what they believe in – we must take this and go bury it at home and I come and say human tissue act – Dilemma.

Jehovah's witnesses – you know that Jehovah's witnesses don't accept blood or blood products, you know this experience that I'm having without mentioning my own religion, and the patient was saying... she had a medical alert disk – written Jehovah's Witness, she had pamphlets and she had a concern form saying no blood transfusion. I'm not sure if you have seen one?

R: Not yet

P: There is one, and the patient was bleeding and the Hb (haemoglobin levels) was four (4) and in fact there were two experiences the other bled hb was four post theatre, patients still said no. The husband also is a Jehovah's Witness. They had a new born baby, the wife went for an operation for a Caesar. They said no to blood transfusion until the woman passed on and she left a three days old baby. To me this is what they believed in, it didn't affect me much because it is what they believed in. This is what this woman consciously said if I start bleeding and I need to be transfused please don't transfuse me. My religion and my belief say no transfusion. The second experience I think because of the previous one the management had to come, the CEO (chief executive officer) was in the ward, the nursing service manager was in the ward. You know they were threatening this patient. Their tone of voice was not around the issue of supporting the patient but their tone of voice was actually saying to this patient, they were threatening this poor patient " you are going

to die", the patient was actually saying I know I'm going to die. But I don't want to be transfused. I remember the patient – you are there and you're the patients advocate, you explain the advantages and you explain what transfusion is to the patient, the reasons and indications, why it would help and the risks, but the patient came in and said, Sister I fully understand and I'm sorry you feel that it is not right to be a Jehovah's witness – but I say please - I don't need transfusion.

So the doctors pushed, this patient couldn't talk and the one said I'm going to call the CEO and the CEO was here and the nursing service manager and you know they were so strong for this patient. As an advocate for this patient I think I just melted or I just froze. Because trying to explain what this patient said it was like wearing two caps or I was mad myself like the patient and I was actually trying to advocate for the patient. Patients' rights – the patient was saying even if I die allow me to die in peace with no transfusion. The patient ended up covering herself with a blanket and the doctors and management gave a go ahead and the patient was transfused.

R: So do you mean to tell me that the patient was transfused despite her saying I am a Jehovah's Witness – so it was against the patients will to receive blood? How was the patient did she take legal actions? What was the outcome thereafter?

P: What I remember is that the patient was so sad and the only thing I remember when I spoke to her was, I wanted to know how this patient was feeling and the patient actually said she will pray because this whatever happened to her was against her wish and remember if you know the principles of counselling the patient, remember the patient is in bed and, so when you talk to the patient standing it is authoritative enough and you can imagine someone saying I am going to call the CEO! And the CEO was in the ward with the nursing manager and they were actually saying we are tired of these people who come here and refuse to be transfused out of religion.

R: But then didn't they consider somewhere at the back of their minds the issue of patient rights? Patient's rights to refuse treatment and I assume blood transfusion is one of those rights

P: You know what is worse to me – we have documents, legal documents that we use in this institution that would ask, like our pre- operative document – Jehovah's witness, it doesn't ask religion it specifies are you a Jehovah's witness, you tick a yes or a no but it was puzzling for me to see the highest authority of the hospital or institution coming to intimidate this patient for refusing blood transfusion. They were actually saying rubbish is you Jehovah's Witness and your belief. It was totally..., they lost it.

R: Ok

P: And the dilemma to me, the patient said she understands fully what can happen to her when she refuses transfusion and she refuses to be transfused. You know it was like now they are on me. They are here trying to convince the patient and here is me saying something else. I ended up freezing and the dilemma to me is I failed to advocate for the patient and that was her belief.

You know we've got here some of the things we do here is rituals. The rituals that are practiced when the patient has passed on and they here coming to fetch the patient's spirit. The dilemma is when there is someone occupying that bed and they

are coming to do that belief or their ritual the dilemma to me is as they come to do their ritual the patient gets to wonder - what now! And you end up not knowing how best you can handle this thing so that both the patient coming to do the ritual feel comfortable doing the ritual without interfering with the new patient in bed.

R: Anything else you would like to add on ethical dilemmas/

P: Eish the list is so long but I think these are the few in my mind.

R: We can move on to the next question which is also related to the ethical dilemmas that you just described. Now that you have described the ethical dilemmas you have encountered, what do you think influences the experiences of these ethical dilemmas? For example what exacerbates the experiences of these dilemmas?

P: I'm not sure if it is the ... I think personally feel some them, the fact that as nurse we come from different religious beliefs – we are unique beings and have our rights as well, makes these dilemmas worse. Because we don't see with the same eye, at times what is a patient's right infringes with my rights as a person. So, I practically feel that.

R: Now have you exhausted the experiences of ethical dilemmas you have experienced or do you feel you have to add anything?

P: The experience of these dilemmas makes us to be careless type of people at times, to work like robots you come to this situation with no resources you do what you can until the shift is ends. People turn to sort out problems the way best it suits them everybody does what she wishes to do in her little corner. I think this happens to escape time, so long as I'm out of that place, as long as the problem is longer on my back, because these things are not addressed as dilemmas where we know exactly what to do when we have these dilemmas. You know like the very issue of Jehovah's Witness around the issue of consent that lady came - the issue around being intubated was proposed, sorry to take you back.

The patient said there was no need to be kept on the ventilator for long if that wouldn't help. It sounded very vague;

I don't think if they are going to intubate me is it an alternative to blood transfusion

because then if it's not going to help me then I rather not be intubated. We are here to preserve life, so those dilemmas they are not addressed so that gives a clear guide as to say this is the route so as to say here is a dilemma so that whoever is enquiring service is aware of these dilemmas and know how to go around without him feeling it as a challenge to her. Let it be a challenge to the patient but not herself, because these things are draining.

If I can tell you this is the reason why we as nurses turn to talk about our experiences at home. You come at home – you start talking, yo! we had this patient today, it's because remember we don't have debriefing sessions to derode where we talk about the experiences we had for the week that bad and good experiences. So the only best place to take them is home and that is why most of the time you hear people saying nurses talk about patients but if I think to me those who do that it's because they don't have an appropriate place where they meet to talk. For example you get a place where you meet a psychologist, where you meet to talk the experiences with the psychologist it should be work related session where you talk about your work related experiences, and you live there

R: Is there anything else you would like to add in general with regards to the whole interview? We are rounding off now anything you would like to add

P: No except that I wish to know the objective of this interview, how will you address these issues?

R: The outcome will be based on the findings of the research as we are talking, I'm gaining more knowledge, as you know I'm in intensive care and it is then that I can

write a comprehensive report on the ethical dilemmas in ethical context, based on the dilemmas that have been encountered.

P: I think it is a good thing, I hope I have given you objective information with no emotions.

R: No no no - this is experiences, it has to do with experiences so emotions are part and parcel of those experiences because I should assume your experiences are imposing – be it educations, be it information be it emotions, we are also cultural beings so we are bound to have motions, we are also religious beings.

Thank you very much for your participation - you have given me a lot of information.

P: If you need some more ... come

R: OK sure will

Appendix G: Letter from Language Editor

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To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MCur thesis by **Thembeka Monica Mbangula**: "**The Experiences of Professional Nurses with Ethical Dilemmas in Nursing Practice at Witbank Hospital, Nkangala District Mpumalanga Province**".

Sincerely Yours

Donavon C. Hiss
Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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A place of quality, a place to grow, from hope to action through knowledge