RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

Nurses' Response to Ethical Dilemmas on Patient Care Issues in the Critical Care Set Up

Jostine Ndunge Mutinda[1], *Mrs. Teresa Odero*[2]

[1]School of nursing, University of Embu; Embu town- Kenya
[2]University of Nairobi School of Nursing, Nairobi- Kenya

Abstract:

Background:

Ethical issues have emerged in the recent years as a major component of health care for the critically ill patients, who are vulnerable and totally depended on nursing care provider. The study sought to establish the perception and magnitude of ethical dilemmas faced by nurses working in critical care unit of Kenyatta National Hospital (KNH) as well as the ways they respond to them. The common patient care issues which posed a dilemma as identified during the study included: unsafe nurse- patient ratios, allocation of scarce medical resources, breach of patient's confidentiality, ignoring patient's autonomy, dealing with impaired colleague, discriminatory treatment of patients and patients/relatives uninformed about the prognosis of the patient.

Methods:

An exploratory survey was conducted on 123 nurses working in three critical care areas of the Kenyatta National Hospital (Kenya). These were the intensive care unit, the renal and the burns units. The research aimed to identify the ethical dilemmas experienced by nurses working in Critical Care Units of the Kenyatta National Hospital in their everyday practice. It also aimed to explore what actions the nurses take to deal with the issues and what factors influence the decisions. Data were collected using questionnaires which were distributed to 123 nurses working in the critical care areas. The participants were selected using stratified random sampling method. Data was cleaned and analyzed using SPSS. Chi square test was used to assess the relationship between variables.

Results:

The study identified various ethical dilemmas relating to patient care issues to include: unsafe nurse-patient ratios, allocation of scarce medical resources, breaches of patients' privacy, ignoring patients' autonomy, dealing with incompetent colleagues, discriminatory treatment of patients, and uninformed patient/ relatives about the patient's prognosis. Other dilemmas reported were and Human rights issues and End-of-life decisions. Nurses reported to have adopted various strategies to address the dilemmas touching on patient care issues among others.

Conclusion and recommendations

This study shows that ethical dilemmas are an issue of concern among the nurses working in the critical care units of the KNH. Nurses have adopted various strategies to deal with these dilemmas which affect them almost on a day to day basis.

Key words: Ethical dilemmas, Critical care areas, critical care nursing, patient care issues, responses to dilemmas

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

1.0 BACKGROUND

Nurses are the largest group of healthcare providers serving in all the facilities providing health services. In Kenya they form 80% of the workforce as depicted in the Kenya national workforce and training analysis data (NCK, 2012). Nurses are deployed in nearly all the departments in the health care institutions to include the critical care units where they face various issues and are required to make decisions pertaining to patient care.

Contemporary studies conducted in the developed countries have consistently demonstrated that nurses working in critical care units as well as other areas face ethical dilemmas concerning issues of patient care (Fant , 2012).

Ethical dilemmas occur when; a problem exists between ethical principles, deciding in favor of one principle usually violates another, or when a situation involves a conflict between two conflicting principles or values. Recently ethical issues have emerged as a major component of health care for the critically ill patients (Sivy, 2012). This has been due to recent trends in healthcare setup which have created potential for high levels of ethical dilemmas especially for nurses who are key players in provision of healthcare to the critically ill (Sivy, 2012). These trends include: emigration of nurses creating shortage of nursing workforce, increased public expectation and widespread consumer involvement in healthcare. Other trends include increased numbers of emerging and re- emerging diseases, decreased funding for health care, technological and pharmacological advances which are new but expensive (Procaccino, 2012).

Despite advancement in medical technology many patients spend their final hours in critical care units which have provided a solution to most life threatening conditions. Latest developments in life sustaining and life saving technology have played a major role in determining the success of treatment of critically ill patients. However the greater control over life and death through advanced resuscitative techniques and life support system appears to challenge basic ethical principles. Due to this fact, moral and ethical questions arise concerning: when to stop treatment, who should decide and what criteria should be applied in arriving at the decision (Stewart, 2007).

The International Council of Nurses (ICN) Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct displaying a reflection of the ethical principles governing care in the critical care units. These are: Nurse and people- To safeguard the rights of patients to confidentiality and informed consent the patient/ legal proxy should receive sufficient information on which to base consent for care and associated treatment; Nurse and practice (advocacy)- this advocates for professional accountability on the part of the nurse working in the critical care area; the Nurses and profession (justice)- In this principle the nurse participates in creating and maintaining safe, equitable, social and economic working conditions in the critical care area. Lastly is the Nurse and co-workers (non- maleficence) which advocates that nurses take appropriate actions to safeguard individuals, families and communities when their health is endangered by a coworker or any other person (ICN, 2006).

Studies have revealed that both nurses and physicians face ethical dilemmas pertaining to end- of –life decisions, patient care and social conflicts (Sortan, 2011). Despite the magnitude of ethical dilemmas faced in critical care areas there is little documented information concerning the

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

role played by critical care nurses in resolving them. Moreover studies have shown that nurses do not follow a systematic pattern of ethical decision making (Kalvemark, 2004; Megan, 2004). In addition there is evidence that socio- demographic factors of the nurses working in the critical care units exert a big influence on the nurses' involvement in ethical decision making (Megan, 2004; Fry, 2002).

1.1. Problem Statement

Ethical dilemmas are a source of stress for health professionals and remain one of the major concerns in the nursing profession that require urgent attention in Kenya (Westphal and Stephanie, 2009). The dilemmas occur due to changes in health care delivery which has created new nursing roles and responsibilities, raised new questions and produced new stressors. Other sources of ethical dilemmas are the complexity of patient health problems and the increasing use of high technology which can lead to increased patient morbidity and mortality (Errickson, 2010). As the provision of care to the critically ill becomes more composite and the profession of nursing more autonomous, professional accountability cannot be overemphasized. The complex nature of the health problems faced by patients admitted in ICU coupled with extensive use of very sophisticated technology requires at times rapid decision making. These critically ill patients are vulnerable and entirely depend on the caregiver, optimally the nurse working in the critical care unit (Maren, 2004).

The nurses working in the critical care may or may not utilize ethical decision making process in dealing with the dilemmas. Despite the importance of ethical dilemmas faced by these nurses, little is known about their prevalence, causes, effects and factors affecting their resolution. The existing literature focuses primarily on the problem of nurse-physician conflict, and nurse-family conflict, and emphasizes coping mechanisms for nurses rather than improving patient care (Johansen, 2012). Several Studies conducted in other countries e.g. in USA (Ulrich, 2010) revealed the evidence of ethical dilemmas and stress experienced by nursing in their workplace. However searches have not revealed any results of a study conducted on this area, in a public hospital of a developing nation. In Kenya the ethical dilemmas nurses face while working in these areas, their magnitude, and how they perceive and resolve them have not been studied. The past structure of medicine and nursing which created hierarchies in both professions with clear lines of authority and respect for seniority has greatly affected decision making in nursing. This has resulted in most nurses choosing to report dilemmas affecting patient care issues to the physician as opposed to making an independent decision. Moreover, studies have identified gaps in ethical decision making process among critical care nurses in other countries (Oberlek, 2004; Megan, 2004). These gaps usually occur due to their perception of the ethical problems.

1.2. Purpose of the study

The study sought to identify the dilemmas and the socio-demographic factors affecting their perception.

2.0 METHODS

2.1. Study Design

This was an exploratory survey of 120 nurses working in three critical care areas of the KNH. Exploratory surveys are carried out to obtain more information in areas in which little information is available.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

2.2. Variables under study

Independent variables:Common ethical principles and nurses' socio-demographic data were considered as the independent variable.

Dependent variables: The dependent variables for this study included the types, frequency and resolution of ethical dilemmas.

2.3. Study Area

The study was conducted in the Intensive care, renal and the burns units at the Kenyatta National hospital. KNH is a national referral and teaching hospital in Kenya which receives patients from all over the country. During the time of research the hospital had a bed capacity of 21 in the intensive care unit making it the largest ICU in the country. The burns unit had a bed capacity of 18 while the renal unit had 12 dialysis machines. An average of 36 patients is dialyzed per day. Critically ill patients are admitted in these three units of the KNH. Being a public national referral hospital it caters for patients of different social classes, ages and illnesses. Due to the large number of patients admitted there, KNH faces problems of scarcity of resources which may put the nurses in a dilemma as to how to prioritize the allocation. Problems may arise with confidentiality because of the hospital set up (no partitions) coupled with the fact that it is a teaching hospital whereby a patient's diagnosis may be known by the others during hospital rounds. Some patients may not afford the expensive treatment (for instance when required to buy some drugs) in the critical care unit and these put the nurses in a dilemma of withholding treatment. There are many critically ill patients who are brought in by the police following road accidents and whose relatives may not be traced hence decisions concerning their management are done without their consent or that of their relatives which violates the principle of informed consent.

This mix of clients implied that diverse ethical issues were likely to be encountered during the provision of care to these patients. These coupled with the fact that KNH is located in the capital City of Kenya (Nairobi) which is a cosmopolitan town admitting patients from different counties made KNH an ideal facility for the purpose of this study. Based on what previous studies had shown (literature review) about the dilemmas experienced by nurses and the fact that KNH being a National Teaching and research hospital should have the most experienced and qualified nurses. The fact that Nairobi is cosmopolitan and that KNH is National referral hospital it is expected to have nurses from different socioeconomic backgrounds and educational levels. One would therefore expect the nurses to display diverse ways of Ethical decision making.

2.4. Study population

This constituted a total of all (184) nurses working in the critical care areas in KNH since they were all eligible for the study save for the exclusion criteria.

2.5. Sample size determination

The sample size was determined using the Fisher et al 1999 formula for determination of sample size (Wayne, 2010).

$$n = \frac{z^2 pq}{d^2}$$

where n = desired sample size (if the target population is over 10,000)

z = the standard normal deviate at 95% confidence interval (= 1.96).

p = the proportion in the target population estimated to have faced and handled ethical dilemmas in critical care nurses. The estimated proportion of those who have experienced the problems is not known.

q =1-p, d= level of precision (set at + or - 5% or 0.05).

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

Substituting the above formula with figures:

$$n=\frac{1.96x1.96)x(0.5x0.5)}{0.5x0.5} = 384.16$$

Since the target population is less than 10,000 the sample size shall be determined using the following formula:

$$Nf = \frac{n}{1+(n/N)}$$

Where Nf is the desired sample size when the target population is less than 10,000.

n= the desired sample size when the target population is less than 10,000.

N is the estimate of the population size which as per the above calculation is 384.

Hence $$Nf = \frac{384}{1+ (384/184)}$$

= 123 nurses.

Out of these 3 did not return their questionnaires hence the study sample had 120 respondents.

2.6. Sampling frame and procedure

The area of study (critical care areas in KNH) was be identified using non- probability (purposive) sampling method as the hospital has the largest critical care unit in the country admitting patients from all walks of life. Purposive sampling was chosen because it enabled the researcher to choose a sample from a population that is likely to generate the information required for the study in relation to the objectives. It was assumed that nurses working in the critical care areas were more likely to face ethical dilemmas related to critical care than those working in other areas.

Stratified random sampling was used at the unit level in relation to the proportion of nurses working in each unit. To ascertain the number of subjects required from each unit for proportionate allocation, the following formula was used;

$$\left[\frac{n1}{N2}\right] nf$$

Whereby: n1 = number of nurses in a specific unit, N2= total number of nurses in the three critical care areas and nf = minimum sample size.

Simple random sampling method was then applied to come up with the desired sample size in each unit.

As per the records of the duty rosters availed by the assistant chief nurses in the critical care areas, the nurses have been distributed as follows; 110 in the ICU, 44 in the renal unit and 30 in the burns unit adding up to 184 nurses. Out of these, a hundred and twenty three were sampled to participate in the study. The sample frame was as follows:

Table 1: sample frame

Critical care unit	Number of participants
Critical care unit	74
Burns unit	21
Renal unit	28

NB: Inclusion and exclusion criteria were considered when sampling the respondents.

2.7. Research Instruments

A 40 items self administered Questionnaire was prepared by the researcher and distributed to the participants. The questionnaire is a modification of Fry and Duffy *Ethical issues scale* (Fry, 2002) which was used for psychometric analysis of ethical issues in 2002. It had five parts: part one had questions on socio- demographic information of the participants. The other parts had questions on the nurses' knowledge of ethical issues, dilemmas on: end- of- life issues, patient care and human rights; and how to handle the dilemmas. The questionnaire was developed based on extensive review of literature related to common ethical problems that face nurses and was modified to suit the research. It contained questions framed to guide the participants in giving the required information. The questionnaire was used to collect demographic data of the

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

participants as well as information pertaining to ethical dilemmas they experience and how they resolve them. It was modified to exclude issues of personally disturbing ethical dilemmas and the most preferred topics while addressing education needs among others.

2.8. Validity and reliability

The validity and reliability of the questionnaire was ensured through pre-testing of the questionnaire. Validity of an instrument is a determination of how well the instrument reflects the abstract concept being examined while reliability is concerned with the consistency of the measurement technique (Grove and Burns, 2007). The questionnaire was pretested in the accident and emergency unit of the KNH whereby 5 nurses were randomly sampled for pretesting. The nurses identified to participate in during pre-testing were given each a questionnaire to fill in. The information obtained from the pre-test was analyzed and used to aid in making amendments to the questionnaire.

2.9. Data collection methods

Permission to conduct the research was sought from the University of Nairobi and KNH ethical research committee. Further permission was sought from the Assistant chief nurses in the renal, critical care and burns units. Data was collected using self administered questionnaires which were distributed by the research assistants and the researcher. Those sampled to participate in the study were requested to read and sign the consent for the study then fill in the hand delivered self administered questionnaire with the information requested. The questionnaires were then collected by the research assistants for data analysis by the researcher. Use of self administered questionnaires saved time as the information was collected simultaneously.

2.10. Data management

2.10.1. Data cleaning and entry

Data from complete questionnaires were coded and entered into the computer for analysis.

2.10.2. Data analysis and presentation

Data analysis was undertaken using the SPSS (statistical package for social studies). Descriptive statistical analyses were performed on the data relating to questions based on three major areas. The aim of these analyses was to summarize the nurses' responses on a number of issues within these major areas. These were: ethical dilemmas experienced by the respondents and the magnitud considerations e, actions taken to resolve the dilemma and the factors influencing the experience of dilemmas. The main quantitative statistics were based on frequencies, percentages and means of variables. The relationship between variables were determined and expressed by use of chi square method of data analysis. P value was set at 0.05.

Data presentation was done using pie charts and frequency distribution tables.

2.11. Ethical considerations

2.11.1. Study approval: Approval to conduct the research was sought from the Kenyatta National Hospital/ University of Nairobi ethics and research committee and the KNH administration. Permission to access the participants was sought from the unit assistant chief nursing officers in-charge of the three critical care units.

2.11.2. Study duration

The study took six weeks from the day of commencement of data collection.

2.11.3. Informed consent

There was full disclosure of information whereby participants were given an explanation concerning what they needed to know about the study to include the purpose and benefits of the study. They were also told what was required of them to

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

ensure that they understood the components of the questionnaires and the information they were required to give. Verification to this understanding was done to ensure that the participants were competent enough to give the required information. Participants were then required to sign a consent form once they accepted to participate. Participation was voluntary without any coercion and participants were free to withdraw at any point.

2.11.3. Confidentiality

The participation was based on trust, confidentiality guaranteed and the participants were not required to write their names on the questionnaires. Data was coded and during processing and publishing the names will not be indicated in the report.

2.11.4. Declaration of interest

The investigator declares that there was no conflict of interest between self and the stake holders (training institutions and the research hospital).

3.0 RESULTS

This chapter reports the findings of this study based on quantitative data gathered from 120 respondents. Out of the 123 questionnaires distributed 3 of them were not returned. After data cleaning one questionnaire was found to have missing information on the gender of the respondent hence it was not analyzed in regard to this variable. Eight respondents did not indicate their age hence these questionnaires were not considered when analyzing this variable.

3.1. Demographic characteristics of the respondents

3.1.1. Gender

All the 120 respondents reported their gender except one. Out of those who reported (n=119) 58 percent were female while 42% were male. This gender distribution may be explained by the evolution of nursing as a female dominated profession.

3.1.2. Age

Out of the 120 respondents, 8 did not indicate their age. Of the 112 respondents who indicated age, most were in age group 35-39 yrs (36.6%) followed by 30-34 years at 27.7%. Minimum and maximum ages of the respondents were 25 and 48 years respectively, giving a range of 23 years.

3.1.3. Professional qualification

Two thirds of respondents, 67.5% (81) had a post basic diploma as the highest level of education, followed by diploma holders at 23.3%(28). 7.5% (9) had a basic degree in nursing while 1.7% (2) who formed the least number had a master's degree. This distribution represents the trends in nursing education in Kenya where most of the nurses are trained at diploma level, a few have degrees and very few are training in masters and remaining as clinical nurse practitioners.

3.1.4. Length of Working Experience of the respondents in the Critical Care units

All (120) interviewees responded to this question. Almost a half, 45.8% (55) had work experience of less than 5 years in the critical care unit, followed by 30.8% (37) who had working experience of between 6-10 years. This may be explained by the fact that majority of the nurses working in the critical care units are aged below 40 hence majority (76.2%) have work experience ranging between 0 and 10 years.

3.1.5. Knowledge of human rights issues

Majority, 98.3% (118) of the respondents reported to have knowledge of human rights issues in nursing. However, 1.7% (2) of the respondents admitted that they were not knowledgeable at all on human rights issues.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

3.1.6. Need for ethics and human rights education

Out of the 120 respondents, 56.7% and 40.8% expressed the view that there is very great need and a great need for ethics and human rights education. The rest, who comprised a combined minority of 2.5% either, said there was no need or there was just a slight need for ethics education.

3.1.7. Ethics content taught

i) Type of ethics content covered during educational preparation

107 which represents 89.2 % of the nurses surveyed reported having ethics content integrated into regular nursing courses within their curricula. Out of these 12.5%, 9.2%, 65% and 2.5% reported to have had ethics content: integrated throughout the program of study, taught in a specific course, taught by nursing faculty and taught by non-nursing faculty respectively. 10.8% reported to have had no ethics content taught during their regular training.

ii) Type of ethics content covered in Continuous Professional Development (CPD)

79.2% (95) of the nurses surveyed reported having ethics content taught in continuous professional development courses. Out of these 24.2% (29), 5% (6), 43.3% (52) and 6.7% (8) reported to have had ethics content: integrated throughout the program of study, taught in a specific course, taught by nursing faculty and taught by non-nursing faculty respectively. 20.8% (25) reported to have had no ethics content in CPD programs.

3.1.8. Availability of resources for ethics and human rights at place of work

Majority 78.3 % (94) of the respondents reported to have inadequate to totally inadequate resources to help them deal with ethics and human rights issues. Only 21.7% (26) reported to have adequate resources.

3.2 Nurses' Experience Of Ethical Dilemmas In Critical Care Unit

Reference to the pie chart (figure 3) below shows that 97 (80.8%) respondents have experienced ethical dilemmas while working in critical care setting.

This finding was in line with the expectations of the researcher as previous studies conducted in other countries revealed that ethical dilemmas were an issue of concern to nurses and other health care professionals.

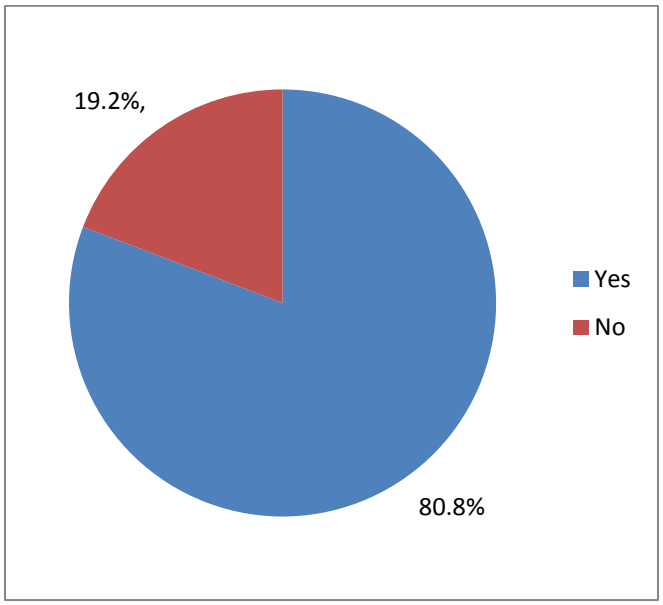

Figure 1: Distribution of frequency on experience of ethical dilemmas.

3.3 Magnitude of patient care related ethical dilemmas experienced by nurses working in the critical care units

Table 2 shows the Frequency of experiencing various forms of ethical dilemmas relating to patient care issues (unsafe nurse- patient ratios, allocation of scarce medical resources, breach of patient's confidentiality, ignoring patient's autonomy, dealing with impaired colleague, discriminatory treatment of patients and patients/relatives uninformed about the prognosis of the patient).

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

3.3.1 Scarce medical resources

As depicted in the table, the most commonly experienced ethical dilemma was relating to allocation of scarce medical resources whereby 87 respondents had experienced it. The resources included dressing material, detergents, linen as well as medication. Out of the 87, majority of them 42.5% (37) had experienced it between 1-5 times, while 34.5% (30) had experienced it over 10 times during the previous year, while working in the Critical Care Unit.

3.3.2 Unsafe nurse- patient ratios

The next commonly experienced ethical dilemma was relating to unsafe nurse- patient ratios whereby 80 respondents had experienced it with 48.8% (39) having encountered it over ten times during the previous year. Ideally every critically ill patient should have a nurse allocated to them. Shortage of staff may force a nurse to take care of two patients with assistance of students. This may not be very safe in case a patient develops complications requiring quick intervention.

3.3.3 Breaches of patient privacy

40 respondents had experienced breaches of patient privacy with 55% (22) of them encountering it 1-5 times during the previous year. KNH being a teaching has many students visiting the critical care unit. It may be difficult to control the amount of information that a student can divulge to colleagues and others about a patient's care. A critically ill patient requires total nursing care hence it may be difficult to maintain patient's personal privacy due to their vulnerability.

3.3.4. Ignoring patients' autonomy

Patient's autonomy allows them to make decision concerning their healthcare without interference by the healthcare provider. In the critical care set up this may be hard especially when one is dealing with an unconscious patient who has to rely fully on the decisions made by the care provider. In other instances on may be forced to go against the patient's decision especially when they consider their demands as being hard to meet. 28 respondents encountered conflict with ignoring patients' autonomy with 67.9% (19) of them experiencing that 1- 5 times during the previous year.

3.3.5. Patients/ relatives uninformed about the patient's prognosis

Patients may lack adequate information concerning their prognosis if the Doctor fails to divulge this information for fear of causing psychological trauma to the patient. Illiteracy may also pose a barrier to communication whereby the healthcare provider encounters difficulties in passing information about the prognosis to the relatives who may not understand. Dealing with patients/ relatives uninformed about the patient's prognosis posed dilemma to 57 nurses with 56.1% (32) of the respondents experiencing it 1- 5 times during the previous year.

3.3.6 Dealing with incompetent / impaired / unethical colleagues

The other source of dilemma relating to patient care issues was dealing with incompetent/ impaired/unethical colleagues whereby 24 respondents reported to have encountered it with 62.5% (15) of them experiencing it 1-5 times during the previous year.

3.3.7 Discriminatory treatment of patients

Discriminatory treatment of patients may occur due to ethnicity which is a common problem in Kenya. It may also occur due to stigma that goes with some infectious conditions and terminal illnesses. This dilemma was experienced by only 18 respondents with 11(961.1%) experiencing it 1-5 times during the previous year.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

Table 2: Frequency of experiencing various forms of ethical dilemmas relating to patient care issues

Type of dilemma	Category of No. of experiences of each dilemma.	Frequency of responses	Percentage
Unsafe nurse- patient ratios (n= 80).	1-5 times 6-10 times Over 10 times	26 15 39	32.5 18.8 48.8
Allocation of scarce medical resources (n= 87)	1-5 times 6-10 times Over 10 times	37 20 30	42.5 23.0 34.5
Breaches to patient privacy/confidentiality (n= 40).	1-5 times 6-10 times Over 10 times	22 7 11	55.0 17.5 27.5
Ignoring patient autonomy (n= 28).	1-5 times 6-10 times Over 10 times	19 5 4	67.9 17.9 14.3
Incompetent/impaired colleague. (n= 24).	1-5 times 6-10 times Over 10 times	15 7 2	62.5 29.2 8.3
Discriminatory treatment of patients (n= 18)	1-5 times 6-10 times Over 10 times	11 1 6	61.1 5.6 33.3
Patient/relatives uninformed about the prognosis. (n= 57)	1-5 times 6-10 times Over 10 times	32 13 12	56.1 22.8 21.1

4. NURSES' RESPONSE TO ETHICAL DILEMMAS (ACTIONS TAKEN TO RESOLVE CONFLICTS OVER PATIENT CARE ISSUES)

4.1 Unsafe nurse- patient ratios

To resolve this conflict 78 out of the 80 respondents who experienced the dilemma took the actions shown in table 3 below. 2 of the respondents did not indicate the action taken. Majority, 43.6 % (34) of the nurses while faced with conflicts relating to unsafe nurse- patient ratios opted to work under strain without consulting with the authority. However 50% consulted with either the team leader or the nurse in- charge of the ward. 6.4% (5) of the respondents sought for help from colleagues.

Table 3: Action taken when faced with unsafe nurse- patient ratios.

Action taken	Frequency	Percent
Consulted nurse in-charge	18	23.1
Reported to nursing team leader	21	26.9
Worked under strain	34	43.6
Sought for help	5	6.4
Total	78	100.0

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

4.2 Allocation of scarce medical resources

To resolve this conflict 85 out of the 87 nurses who experienced the dilemma took the actions shown in table 4 below. Majority, 58.8 % (50) of the nurses while faced with conflicts relating to allocation of scarce medical resources opted to improvise the resources. This means that due to scarcity of resources they utilized supplies intended for other purposes in order to meet the patients' needs. However 31.8% (27) reported to the nursing team leader. Only 8 (9.4%) respondents based allocation on patient's condition. This means that they gave priority to the most needy patient.

Table 4: Actions taken to resolve issues with allocation of scarce medical resources.

Action taken	Frequency	Percent
Reported to nursing team leader	27	31.8
Improvised	50	58.8
Based allocation on patient condition	8	9.4
Total	85	100.0

4.3 Breach of patient's confidentiality due to pressure from relatives.

To resolve this conflict 35 out of the 40 respondents who experienced this dilemma took the actions shown in the table 5 below. Majority i.e. 42.9% (15) of the nurses while faced with conflicts relating to breach of patient's confidentiality consulted with the nursing team leader. 37% (15) reported to the physician while the rest either ignored the relatives or complied with their demands.

Table 5: Actions taken to resolve dilemmas of breach of patient's confidentiality

Action taken	Frequency	Percent
Consulted physician	13	37.1
Reported to nursing team leader	15	42.9
Ignored the relatives	6	17.1
Complied	1	2.9
Total	35	100.0

4.4 Ignoring patient autonomy

To resolve this conflict of ignoring the patient's autonomy the 28 respondents who faced the dilemma took the actions shown in table 5 above. Majority, 39.3 % (11) of the respondents while faced with conflicts relating to patient's autonomy went on to perform the procedure disregarding objections from the patient. However 32.1% (9) consulted with the physician. 17.9% (5) of the nurses reported to the nursing team while the minority, 10.7% (3) contacted the proxy.

Table 6: Actions taken to resolve dilemmas on ignoring patient autonomy

Action taken	Frequency	Percent
Consulted physician	9	32.1
Reported to nursing team leader	5	17.9
Just carried out the procedure	11	39.3
Contacted the proxy	3	10.7
Total	28	100.0

4.1.5 Dealing with an unethical/incompetent/ irresponsible colleague

To resolve this conflict the 24 respondents who had experienced the dilemma of dealing with an

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

unethical/incompetent/ irresponsible colleague took the actions shown in table 7. Majority (56%) of the nurses while faced with this conflict reported to the nurse team leader. A third of the respondents (33.3%), ignored the actions of the colleague while a eighth (12.5 %) reported the matter to the administration.

Table 7: Actions taken to resolve conflicts over dealing with unethical/ irresponsible/incompetent colleague.

Action taken	Frequency	Percent
Reported to nursing team leader	13	54.2
Reported to the personnel department	3	12.5
Ignored colleagues' actions	8	33.3
Total	24	100.0

4.1.6 Discriminatory treatment of patients

To resolve this conflict 14 out of the 18 who experienced the dilemma took the actions shown in table 8. Majority, 42 .9% (6) of the respondents reported the issue to the nursing team leader. 35.7% (5) consulted with the physician, 7.1% reported to the administration while the rest, 14.3% (2) ignored the actions completely.

Table 8: Experience of conflict over discriminatory treatment of patients

Action taken	Frequency	Percent
Consulted the physician	5	35.7
Reported to nursing team leader	6	42.9
Reported to administration	1	7.1
Ignored the discriminatory actions	2	14.3
Total	14	100.0

4.1.7. Dealing with uninformed patients/ relatives

To resolve this conflict the 57 respondents took the actions shown in the table 20 below. Majority i.e. 43.9% (25) of the nurse who faced the dilemma of dealing with patients/relatives, who were uninformed about the prognosis of the patient, referred the cases to the counselor. 28% (16) of the respondents consulted with the physician while 22.5 (13) explained the facts to the clients. A small number 5.3% (3) reported the issue to the team leader.

Table 9: Experience of conflict over patients/relatives uninformed about the patient's treatment/prognosis

Action taken	Frequency	Percent
Consulted the physician	16	28.0
Reported to nursing team leader	3	5.3
Referred case to a counselor	25	43.9
Explained the facts to the clients	13	22.8
Total	57	100.0

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Purpose of the study: This study has sought to ascertain what nurses experience as ethical dilemmas while working in the critical care areas and how they dealt with these issues. Majority (80.8%) of the respondents reported to have experienced ethical dilemmas while working in critical care setting. This finding was in line with the expectations of the researcher as previous studies conducted in other countries revealed that

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

ethical dilemmas were an issue of concern to nurses and other health care professionals.

5.1.2. Major dilemmas experienced: The dilemmas of major concern to nurses included: those touching on end- of - life issues such as prolonging the dying process, withdrawing/ withholding treatment, resuscitation (DNR) orders. Others are those touching on patient care issues to include: unsafe nurse- patient ratios and allocation of scarce medical resource. Other issues are those touching on patient / human rights to include: rights of pediatric patients, and nursing of critically ill patients who may pose a risk to the nurses.

5.1.3. Actions taken by nurses while faced with dilemmas relating to patient care

In dealing with the dilemmas majority of the respondents indicated that they would consult with the physicians. This may be explained by the fact that for a long time the nursing profession has been in a position of subordination to the medical profession. It is however, contrary to another study conducted in Australia (Megan, 2004) which revealed that a few nurses were willing to involve the physicians while dealing with ethical issues.

When dealing with dilemmas touching particularly on patient care it was clear that most nurses opted to report their issues to the nursing team leaders. The reason may have been that the ethical issues confronting the nurses may have directly concerned medical and /or administrative staff (e.g. discriminatory treatment of patients), which makes the nurse find it difficult to confront the medical colleagues. On the other hand some matters may be best addressed by nurses from a nursing perspective. For instance when one is faced with an incompetent nurse colleague it would be more appropriate to let the nurse manager deal with the matter since they understand the profession better. In such instances, it is understandable that nurses might prefer to seek advice and assistance from a nursing peer or a nurse manager instead of taking the matter further or raising it with a medical colleague.

Some respondents however decided to take various actions without consulting with anyone. The reason may have been that the nurses surveyed felt competent to deal with the situations they faced and genuinely did not need to consult with a third party for assistance.

Finally, it is significant that the nurses surveyed indicated they would be unlikely to consult with the patient's relatives when dealing with ethical issues. For instance when dealing with breach of patient's autonomy only 3 (10.7%) nurses indicated they would consult the proxy in resolving the matter. This reluctance may be due to a number of factors, including: reluctance to burden family members with the problem and a reluctance to involve the family in what is essentially a confidential matter involving the patient.

5.2. Conclusion

Nurses in the Kenyatta national Hospital critical care units frequently experience ethical dilemmas in the course of their nursing practice that warrant focused attention by health service managers, educators and policy makers. The results of the study revealed that socio- demographic characteristics affected experience of ethical dilemmas by the respondents. These included: The nurses' level of professional qualification and the age. Work place resources to support identification and resolution of ethical dilemmas were cited as inadequate. Nurses reported great need for enhancement of the resources.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

5.3. Recommendations

The employing institution (KNH) can help the nurses improve their knowledge on ethical issues through, formulation of ethical policies and standards, role modeling of ethical conduct by the managers and rewarding good moral conduct; through praise and recognition.

NB: The findings of this research can be used to facilitate a comparative study of the ethical issues experienced by other nurse working in other institutions for instance the private hospitals

REFFERENCES

1. Allison H. (1990). Kant's theory of freedom, Cambridge University press, New York.
2. American nurses Association. (1985). Code for nurses with interpretive statements, Lippincott Williams, Missouri.
3. Basavanthappa B.T.(2007). Nursing research 2nd edition, Jaypee Brothers medical publishers, New Delhi.
4. Betty F. et al (2000). Dignity in dying – how we are meeting end- of –life issues, *Journal of Nursing management* , **31**(9), 52.
5. Breen, C. M.et al. (2004). Conflict Associated with Decisions to Limit Life-Sustaining Treatment in Intensive Care Units, *Journal of General Internal Medicine*, **(16)**, 283–289. (http://www.ncbi.nlm.nih.gov/pmc/articles /PMC1495214, available in May 2010, Viewed on 1st march 2012).
6. Chadwick R. (1992). Ethics and nursing practice a case study approach, Macmillan, London.
7. Dominic L.F. (1991). Advance directives, *Journal of nursing administration*, **21** (11),16- 19.
8. Ellis R.J. (1988). Nursing in today's world – challenges, issues and trends, Lippincott publishers, Philadelphia.
9. Erlen and Sereika. (1997). Critical care nurses, Ethical decision making and stress, *Journal of advanced nursing* **26** (5), 953-961.(http://www.ncbi.nlm.nih.gov/pubmed /9372400, available in November 1997, viewed on 1st march 2012).
10. Errickson et al. (2010). Journal of healthcare analysis. Ethical dilemmas and ethical competence in the daily work of research Nurses. September 2010, Volume 18, Issue 3, pp 239–251.
11. Ferrand E. et. al (2003). Discrepancies between perceptions by physicians and nursing staff of ICU end- of – life decisions, *American journal of respiratory critical care medicine*, **167**, 1310- 1315.
12. Friedman Y. (2001). Ethical issues in the critically ill patient, *current Opinions on Critical care*, 7 (6), 475- 479. (http://www.ncbi.nlm.nih.gov/pubmed/118 05555, available in December 2001, viewed on 2nd March 2012).
13. Fry T.S. (2002). Ethics in nursing practice, a guide to ethical decision making, Blacwell publishing, Oxford.
14. Fry T.S.(2001) the development and psychometric evaluation of the ethical issues scale, *Journal of nursing scholarships* **33**(3), 273- 277. http://www.ncbi.nlm.nih.gov/pubmed/115 52555, available in 2001, viewed on 2nd March 2012.
15. Gantt H.L. (1974). Work, wages and profits, Hive publishing company, Pennsylvania.
16. George J. B. (2002). Nursing theories the base for Professional Nursing Practice ,Prentice hall, Carlifonia.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

17. Hicks F.T.(2003). Critical thinking and clinical decision making in critical care, *Heart and lung Journal of acute and critical care.* **32** (3), 169- 180. (http://www.ncbi.nlm.nih.gov/pubmed/12827102, available in may 2003, viewed on 3rd March 2012).
18. International Council of nurses (2006). International code of ethics for nurses , Illinois Institute of technology, Geneva.
19. Jaya K. (2006). Essentials of critical care nursing, Jaypee brothers publishers, new Dheli.
20. Joan M.R. (2002) Nurse executives response to ethical conflicts and choice in the workplace, Nursing Ethics Network, Boston.
21. Johansen, Mary L. PhD, RN, NE-BC. Nursing Management: *Keeping the peace: Conflict management strategies for nurse managers.* February 2012 - Volume 43 - Issue 2 - p 50–54 doi:10.1097/01.NUMA.0000410920.90831.96
22. Johnstone M. 2004. Leadership ethics in nursing and health care domains. Churchill Livingstone, Sydney.
23. Keffer. (2001). Attitudinal patterns determining decision making in severely ill elderly patients, *International journal of nursing studies*, **38** (4), 381- 388.(http://www.springerlink.com/content/be8yerqb9ee1rc7x/, available on 3rd may 2001, viewed on 16th January 2012).
24. Kirchhoff et al. (2000). Intensive care nurses experiences with end– of–life care, *American Journal of critical Care,* **9** (1), *36- 42.* (obtained from http://ajcc.aacnjournals.org/content 9/1/36.abstract , available on 1st, Feb 2000, viewed on 23rd February 2012).
25. Laura M. (2005), Helping the terminally ill to a good death, *American nursing journal of hospice and palliative nursing,* **7**(2),113- 116. (abstract).
26. Lyndsay S. (2007). Ethical decision making: How to Make Ethical Decisions in 5 Steps." Mftrou.com. (http://www.mftrou.com/ethical-decision-making.html, obtained on 21 February 2010, viewed on 3rd March 2012).
27. Marcia S.D.B.(2005). Nurse executive's legal primer: Jona's healthcare law, ethics and regulation, *Journal of nursing administration,***7**(1),10-12. (http://journals.lww.com/jonalaw/Citation/2005/01000/Nurse_Executive_s_Legal_Primer.5.aspx , available in March 2005, viewed on 29th january, 2012).
28. Maren E.J. 2004. Ethical issues in the Intensive Care Unit, *pulmonary disease board review manual,* **11**(3), 3- 11. (http://www.turnerwhite.com/pdf/brm_PD_pre11_3.pdf, available in 2004, viewed on 5th February, 2012).
29. Megan J.J. (2010). Registered and enrolled nurses experiences of ethical issues in nursing practice, *Australian journal of advanced nursing.* 22(1), 24-30. http://dro.deakin.edu.au/view/DU:30025953, available on 29th march 2010, viewed on 1st February 2012).
30. Mugenda and Mugenda O.M.(1999). Research methods, qualitative and quantitative approaches, African Centre for Technological Studies press, Nairobi.
31. Nancy B.(2001). The practice of nursing research conduct, critique and utilization, W.B. Saunders Company, Philadelphia.
32. Nermin E.(2001). Turkish nurses decision on distribution of ICU beds, *Journal of nursing ethics,* **17** (87), 85- 98.

RA Journal of Applied Research
||Volume||3||Issue||10||Pages-1116-1131||Oct.-2017|| ISSN (e): 2394-6709
Index Copernicus ICV: 74.25, DOI: 10.18535/rajar/v3i10.09
www.rajournals.in

http://nej.sagepub.com/content/17/1/87, available in January 2010, viewed on 7th December 2011).

33. Nesrin C. (2004). A qualitative analysis of ethical problems experienced by physicians and nurses in intensive care units, *Journal of nursing ethics*, **5** (11), 444–458. http://nej.sagepub.com/content/11/5/444, available in September 2004, viewed on 7th December 2011).
34. Oberlek and Hughes. (2001).Doctors and nurses perception of ethical problems in end- of –life decisions, *Advanced nursing journal*, **33**(6), 707- 715. http://www.ncbi.nlm.nih.gov/pubmed/11298208, available in march 2001, viewed on 6th, February 2012.
35. Procaccino J.R., (2012), Legal and ethical dilemmas in healthcare decision making. Acma Maryland chapter conference, September 15, 2012.
36. Rebecca F.C. (2005). Nurse executive's legal primer, *Journal of nursing administration, Jona's healthcare law, ethics and regulation*, **7** (1), 10 -12. http://journals.lww.com/jonalaw/Citation/2005/01000/Nurse_Executive_s_Legal_Primer.5.aspx, available in may 2005, viewed on 17th January, 2012).
37. Redman B.K. (2006). Clinical ethics, Review of measurement instruments in clinical and research ethics, *Journal of Medical Ethics*, **32** (3),153-156. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2564469/, available on 29th June, 2005.
38. Rumbold G. (1993). Ethics in nursing practice, BailliereTindal, London.
39. Sivy M. (2012) Facing up to the Ethical Dilemmas in the Healthcare Debate. UNICAF University. USA.
40. Sorta Iva (2011). Journal of Nursing Ethics. *How nurses and physicians face Ethical Dilemmas.*Vol 18, Issue 3, 2011.
41. Stewart, R. S. (2007). Withholding and Withdrawing Life Support: Moral Dilemmas, Moral Distress, and Moral Residue. *Online Journal of Health Ethics*, *4*(2). http://dx.doi.org/1018785/ojhe.0402.04
42. Thompson I.E. (2000). Nursing ethics, Churchill Livingstone, London.
43. Ulrich et al (2013). *Ethical issues and stress in nursing practice*. Available as J Adv Nurs. 2013. Published as: J Adv Nurs. 2010 Nov; 66(11): 10.1111/j.1365-2648.2010.05425.x.
44. Wayne W.D.(2010). Biostatistics- basic concepts and methodology for the health science. Wiley Inc. New Dheli.
45. Westphal M. Stephanie A. (2009). End of care decision making in the intensive care unit: physicians and nurses perspective, *American journal of medical quality*, *American journal of medical quality*, **24**(3), 222- 240. (http://ajm.sagepub.com/content/24/3/222.full.pdf , available on may 20th 2009, viewed on 11th April 2012).