ETHICAL DILEMMAS EXPERIENCED BY NURSES IN THE CRITICAL CARE UNITS IN KENYATTA NATIONAL HOSPITAL.

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING (CRITICAL CARE).

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Declaration

I, Jostine Ndunge Mutinda declare that this thesis is my independent work. It is an original work except where references are made and has never been submitted for award of a degree in any other university.

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Certificate of approval

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DEDICATION

My work is dedicated to my husband Bernard and my three sons Dennis, victor and Gideon. I wish to thank them for the support they gave me. May God bless them.

To all critical care nurses who tirelessly care for the critically ill and face various moral and ethical issues.

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LIST OF ABBREVIATIONS

DNR- do not resuscitate.

ANA- American nurses association.

UKCC- United kingdom Central council of Nurses.

DPAHC- Durable power of attorney for healthcare.

ICN- International council of nurses.

ICU- intensive care unit

CCN- Critical care nurse

CCU- critical care areas

HIV- Human immune deficiency virus.

A&E – accident and emergency

KNH- Kenyatta National Hospital

NCK- Nursing Council of Kenya

KNH/UON- REC – Kenyatta National Hospital/University of Nairobi Research and ethics Committee.

CPD- Continuous professional development.

OPERATIONAL DEFINITIONS

Ethical dilemma: It is a situation in which a choice has to be made between unsatisfactory alternatives-issues between 2 conflicting ethical principles. The dilemmas shall be grouped into: end- of- life issues, human rights, and patient care issues. The responses obtained by the nurses will be put as percentages to determine the magnitude of the problems.

Critically ill patients: A patient suffering from life threatening or a potentially life – threatening condition that is deemed recoverable.

Critical care areas: areas in a hospital set up where the critically ill who are deemed recoverable are admitted, treated and cared for. For the purpose of this study it refers to Intensive care Unit, burns unit and renal unit of the Kenyatta national hospital.

Critical care nursing: That specialty within nursing that deals specifically with human responses to life- threatening problems.

A critical care Nurse: a nurse who is trained and licensed to provide optimal care to the acutely ill patients and their families.

ICU nurses: Nurses deployed to provide nursing care to the patients in the critical care units who may not necessarily be trained and registered as critical care nurses.

Socio-demographic factors

Age, gender, professional qualification, post- basic training, years of experience.

Ethical decision making: trying to distinguish right from wrong in situations without clear guidelines. Systematic resolution will be based on the use of Lyndsay five steps of ethical decision making process.

Ethical decision: A moral decision made in regard to patient care.

Death: Permanent cessation of physiological processes that sustain a living organism.

ABSTRACT

Introduction- 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 depend on the caregiver, optimally the nurse working in the critical care unit. As a result nurses working in the Critical Care Units are faced with ethical dilemmas on a day to day basis in the course of executing their duties.

Ethical dilemmas have therefore become one of the priority concerns in the nursing profession that require urgent attention in Kenya. As the provision of care to the critically ill becomes more complex due to technological advancement, and the profession of nursing more autonomous, professional accountability cannot be overemphasized. (Fry, 2002). 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.

Ethical dilemmas confront even the most experienced nurse (Breen C.M. et al, 2004). Those working in KNH ICU are not any different particularly considering particularly considering that KNH is public hospital having the biggest ICU in the country. Additionally it admits patients from various walks of life and the nurses have diverse socio- demographic factors. However their perception and magnitude of ethical dilemmas they face while working in these areas and how they resolve them have not been studied.

Duration of the study: The study took five weeks. Pretesting of the questionnaires took two days.

Objective: To explore ethical dilemmas experienced by nurses working in the critical care areas at Kenyatta National Hospital and factors influencing the nurses' ethical decision making.

Study question: What ethical dilemmas face nurses working in the critical care areas at KNH and how do they resolve them?

Materials and methods: An exploratory survey study design was adopted whereby 123 nurses shall be requested to participate in the study upon signing an informed consent. These participants were employees of KNH working in the critical care areas during the time of data collection. The study was conducted in the critical care units of

KNH. Permission to conduct the study was sought from the KNH management. Clearance to conduct the study was sought from University of Nairobi and KNH ethical research committee.

Sampling was done using simple random sampling method whereby 123 nurses were picked from the total of 184 nurses. Out of these 3 did not return the questionnaires.

Questionnaires were distributed to the participants to give the information needed.

Data management: Upon completion, data was cleaned and analyzed using SPSS. Chi square test was used to assess the relationship between variables.

Finally, propositions and conclusions were made based on apparent patterns or relationships within the data.

Results: This study on has sought to ascertain what nurses experience as ethical dilemmas while working in the critical care areas and how they have dealt with these issues. The dilemmas which were of major concern to nurses included: prolonging the dying process, withdrawing/ withholding treatment, resuscitation (DNR) orders (table 8), unsafe nurse- patient ratios and allocation of scarce medical resource, rights of pediatric patients, and nursing of critically ill patients who may pose a risk to the nurses.

In dealing with the issues majority of the nurses of the respondents indicated that they would consult with the physicians. Others reported to the nurse team leaders while a few made decisions without consulting a third party.

Some socio- demographic factors were shown to influence the experience of ethical dilemmas by the respondents. These included: the age, level of knowledge on ethical issues, professional qualification and availability of work place resources. It was noted those aged below 35 years experienced more dilemmas than others while those whose level of knowledge was low experienced less dilemmas probably due to their inability to identify the dilemmas as accurately as those more knowledgeable. Those who reported to have adequate work place resources experienced fewer dilemmas. They probably knew the channels to follow to resolve issues compared to their colleagues who reported inadequate resources.

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. The experience of ethical dilemmas is influenced by various socio- demographic factors. In

resolving the dilemmas most nurses would consult the Doctors showing that probably the profession is still at the place of subordination to the medical profession. It is notable that some nurses chose to make decisions without consulting. They may probably be confident of their ability to solve problems without involving a third party.

Results of the study will be used to make recommendations for shaping of the curriculum for training of critical care nurses to include ethical decision making process as this need for education on ethical issues has been identified as shown in the results. The findings can be utilized as literature for further research on ethical issues.

CHAPTER ONE: INTRODUCTION

1.1 Background information

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. 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 done in developed countries have consistently demonstrated that nurses working in critical care units face ethical dilemmas concerning issues of patient management (Erlen and Sereika, 1996).

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 contradictory principles or values. Recently ethical issues have emerged as a major component of health care for the critically ill patients (Miller, 2001). This has been due to recent trends in healthcare 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 (Keffer, 2001). 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 (Ellis, 1988).

Despite advancement in medical technology many patients spend their final hours in critical care units. Treatment of critically ill patients in today's world is being dictated by latest developments in life sustaining and life saving technology. 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 (Myra, 1977).

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. The first one is on the Nurse and people: To enhance the protection of patients' rights to confidentiality and informed consent the patient/ legal proxy should receive sufficient information on which to base consent for care and related treatment. The second one is on the Nurse and practice which advocates for professional accountability on the part of the nurse working in the critical care areas (advocacy). The third one is on the Nurses and profession in which the nurse participates in creating and maintaining safe, equitable social and economic working conditions in the critical care area (justice). Lastly is the Nurse and co-workers 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 (non- maleficence) (ICN, 2006).

Studies have revealed that both nurses and physicians face ethical dilemmas pertaining to end- of –life decisions, patient care and social conflicts (Nesrin, 2004) and (Nermin, 2001). Despite the magnitude of ethical dilemmas faced in critical care areas there is little documented information concerning the role played by critical care nurses in resolving them. Moreover studies have shown that nurses and 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).

1.2 Problem statement

Ethical dilemmas are a source of tension for health professionals and remain one of the priority concerns in the nursing profession that require urgent attention in Kenya (Westphal M. and Stephanie A., 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 (Erlen and Sereika, 1997). As the provision of care to the critically ill becomes more complex 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 patients are vulnerable and totally depend on the caregiver, optimally the nurse working in the critical care unit (Maren, 2004).

Ethical decision-making by the critical care nurses should be a deliberative process requiring them to identify, plan implement and to evaluate alternative actions and consequences in order to determine what they ought to do in the care of these patients. Most of these ethical issues relate to quality of life of the critically ill patients. At times the treatments are no longer benefiting the patient, or the burden of the treatment is greater than its benefit. Sometimes, medical machines used to prolong life cause discomfort in spite of the best attempts to lessen suffering. Due to these issues among others, some decisions regarding continuing or withholding life-sustaining therapies need to be made. Being a very important member of the healthcare team in ICU, such problems requiring decision making face the nurse caring for these critically ill patients every day which may cause stress and burn out to the nurse if not appropriately resolved.

Ethical dilemmas confront even the most experienced critical care nurse (Nesrin, 2004). Those working in KNH ICU are not any different particularly considering that KNH is a public hospital admitting clients from various socio- economic and religious backgrounds, age and illnesses as well as having a challenge of scarcity of resources in the working environment. The nurses working in the critical care areas also have various socio- demographic factors which may affect their ethical decision making process. Critical Care Nursing has ethical dilemmas that are unique to the specialty which may arise from issues touching on the; Self (personal values), Profession (duty to safe life), Client and family (conflicting interests of a proxy), employing institution and society (values conflicting with duty to safe life).

Ethical decision- making process is the core element that embodies health care practice yet its nature and complexity have changed dramatically owing to major advances in technology and scientific progress. These trends have placed a heavier burden and more demands on healthcare providers, nurses included, to cope effectively with emerging ethical problems (Friedman, 2001). In addition, due to widespread awareness of consumer rights, the role of the nurse working in key areas e.g. critical care units has changed from that of legal dependency to that of legal accountability (Laura, 2005). Ethical decision making process can take long and sometimes involve the legal system which may negatively affect patient care, as well as the satisfaction of both family members and the critical care nurses (Breen, 2004).

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 (Nesrin, 2004; Breen, 2004). Several Studies conducted in other countries e.g. Turkey, Sweden and Australia (Nermin, 2001; Nesrin, 2004; Kalvemark, 2004; Megan, 2004) revealed the evidence of ethical dilemmas experienced by nurses working in critical care units. However searches have not revealed any results of a study conducted on this area, in a public hospital of a developing nation. Previous studies also revealed that socio- demographic characteristics of the nurses affect ethical decision making process. According to personnel records in the critical care units of KNH (as availed by the Assistant chief nurses in the respective areas of study) the nurses working in these areas have varied qualifications and clinical experiences as well as age differences among other socio- demographic characteristics. However the ethical dilemmas they face while working in these areas, their magnitude, and how they resolve them have not been studied. Moreover, studies have identified gaps in ethical decision making process among critical care nurses in other countries (Oberlek, 2004; Megan, 2004). These therefore are the gaps which this study sought to address.

1.3 Purpose of the study

It is widely believed that nurses caring for the critically ill patients frequently encounter ethical issues during the practice. Few studies however, have identified the types of ethical issues that these nurses encounter, how frequently they occur, and the factors affecting the nurses' ethical decision making process. The degree to which nurses working in critical care units at KNH experience ethical dilemmas, how effectively they resolve them and factors influencing their ethical decision- making process have never been explored. Thus, the purpose of this study was to determine the ethical dilemmas experienced by nurses in the critical care areas at KNH, their magnitude and factors influencing the experiences and their ethical decision making process.

1.4 Study justification

Despite the fact that ethical dilemmas are a big challenge in critical care nursing records show that no study so far has been conducted in KNH on ethical decision making among nurses working in the critical care areas. The existing literature shows results of studies done in other countries outside Africa.

Understanding the dilemmas and the ethical decision making process by nurses working in the critical care units in KNH as well as the factors that influence the process will yield benefits to the nurses, the hospital, the nurse training institutions as well as to patients.

This study will enhance an understanding of the ethical dilemmas that nurses encounter in the course of executing their duties in the critical care units, factors influencing how they resolve them in order to appreciate the importance of sound ethical decision making process in critical care.

1.5 ASSUMPTIONS AND LIMITATIONS

1.5.1: Assumptions

His study was guided by the assumption that:

1. The administration would be supportive to allow the study to be conducted.
2. Nurses/respondents would be interested in giving information.

1.5.2: Limitations

The nurses' knowledge of the common ethical dilemmas can create a bias as the respondent may give information based on what they know other than what they have experienced. This was addressed by assessing the nurses' knowledge on ethical issues (appendix 1 part A).

1.6 Objectives

1.6.1 Main objective

To determine ethical dilemmas experienced by critical care nurses working in the critical care areas at Kenyatta National Hospital.

1.6.2 Specific objectives

1. Describe types of ethical dilemmas experienced by nurses in the critical care areas in KNH.
2. Determine the magnitude of the dilemmas.
3. Explore the nurses' ethical decision making process.
4. Determine the factors affecting experience of ethical dilemmas.

1.7 Research questions

1. What ethical dilemmas do the nurses experience while working in the critical care units at KNH?
2. How frequently do these problems occur?
3. How do the nurses resolve the dilemmas once encountered?
4. What are the factors influencing the nurses' experience of ethical dilemmas?

1.8 Study hypothesis

H_o: Ethical dilemmas are not frequently experienced by nurses working in critical care units in KNH.

The nurses do not encounter problems with ethical decision making process.

CHAPTER 2: LITERATURE REVIEW

2.1 Historical perspective

Critical care units have evolved over the last four decades in response to medical advances. Development of Critical care nursing dates back to the time of Florence Nightingale who recognized the need to consider the severity of illness in bed allocation and placed the seriously ill near the nurse's station (Jaya, 2000). Similarly, ethical values in nursing date back to the same time. In 1860 Florence Nightingale started a school of nursing and the Criteria for training as a nurse was that one had to be a sober, honest and truthful woman (George, 2002). In 1946 the principal of the Farrand training school for nurses devised the nightingale pledge which in part states "…..I will abstain from whatever is deleterious and mischievous and will not take or administer any harmful drug…" Nurses were therefore required to be ethical in their practice (Ellis, 1988).

The term critical care unit came into existence in the 1970s and more and more hospitals are being equipped with critical care facilities. The challenge for the ICU nurses today is the need to examine and handle conflicts, character traits and social issues affecting patients and families under their care (Jaya, 2006).

Ethical Dilemmas in nursing are situations which 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 contradictory principles or values (Thompson, 2000).

2.2 Definitions of common ethical terminologies

Ethics: The term is derived from a Greek word '*ethos'* meaning character (Friedman 2001). It refers to social customs regarding the rights and wrongs, in theory and practice of human behavior (Rebecca, 2005).

Nursing ethics: refers to a system of principles governing the conduct of a nurse (Thompson, 2000).

Ethical codes: are formal statements of rules for a particular group of individuals that guide professional behavior. Currently nurses are guided by the codes of nurses from various regulatory bodies e.g American Nurses Association (ANA) code for nurses (1950), ICN code of ethics (1973), UKCC code of professional conduct (UKCC 1992),

nursing Council of Kenya (NCK) code of ethics (2005) among others. These codes are drawn from the Nurses Acts.

2.3 Ethical decision making process

Ethical decision making involves trying to distinguish right from the wrong in situations without clear guidelines. Ethics do not give clear cut answers, only guidelines of possible behavior. Ethical decision making process is therefore not as clear cut as other decisions made in other areas of life since moral problems are complex incorporating a mix of values, benefits and harms. Being the optimal care givers, nurses working in Critical care units should be involved and ensure that decisions made regarding planning and the provision of care to their patients fall within the laid down ethical guidelines. Researchers have however shown that the nurses' involvement in ethical decision making is minimal (Vreeland and Ellis 1969, Oskins 1979, Robinson and Lewis 1990).

Most of the decisions made regarding the provision of care to the critically ill are done without their involvement since most of them lack the capacity to decide. Some of these decisions may violate the patients' customs and beliefs which may be unethical though most of the actions taken are for the patient's benefit. The critical care nurse therefore may be faced with a dilemma as to whether to abide by the duty to save life or fully adhere to the laid down ethical principles.

In order to have sound resolution of ethical dilemmas it is imperative to adopt a systematic ethical decision making process. Swinton Lyndsay identifies five steps of ethical decision making process as follows: (Lindsay, 2007).

1. **Is it an ethical issue?**

Being ethical does not always mean being possible or following the law. One should listen to their instincts - if it feels uncomfortable making the decision alone, get others involved and use their collective knowledge and experience to make a more considered decision.

2. Get the facts:

The decision makers should establish what they know about the ethical issue, the people affected by the ethical decision and whether they have been consulted, the available options and the need to review the options with someone they respect.

3. Evaluate alternative actions: There are different ethical approaches which may help one make the most ethical decision:

Utilitarian Approach - which action results in the most good and least harm?

Rights Based Approach - which action respects the rights of everyone involved?

Fairness or Justice Approach- which action treats people fairly?

Common Good Approach - which action contributes most to the quality of life of the people affected?

Virtue Approach - which action embodies the character strengths you value?

4. Test your decision: The decision makers should establish if they could comfortably explain their decision to those close to them or to the public. If not, re-think the decision before taking action.

5. Just Do It - but what did you learn? Once the decision is made it should be promptly implemented. A date to review the decision should be set and adjustments made if necessary. Often decisions are made with the best information to hand at the time, but things change, and the decision making needs to be flexible enough to change too.

2.4 Factors affecting ethical decision making process

Ethical decisions are not made in a vacuum. Many factors exert pressure and demand response as the critical care nurses search for appropriate answers to the dilemmas they face (Ellis, 1988). These factors include:

2.4.1. Social and cultural attitudes

The size of the group being affected by ethical decisions has a bearing on the ethical decision making process. This is because the meaning of a consumer unit is shifting from an individual to a family and decisions made regarding the care of the critically ill may require consultation with the family who may have different views.

2.4.2 Technological advancement

The scientific and technological advancement in life sustaining procedures has raised ethical questions. For instance, the advent of life support machines have challenged the medical and legal professions to examine their definition of life and brought about the problem of when to turn out the machine.

2.4.3. Judicial decisions

Many ethical issues have legal implications and recently more issues of ethical dilemmas are being resolved by the court. These court decisions may challenge moral principles and create a dilemma e.g. in case of DNR a court may decide that the patients deserve right to autonomy but it challenges the nurses' duty to save life.

2.4.4. Resources

Availability of resources determines what services an institution can provide. Scarcity of resources challenges the principle of justice since the critically ill patients may be many and the resources are few.

2.4.5. Nurse's status as an employee

There are pressures that divide the nurses' loyalty between the patient, employer and self. Ethical decisions may involve conflicts between the best interest of the employer and the patient.

2.4.6. Authoritarian and paternalistic backgrounds

Historically nurses have been forced to be subservient since most of them are women. Some physicians feel that they should make all decisions for all healthcare team members. This may cause critical care nurses to absolve themselves of moral responsibility by following orders.

2.4.7. Consumer involvement in healthcare

Consumers are demanding a greater involvement in all aspects of their own healthcare delivery part of which is in ethical decision making.

2.5 ETHICAL PRINCIPLES

Ethical principles guiding the practice of critical care nurses include; Autonomy, veracity, beneficence, non- maleficence, justice, fidelity and confidentiality (Ellis 1988).

2.5.1: Autonomy

Autonomy means the freedom to make decisions about own destiny (Friedman, 2001).The critically ill patient who in most cases lacks decision-making capacity also has the right of choice exercised by a surrogate or designated proxy. Critical care nurses have an obligation to respect the autonomy of their patients and ensure that decisions are made in the best interest of the patient.

Informed consent is based on the principle of autonomy and incase the patient is critically ill and unable to make his own decisions, informed consent can be obtained by proxy consent from a legal guardian, next of kin, or designated health care surrogate. A dilemma may arise when the interests of a surrogate conflict with those of the critical care nurse concerning what is best for the patient (Thompson, 2000). Studies have shown that nurses experience dilemmas with autonomy especially when dealing with pediatric patients since most of the decisions are made by the parents (Nesrin, 2004). For instance a parent may desire euthanasia which may conflict with the nurse's duty to save life. The study did not however recommend who should be the final decision maker concerning the treatment of pediatric patients when there are conflicts between parent's desires and the physician's/nurses' duty.

2.5.2: Beneficence and Non- maleficence

Beneficence means "doing good" for others while non- maleficence means doing no harm. It is the duty of a critical care nurse to act for the well-being of the critically ill patient. This involves meeting all the patients' needs (Biological, Psychological& Social). A question of moral necessity may arise as to whether one should aim at doing no harm even when it is not possible to do good e.g. prolonging life for years in a critically ill patient who has a brain death may be termed dehumanizing (Friedman, 2001).This brings about conflict between the principles of beneficence and maleficence. The principle of non- maleficence requires nurses to protect the critically ill patients against any harm. The American Nurses association code of ethics supports nurses in their whistle blowing activities in response to incompetent or unethical practice (ANA, 2001).

2.5.3: Justice

Justice means treating all individuals equally which require nurses to be non-judgmental. The common good as well as individual benefit must be considered (Thompson, 2000). Critically ill patients and their families should be treated equally unless there is a difference in them that is relevant to the treatment in question. The American code for nurses states that the need for healthcare is universal; transcending all national, ethical, racial, religious, cultural, political, educational, economic, developmental, personality, role and sexual differences (ANA, 1985).Provision of care to the critically ill should be without prejudicial behavior.

Inherent in nursing is the respect for life, dignity and human rights which should be unrestricted by nationality, race, sex, political or social status. Critical care nurses (CCNs) render services to both the patients and family and coordinate their services with the family and the rest of the medical team (Betty, 2000). Personal values of the critical care nurses are motivational sources for their actions and although professional values should take priority, personal values can affect nurses' decisions regarding critical care (Leininger, 2005). For instance, a study revealed that nurses were reluctant to admit HIV positive patients who were terminally ill to Intensive Care Unit (Nermin, 2001). This conflicts with the principle of justice as all patients should be treated equally.

2.5.4: Veracity and confidentiality

Veracity implies "truthfulness" while confidentiality refers to keeping secret issues pertaining to patient's information. This should be maintained unless otherwise recommended (Friedman, 2001). Critical care Nurses are required to be truthful, open and honest to their clients. Nurses should be truthful and to hold in confidence personal information and use judgment in sharing this information while maintaining the highest standards of nursing care possible within the reality of a specific situation and should at all times maintain standards of personal conduct which reflect credit upon the profession (ICN, 2006).

Dilemmas to veracity occur because of apparent or actual conflict between the patient's right to know and the nurse's duty to care. The nurse may be afraid that shocking news

may distress the patient leading to despair. On the other hand relatives may demand to know about the patient's confidential issues or refuse the nurse from disclosing some information to the patient (Rebecca, 2005). Confidentiality has also been an issue of ethical concern to an extent that when nurses are named in malpractice suits it is hard to determine how much information one should volunteer to the defense counsel (Miller, 2001).

2.6: Ethical dilemmas commonly experienced by nurses in the Critical care units

Critical care nurses are faced with ethical dilemmas on a day to day basis in the course of executing their duties. These occur in a situation where two or more ethical principles seem to apply but supporting mutually inconsistent courses of action (Fry, 2002). Ethical dilemmas commonly encountered by nurses working in the critical care set up include:

2.6.1: End-of-Life Issues

End- of- life issues involve dealing with withholding or withdrawal of life sustaining treatments, respecting the wishes of the patient and counseling the patient's family. Studies have revealed that end of life issues are a source of dilemma to both nurses and physicians (Nesrin, 2004).

2.6.1.1: Withholding or withdrawal of life- sustaining treatments

Once it is agreed that a particular intervention is not appropriate because patient refuses it or it proves ineffective, it may be withdrawn. The moral issue in withholding/withdrawal of an intervention is to ensure patient comfort. Studies have shown that the most prevalent conflicts in critical care decision making are to do with withdrawing life sustaining equipment (Breen et al, 2004).

2.6.1.2: Euthanasia

The word is derived from Greek words *eu* and *thanatos* which means a gentle and easy death. It is a method of terminating life without pain. It could be done passively through withholding or withdrawing treatment or actively through overtreatment (Friedman, 2001). Euthanasia though legalized in some countries like Holland may pose dilemmas to the critical care nurses since it conflicts with the duty to save life. Euthanasia was legalized in Holland in 1991 under the following conditions: If the patient was suffering unbearably, he/she requested voluntarily for euthanasia, the attending physician

consulted with other physicians and that the physician submitted an official report that he/she complied with the law (Myra, 1977). A survey conducted later revealed that among all the cases of euthanasia conducted only 25% complied with the requirements.

Beloniel another researcher, discussed humanized personalized patient care as including respect for patient's choice including the choice of non- compliance with medical recommendations. He pointed out that the structural conditions of work in some settings can be such that providers as well as recipients of care undergo dehumanization e.g. prolonging of suffering as opposed to doing euthanasia. Advocates of euthanasia considered the quality of life and right of choice to be of great value while the opponents believed life is valuable and God given and only God can take it away (Myra, 1977).

2.6.1.3: Do-Not-Resuscitate (DNR) Orders

If Cardio Pulmonary Resuscitation will not have demonstrable benefit, the patient or family desire for the intervention is irrelevant. The patient through their proxy may also want to exercise their 'right to die' for instance, in the USA the society for the right to die receives more than 100,000 requests each month for living wills since June 1990 (Dominic, 1991). The critical care nurse may face a dilemma in case relatives demand resuscitation to be done on a patient who had given a DNR order before becoming incompetent.

2.6.1.4: Living will

This is a written statement of a patient's wishes regarding utilization of medical therapies should the patient lose decision-making capacity. Living will procedures vary from state to state. "Durable power of attorney" (DPAHC) designates a health care agent who is authorized to make medical decisions for the critically ill upon losing competence to decide (Dominic, 1991). Clients are becoming increasingly informed of their rights and critical care nurses as well as other healthcare providers who ignore valid documents expressing patient's wishes regarding life – sustaining care e.g. the 1durable power of Attorney may face law suits by either the patient or relatives (Laura, 2005).The critical care nurse has a responsibility to ensure decisions are made in the patient's best interests which may generate conflicts with the proxy if he makes life

threatening decisions. Researchers have shown that most of the dilemmas in end- of -life care centered mostly around advance directives (Betty et al, 1988).

2.6.2: Futile treatment

Nurses working in CCU are confronted with life saving treatment decisions which centre on inappropriate use of antibiotics, artificial nutrition, mechanical ventilation which may be of little benefit to the patient as well as burdensome to both the nurse and the patient (Maren, 2004).The dilemma arises as to when some of these therapies should be stopped and who is to decide.

2.6.3: Allocation of scarce medical resources

This may affect the CCN directly or indirectly. Critical care Nurse Managers must understand where they draw the ethics line in order to make these decisions in policy. The ICN statement on nurses role in safeguarding human rights provides that nurses ensure provision of adequate treatment within the available resources and that there is no impartiality. This goes in line with the principle of justice (ICN, 2006).

Most of the developing countries e.g. Kenya lack adequate resources in the critical care areas to include dialysis machines, staff, beds, disposable material etc. Application of justice under these circumstances may pose a dilemma to the critical care nurse. The priorities determined by the professionals in the CCU to give certain preference to some patients over others whom they consider 'more deserving' may be questioned in the name of justice if the patients suffer neglect as a result (Boyd, 1979). Allocation of resources can cause controversy if the decision does not appear to benefit the patient in some way and in situations where resources are scarce. Studies have shown that nurses experience dilemmas with allocation of resources in ICU (Nermin, 2001).

2.6.4: Inappropriate Tasks

When a nurse is deployed to the critical care unit and is asked to provide care when she is inadequately/not trained in the specialty she may have to refuse to provide care to avoid making the patient unsafe. A survey conducted by American nurses' association in 1989 showed that there was 12.9 percent shortage of nurses which led to floating of nurses in the understaffed areas (Miller, 2001). A nurse should acknowledge any limitations of competence and refuse to accept any delegated functions without

receiving instructions in regard to those functions and having been assessed as competent (ICN, 2006).

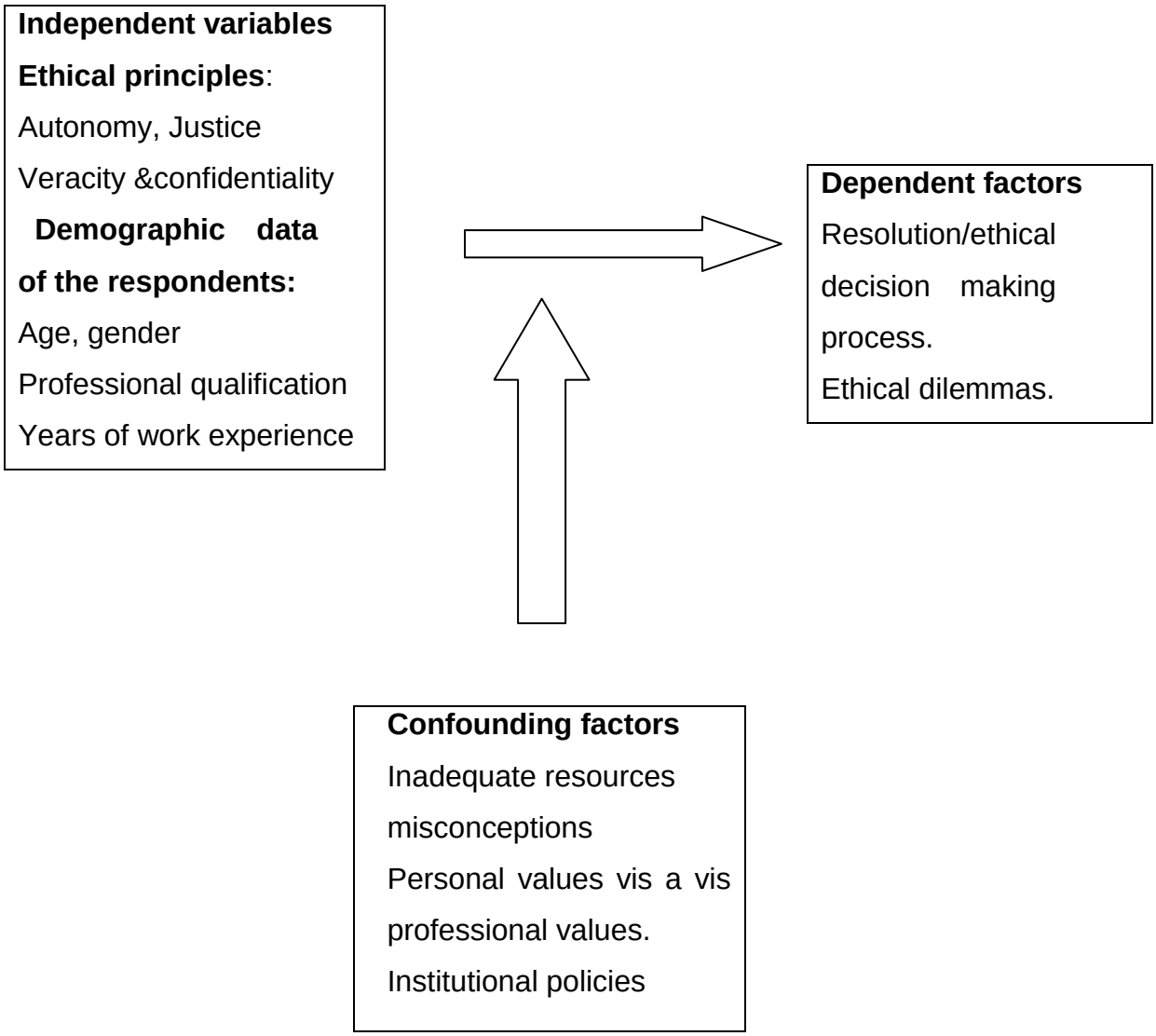
2.7 Theoretical framework

Nurses' ethical decision making process is usually derived from a theoretical framework which provides a basis for the decisions made. Many theories have been advanced to suit the situations in which the decisions are made and this study will adopt the Deontology/Kantianism theory. Deontology is from Greek Deon- duty, logos-discourse. According to this theory duty is the basis of morality and some acts are obligatory regardless of their consequences. This theory holds that one is acting rightly when he/she acts according to duties and rights. The theory denotes that duties and rights are the correct measuring rods for evaluating action. It therefore looks at human duties to others and tries to analyze the principles on which these duties are based.

Some deontologists are moral absolutists, believing that certain actions are absolutely right or wrong, regardless of the intentions behind them as well as the consequences. Immanuel Kant, for example, argued that the only absolutely good thing is a good will, and so the single determining factor of whether an action is morally right is the will, or motive of the person doing it. If they are acting on a bad pronouncement, e.g. "I will lie", then their action is wrong, even if some good consequences come of it (Bowen, 2004).Based on this theory the nurse working in the critical care area chooses the best decision that suits the situation depending on set rules and regulations regardless of the consequences. For instance concealing information from the client by the CCN would be considered morally wrong.

The values and beliefs of a critical care nurse may conflict sometimes with those of the patients, relatives, administration and other team members involved in the provision of care to the critically ill. It is imperative for the nurse therefore to understand the value and ethics of self and those of the patients under his or her care, follow the stipulated guidelines of ethical decision making in order to resolve ethical issues (Jaya, 2000).

2.8: CONCEPTUAL FRAMEWORK



CHAPTER THREE: MATERIALS AND METHODS

3.1. 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.

3.2 Variables under study

Independent variables: Common ethical principles and nurses' socio-demographic data i.e. age, sex, level of nursing education, post- basic training, years of experience were considered as the independent variable.

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

3.3 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. It has a bed capacity of 21 in the intensive care unit which makes it the largest ICU in the country. The burns unit has a bed capacity of 18 while the renal unit has 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 different ethical issues were bound to be encountered during the provision of care to these patients. These coupled with the fact that KNH is located in an urban area where the clients who mostly seek for services there are informed 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. This coupled with their work experience and decision making process made the facility to be considered ideal for this study. It was hence purposively sampled as the study area.

3.4 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.

3.5 Sampling

3.5.1: Inclusion criteria

Participants in this study had to fulfill the following inclusion criteria.

They had to be:

Kenya Registered/enrolled nurses working in any of the three critical care areas in KNH during the time of the data collection (4^{th} to 22^{nd} of June 2012).

Nurses employed by the KNH.

Willing to give consent for participation.

3.5.2: Exclusion criteria

Potential participants found to possess any of the following characteristics were excluded from the study.

Nurses on annual leave during the time of data collection (4^{th} to 22^{nd} of June, 2012).

Nurses not willing to participate in the study.

Nurses working in the critical care areas but not employed by KNH.

3.5.3: Sample size determination

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

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

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).

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.

3.5.4: 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:

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.

3.6 Research Instruments

A 40 items self administered Questionnaire (appendix 1) 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 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.

3.7: 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. Each of the nurses participating during pre- testing was given a questionnaire to fill in. The information obtained from the pre-test was analyzed and used to aid in making amendments to the questionnaire.

3.8: Selection and training of research assistants

Two research assistants were selected and trained on the purpose of the research, objectives, and ethical guidelines to be followed and how to use the questionnaire. The two were Kenya registered nurses, one of whom had a basic diploma while the other one had a post basic diploma in critical care nursing.

3.9: 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.

3.10: Data management

3.10.1: data cleaning and entry

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

3.10.2: 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 magnitude, 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.

3.11: Ethical considerations

3.11.1: 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.

3.11.2: study duration

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

3.11.3: Informed consent

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

3.11.4: 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.

3.11.5: Administrative issues

Any issues of concern requiring further clarifications could be addressed to the secretary to the KNH/UON ERC using the address given on the consent form and the letter of approval.

3.11.6: Declaration of interest

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

CHAPTER FOUR: 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 1 questionnaire was found to have missing information on the gender of the respondent hence it was not analyzed in regard to this variable. 8 respondents did not indicate their age hence these questionnaires were not considered when analyzing this variable.

4.1 Demographic characteristics of the respondents

4.1.1 Gender

All the 120 respondents reported their gender except one. Figure 1 shows that 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.

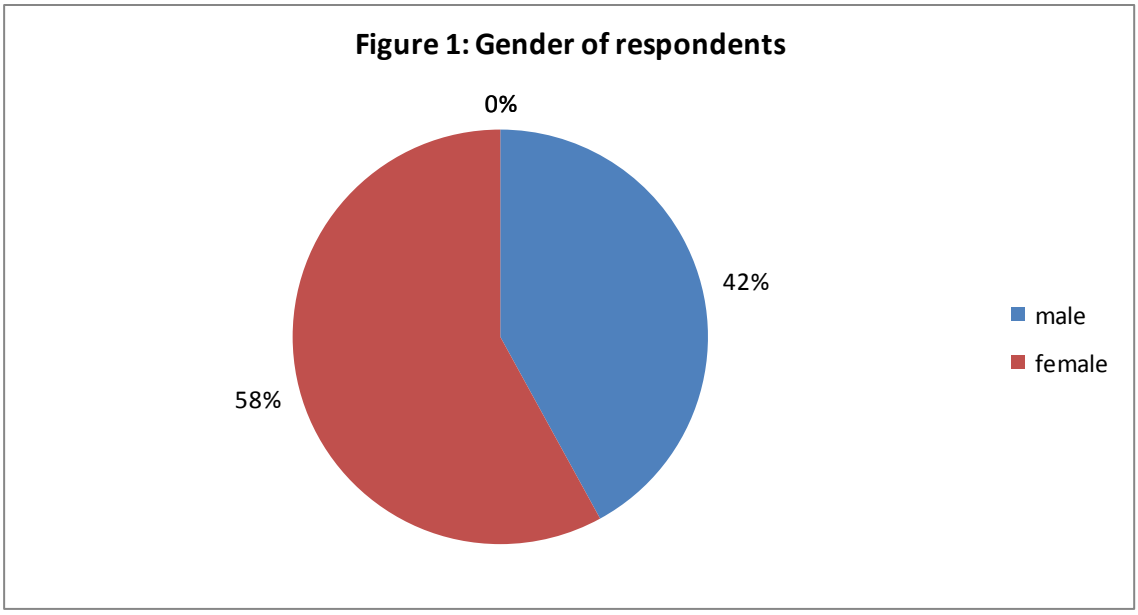


Figure 1: Distribution of the gender of the respondents

4.1.2. 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. The median and modal age was the same, 36 years. The table bar chart below shows age frequency distribution of respondents' age in each age group. The distribution shows that a big percentage (71.3%) of the nurses working in the critical care units is aged below 40.

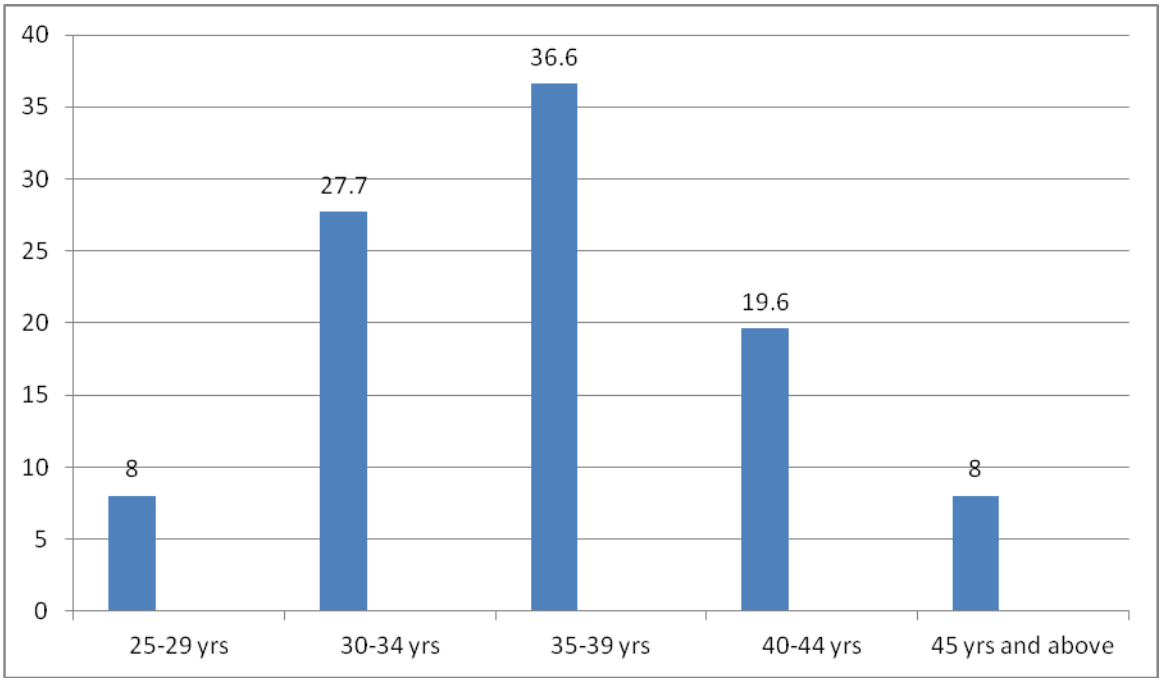


Figure 2: Age distribution (in years) of the respondents. N = 112

4.1.3 Professional qualification

As seen from table 1, over 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. This study sought

to establish if there was a significant relationship between the experience of ethical dilemmas and the professional qualification of the nurse among other factors. To determine whether the above observation was significant, the cross tabulations were subjected to Chi-square test. The results showed a Chi-square statistic of 6.455 with a p-value = 0.011, which means that there was a significant relationship between the two.

Table1: Respondents' professional qualification.

Professional Qualification	Frequency	Percentage	Cumulative Percentage
Masters	2	1.7	1.7
Basic degree	9	7.5	9.2
Post basic diploma	81	67.5	76.7
Diploma	28	23.3	100.0
Total	120	100.0	

4.1.4 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. The full details are as displayed in table 2.

Table 2: Respondents' length of work experience in the CCU.

Length of work experience	Frequency	Percentage
Less than 5 yrs	55	45.8
6-10 yrs	37	30.8
11-15 yrs	26	21.7
Over 15 yrs	2	1.7
Total	120	100.0

4.2: Knowledge of ethical issues

Table 3 shows that 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.

Table 3: respondents' knowledge of human rights issues

Level of knowledge	Frequency	Percentage
Not knowledgeable at all	2	1.7
Knowledgeable	118	98.3
Total	120	100.0

4.3 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.

Table 4: Respondents' need for human rights education

Extent of need	Frequency	Percent
No need	1	0.8
Little need	2	1.7
Great need	49	40.8
Very great need	68	56.7
Total	120	100.0

4.4. Ethics content taught

4.4.1 Type of ethics content covered during educational preparation

Table 5 shows that 89.2 % (107) 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.

Table 5: Respondents' ethics content taught during educational preparation.

Type of ethics content	Frequency	Percentage
Content integrated throughout the program of study	15	12.5
Content taught in a specific course	11	9.2
Content taught by nursing faculty	78	65.0
Content taught by non-nursing faculty	3	2.5
No ethics content in coursework	13	10.8
Total	120	100.0

4.4.2. Type of ethics content covered in Continuous Professional Development

Table 6 shows the distribution of frequencies of responses concerning the ethical content taught in 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.

Table 6: Respondents' ethics content taught in CPD

Type of ethics content	Frequency	Percent
content integrated throughout CPD	29	24.2
ethics content specific CPD program	6	5.0
content taught by nursing faculty	52	43.3
content taught by non-nursing faculty	8	6.7
no ethics content in CPD programs	25	20.8
Total	120	100.0

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

Table 7 shows Distribution on availability of resources to help in ethics and human rights issues. 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.

Table 7: Availability of work place resources for ethics and human rights

Level of resource adequacy	Frequency	Percent
Totally inadequate resources	42	35.0
Inadequate	52	43.3
Adequate	26	21.7
Very adequate	0	0
Total	120	100.0

4.6: Nurses' experience of ethical dilemmas in CCU

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

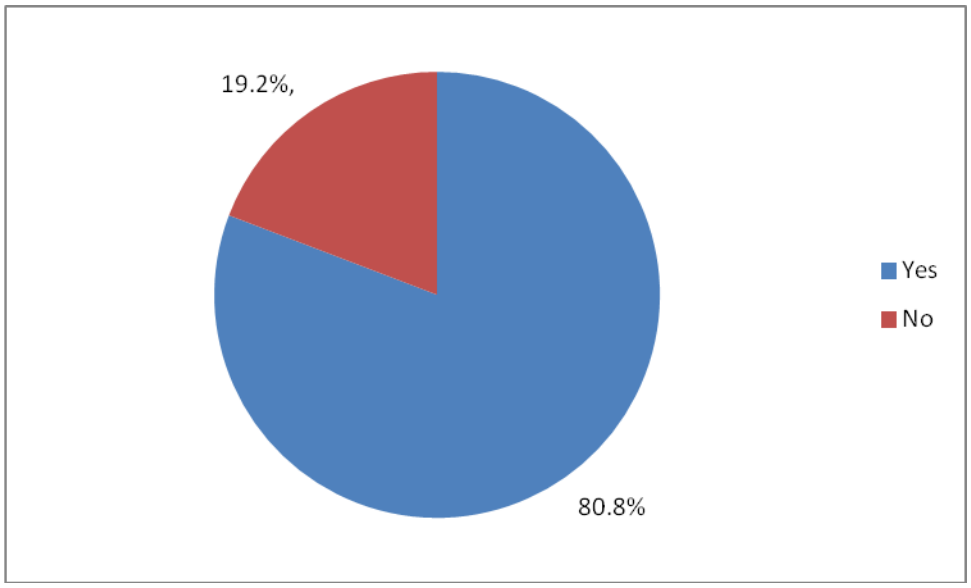


Figure 3: Distribution of frequency on experience of ethical dilemmas.

4.7 Experience of ethical dilemmas relating to end- of – life issues

As depicted in table 8 below, the commonly experienced ethical dilemma is the one relating to resuscitation orders whereby 76 respondents had experienced it. Out the 76,

majority of them, 62% (47) had experienced it between 1-5 times for the last one year, while working in the CCU.

This was followed by the experience of dilemmas relating to withholding/withdrawing treatment whereby 58 nurses had experienced it with 53% (31) of them experiencing it 1- 5 times. 56 respondents reported to have experienced dilemma with matters of prolonging the dying process with 43% (24) of them experiencing it over 10 times in the last one year.

Issues related to patient's religious beliefs, for instance those opposed to blood transfusion and/or resuscitation procedures posed dilemma to 51 respondents with 55% (28) of them reporting to have experienced this dilemma 1- 5 times in the last one year.

Table 8: Respondents' experience of various forms of ethical dilemmas relating to end-of- life issues.

Type of ethical dilemma	Category of no. of experiences of each dilemma	Frequency of responses	Percentage
Prolonging dying process (n= 56)	1-5 times	23	41
	6-10 times	9	16
	Over 10 times	24	43
Withholding treatment (n=58)	1-5 times	31	53
	6-10 times	15	26
	Over 10 times	12	21
Resuscitation (DNR) orders (n=76)	1-5 times	47	62
	6-10 times	8	10
	Over 10 times	21	28
Patient's religious values (n=51)	1-5 times	28	55
	6-10 times	11	22
	Over 10 times	12	23

4.8. Actions taken to resolve ethical dilemmas relating to end- of- life issues

4.8.1 Prolonging the dying process

The results in table 9 show that when faced with a dilemma relating to prolonging the dying process majority (63.6%) would report to the physician, while 25.5% would comply with the order. A small percentage, 7.3% and 3.6% would report to the nurses' team leader or ignore the order respectively.

Table 9: Actions for resolving the dilemma of prolonging the dying process

Type of action	Frequency	Percent
Consulted the physician	35	63.6
Reported to the nursing team leader	4	7.3
Ignored the order	2	3.6
Complied with the order	14	25.5
Total	55	100.0

4.8.2. Withdrawing/ withholding treatment

Table 10 shows the distribution of the actions taken in resolving the dilemma of withdrawing/ withholding treatment. Majority, 56.1% (32) of the respondents consulted with the physician while 22.8% (13) reported to the nurses' team leader. Only 15.8% (8) complied with the order while 5.3% (3) ignored it.

Table 10: Actions taken to resolve the dilemma of withdrawing/withholding treatment

Type of action	Frequency	Percent
Consulted the physician	32	56.1
Reported to the nursing team leader	13	22.8
Ignored the order	3	5.3
Complied with the order	8	15.8
Total	57	100.0

4.8.3 Resuscitation/ Do not resuscitate orders

Table 11 shows the distribution of the actions taken in resolving the dilemma of dealing with resuscitation/DNR orders. Majority of the respondents (44.7%) consulted with the physician, 38.2% complied with the order while 10.5% ignored it. Only 6.6% reported to the nurses' team leader.

Table 11: Action taken to resolve the dilemma of resuscitation/DNR orders

Type of action	Frequency	Percent
Consulted with the physician	34	44.7
Reported to the nursing team leader	5	6.6
Ignored the order	8	10.5
Complied with the order	29	38.2
Total	76	100.0

4.8.4 Conflicts with patient's religious values

Table 12 shows the distribution of the frequencies of the actions taken to resolve dilemmas touching on patient's religious values e.g. refusal of blood transfusion by some religious groups. Majority of the respondents i.e. 35.2% (18) would consult with

the physician while 33.3% (17) would report to the nurses' team leader. Only 11.9% would comply with the order while 19.6% would ignore it.

Table 12: The actions taken to resolve dilemma of patient's religious values

Type of action	Frequency	Percent
Consulted the physician	18	35.2
Reported to nursing team leader	17	33.3
Ignored the order	10	19.6
Complied with the order	6	11.9
Total	51	100.0

4.9. Experience of conflicts over patient care issues

Table 13 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).

As depicted in the table, the most commonly experienced ethical dilemma was the one relating to allocation of scarce medical resources whereby 87 respondents had experienced it. 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 for the last one year, during their working in the CCU. The next commonly experienced ethical dilemma was the one relating to unsafe nurse- patient ratios whereby 80 respondents had experienced it with 48.8% (39) having encountered it over ten times in the last one year. 40 respondents had experienced breaches of patient privacy with 55% (22) of them encountering it 1-5 times for the last one year. 28 respondents encountered conflict with ignoring patients' autonomy with 67.9% (19) of them experiencing that 1- 5 times for the

last one year. 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 for the last one year. 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 for the last one year. The least source of dilemma was discriminatory treatment of patients which was experienced by only 18 respondents with 11(961.1%) experiencing it 1-5 times.

Table 13: 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

4.10. Actions taken to resolve conflicts over patient care issues

4.10.1. Unsafe nurse- patient ratios

To resolve this conflict 78 out of the 80 respondents who experienced the dilemma took the actions shown in table 14 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.

Table 14: 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

4.10.2 Allocation of scarce medical resources

To resolve this conflict 85 out of the 87 who experienced the dilemma took the actions shown in table 15 below. Majority, 58.8 % (50) of the nurses while faced with conflicts relating to allocation of scarce medical resources opted to improvise the resources. However 31.8% (27) reported to the nursing team leader. Only 8 (9.4%) respondents based allocation on patient's condition.

Table 15: 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

4.10.3 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 16 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 16: 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

4.10.4 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 16 above. Table 16 shows that majority, 39.3 % (11) of the respondents while faced with conflicts relating to ignoring

patient's autonomy just carried out the procedure. 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 17: 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

4.10.5 Dealing with an unethical/incompetent/ irresponsible colleague

To resolve this conflict the 24 respondents who had experienced the dilemma of dealing with an unethical/incompetent/ irresponsible colleague took the actions shown in table 18. 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 18: 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

4.10.6 Discriminatory treatment of patients

To resolve this conflict 14 out of the 18 who experienced the dilemma took the actions shown in table 19. 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 19: 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

4.10.7. 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 20: 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

4.11. Conflict experienced over human rights issues

As depicted in table 21, all the respondents (120) attested to the fact that human/patient rights issues were a source of conflict in the critical care units. The most commonly experienced ethical dilemma was the one relating to the fact that nursing the critically ill patients can be risky to the nurse whereby 59.2 % (67) of the respondents agreed with the statement. Violation of rights of pediatric patients was the second most commonly experienced dilemma with 51.7% (62) of the nurses attesting to the fact that it is a source of dilemma. 46 (38.4%) respondents reported having experienced conflicts with advance directives while 18.4% (22) agreed that informed consent was a source of dilemma in the critical care.

Table 21: Human rights issues as a source of dilemma (N = 120)

Type of conflict	Extent of agreement with the statement	Frequency of responses	Percentage
Advance directives a source of conflict.	Strongly disagree	46	38.3
	Disagree	28	23.3
	Agree	35	29.2
	Strongly agree	11	9.2
Informed consent can bring conflicts in critical care	Strongly disagree	68	56.7
	Disagree	30	25.0
	Agree	8	6.7
	Strongly agree	14	11.7
Rights of pediatric patients are violated	Strongly disagree	24	20.0
	Disagree	34	28.3
	Agree	44	36.7
	Strongly agree	18	15.0
Nursing critically ill patients can be risky.	Strongly disagree	21	17.5
	Disagree	28	23.3
	Agree	44	36.7
	Strongly agree	27	22.5

4.12. Actions taken to resolve to resolve dilemmas related to human rights issues

4.12.1 Advance directives

Table 22 shows how conflicts of advance directives were resolved by those who ever experienced them. Majority, 57.6% (53) of the respondents consulted with the physician while faced with the dilemma relating to advance directives. 21.7% (20) reported to the nursing team leader, 14.1% (13) discussed the matter with the proxy while 6.5% (6) talked to the relatives.

Table 22: Actions taken to resolve conflicts of advance directives.

Means of conflict resolution	Frequency	Percent
Consulted physician	53	57.6
Reported to nursing team leader	20	21.7
Discussed with proxy	13	14.1
Talked to relatives	6	6.5
Total	92	100.0

4.12.2. Informed consent

Table 23 shows how conflicts of informed consent were resolved by those who ever experienced them. Majority, 39.5% (34) of the respondents explained the procedure to the patient/proxy while 32.6% (28) of them reported to the nurses' team leader. 24.4% (21) consulted with the physician while 3.5% (3) opted to refer the matter to the administration.

Table 23: Actions taken to deal with conflicts relating to informed consent.

Means of conflict resolution	Frequency	Percentage
Consulted physician	28	32.6
Reported to nursing team leader	21	24.4
Referred case to administration	3	3.5
Explained procedure to patient/proxy	34	39.5
Total	86	100.0

4.12.3. Violation of rights of pediatric patients

Table 24 shows how conflicts of violation of rights of pediatric patients were resolved by those who ever experienced the conflicts. Majority, 47.2% (50) of the respondents talked with the parents when faced with issues relating to rights of pediatric patients. 29.2% (31) of the respondents consulted the physician while 14.2% (15) reported to the nursing team leader. A small number, 10 (9.4) reported the issue to the social worker.

Table 24: Actions taken to resolve conflicts relating to violation of pediatric patients

Means of conflict resolution	Frequency	Percent
Consulted the physician	31	29.2
Reported to nursing team leader	15	14.2
Talked with parents	50	47.2
Reported to the social worker	10	9.4
Total	106	100.0

4.12.4 Nursing critically ill patients may be risky to the nurses

The conflicts of taking a risk to nurse a critically ill patient were resolved by those who ever experienced them, by taking the actions shown in table 25. Majority, 64.2% (68) of the respondents took precautions when nursing such patients. 24.5% (26) of the nurses reported to the nursing team leader while a small number 8(7.5%) consulted with the physician. The rest, 3.8% (4) requested to be allocated a different patient.

Table 25: Dealing with conflicts relating to risks of taking care of the critically ill.

Means of conflict resolution	Frequency	Percent
Consulted physician	8	7.5
Reported to nursing team leader	26	24.5
Requested to be allocated a different patient	4	3.8
Took precautions	68	64.2
Total	106	100.0

4.13. Nurses' experience of ethical dilemmas

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.

4.13.1. Magnitude of various ethical dilemmas experienced by nurses working in the critical care units.

For the purpose of this study these dilemmas were grouped into three broad categories which were: Those relating to end- of – life issues, patient care issues and human rights issues.

4.13.2. Dilemmas relating to End – of – life issues

As depicted in table 8, the most commonly experienced ethical dilemma is the one relating to resuscitation orders whereby 76 respondents had experienced it. Out the 76, majority of them (62%) had experienced it between 1-5 times for the last one year, during their working in the CCU.

This was followed by the experience of dilemmas relating to withholding/withdrawing treatment whereby 58 nurses had experienced it with 53% (31) of them experiencing it

1- 5 times. 56 respondents reported to have experienced dilemma with matters of prolonging the dying process with 43% (24) of them experiencing it over 10 times in the last one year.

Issues related to patient's religious beliefs, for instance those opposed to blood transfusion and/or resuscitation procedures posed dilemma to 51 respondents with 55% (28) of them reporting to have experienced this dilemma 1- 5 times in the last one year.

4.13.3. Dilemmas related to patient care issues

As depicted in table 13, the most commonly experienced ethical dilemma was the one relating to allocation of scarce medical resources whereby 87 respondents had experienced it. Out 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 for the last one year, during their working in the CCU. The next commonly experienced ethical dilemma was the one relating to unsafe nurse- patient ratios whereby 80 respondents had experienced it with 48.8% (39) having encountered it over ten times in the last one year. 40 respondents had experienced breaches of patient privacy with 55% (22) of them encountering it 1-5 times for the last one year. 28 respondents encountered conflict with ignoring patients' autonomy with 67.9% (19) of them experiencing that 1- 5 times for the last one year. 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 for the last one year. The other source of dilemma relating to patient care issues was dealing incompetent colleagues whereby 24 respondents reported to have encountered it with 62.5 (15) of them experiencing it 1-5 times for the last one year. The least source of dilemma was discriminatory treatment of patients which was experienced by only 18 respondents with 11(961.1%) experiencing it 1-5 times.

4.13.4. Dilemmas related to patient/human rights issues

As depicted in table 21, all the respondents (120) attested to the fact that human/patient rights issues were a source of conflict in the critical care units. The most commonly experienced ethical dilemma was the one relating to the fact that nursing the critically ill patients can be risky to the nurse whereby 59.2 %(67) of the respondents agreed with the statement. Violation of rights of pediatric patients was the second most commonly experienced dilemma with 51.7% (62) of the nurses attesting to the fact that it is a

source of dilemma. 46 (38.4%) respondents reported having experienced conflicts with advance directives while 18.4% (22) agreed that informed consent was a source of dilemma in the critical care.

4.13.5 Dealing with ethical issues

When confronted with an ethical issue related to end- of – life issues the nurses surveyed reported that they were mostly likely to handle the issue by consulting with the physicians/Doctors (49.9%). Other actions taken included: complying with the orders (22.6%), reporting to the nurse team leader (17.5%) while a small percentage (10%) ignored the orders.

When faced with ethical issues related to patient care, apart from when it came to dealing with uninformed patient/relatives, most of the respondents (31.9%) reported to the nursing team leader. A smaller percentage (25.2 %) reported the issues to the physician. The remaining percentage either complied with the order or just ignored the orders. When dealing with patients/relatives uniformed about the prognosis, majority (43.3%) referred the patient/relative for counseling.

When dealing with dilemmas related to human/patient rights majority (31.8) of the respondents reported the issues to the physician, 21.2% reported to the nurse team leaders while the remaining percentage took various actions to include: discussing the matter with the patients, relatives, the proxy, social workers as well as taking precautions where the procedure was risky.

4.13.5 Ethical issues of most concern

80.8% (97) of the respondents attested to the fact that they had experienced ethical dilemmas in the course their work in the critical care unit. The five most frequently experienced ethical issues were:

The commonly experienced ethical dilemma is the one relating to allocation of scarce medical resources whereby 87 respondents had experienced it (table 12).

The next commonly experienced ethical dilemma is the one relating to unsafe nurse-patient ratios whereby 80 respondents had experienced it with 48.8% having encountered it over ten times in the last one year (table 12).

Ethical dilemmas relating to the fact that nursing the critically ill patients can be risky to the nurses. 59.2 % (67) of the respondents agreed with the statement (table 20).

Violation of the rights of pediatric patients: 51.7% (62) of the respondents attested to the fact that it is a source of dilemmas (table 20).

Ethical dilemmas relating to withdrawing/withholding of patient's treatment: 53% (58) of the respondents experienced it (table 7).

4.14. Factors influencing the nurses' experience of ethical dilemmas.

Knowledge of ethical issues was considered to have a potential of introducing bias to the study (limitations) hence it was assessed first. To establish this, the respondents' knowledge on human rights issues was assessed as well as the type of ethics content taught to nurses both in regular and CPD programs. The socio- demographic characteristics of the respondents assessed for the purpose of this study were: age, gender, professional qualification and work experience. To determine whether there was any significant relationship between the experience of ethical dilemmas and the various socio- demographic characteristics, Chi square test was utilized. The p value was set at 0.05 and the results were as follows:

4.14.1 Knowledge of human rights issues

Although 98.3%(118) of respondents (nurses) reported they were knowledgeable about ethics/human rights issues in nursing practice, 97.5% (97) of them believed they had a great/ very great need for more education on ethical issues. Only 2.5% (3) felt only a 'slight or no need' for such education.

4.14.2. Gender versus ethical dilemma

58 percent of the respondents were female while 42% were male. This gender distribution may be explained by the evolution of nursing as a female dominated profession. To determine whether there was a significant difference between the frequencies of respondents' gender and how it affected experience of ethical dilemmas the frequencies of both variables were subjected to Chi-square test. The results showed a Chi-square statistic of 0.395 with p-value = 0.530 (the level of significance for this study is 0.05). The observed difference was therefore not statistically significant.

4.14.3. Age versus ethical dilemma

Most (36.6%) of the respondents were in age group 35-39 yrs 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. The median and modal age was the same, 36 years. The distribution shows that a big percentage (71.3%) of the nurses working in the critical care units is aged below 40. For age group variations, determination of any significant relationship between age and experience of dilemmas resulted to a Chi square statistic of 10.973 which has a p-value = 0.001confirming that the difference was highly significant.

4.14.4. Professional qualification versus ethical dilemma.

More than two thirds of respondents (67.5%) had a post basic diploma as the highest level of education, followed by diploma holders at 23.3%. 7.5% had a basic degree in nursing while 1.7% who formed the least number had a master's degree. Further analysis of the results revealed that respondents with educational level of post basic diploma reported to have experienced more ethical dilemmas compared to those with basic diploma. To determine whether the above observation was significant results were subjected to Chi-square test which resulted to a Chi-square statistic of 6.455 (has p-value = 0.011) which is highly significant.

4.14.5. Work experience versus ethical dilemma

Almost a half (45.8%) of the respondents had work experience of less than 5 years in the critical care unit, followed by 30.8% who had 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. Determination of influence of years of experience on experience of dilemmas showed that the observed difference was however not statistically significant i.e. a Chi-square statistic of 0.562 with a p-value of 0.454 was observed.

4.14.6. Level of knowledge of the respondents versus ethical dilemma

The percentage of the respondents who were knowledgeable on ethical issues was 98.3%. It was observed that respondents who had no knowledge at all reported to have experienced less ethical dilemmas compared to those with knowledge on ethical issues. To determine whether there was a significant relationship between the level of knowledge on ethical issues and experience of dilemmas the results were subjected to Chi-square test. The observed difference was highly statistically significant i.e. a Chi-square statistic of 16.791 with a p-value = 0.001.

4.14.7. Ethics content taught versus dilemma

89.2 % (107) 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.

79.2 % (95) of the nurses surveyed reported having ethics content taught in continuous professional development courses. Out of these 24.2%, 5%, 43.3% and 6.7% 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% reported to have had no ethics content in CPD programs.

4.14.8. Availability of workplace resources

Majority (78.3 %) of the respondents reported to have inadequate to totally inadequate resources to help them deal with ethics and human rights issues. Only 21.7% reported to have adequate resources (table 6). The respondents who said the resources were inadequate or totally inadequate reported to have experienced more ethical dilemmas compared to those who reported that to have adequate resources. However, this difference was not statistically significant i.e. the results showed a Chi-square statistic of 1.933 with a p-value = 0.38.

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

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

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 (table 8). 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.

Dealing with dilemmas: In dealing with the issues majority of the nurses 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 issues touching on patient care issues it was clear that most nurses opted to report their issues to the nursing team leaders.

The reason may be that the ethical issues confronting the nurses may have directly concerned medical and /or administrative staff (e.g. discriminatory treatment of patients), and the medical treatment of patients and as such they may find it difficult to confront the medical colleagues. Other matters may be best addressed by nurses from a nursing perspective. 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.

In dealing with human rights issues a big percentage (47%- cumulative percentage), of the respondents decided to take various actions without consulting with anyone which included: discussing the matter with the patients, relatives, the proxy, social workers as well as taking precautions where the procedure was risky. The reason may be that the nurses surveyed might have 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 dilemmas related to advance directives only 6 (6.5%) nurses indicated they would talk to relatives 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.

Factors affecting nurses' experience of dilemmas

The survey went ahead to assess the socio- demographic characteristics of the respondents which would affect the experience of ethical dilemmas. While there was no significant relationship noted between gender and experience of ethical dilemmas there was a significant relationship between age and experience of dilemma. The respondents aged below 35 years reported to have experienced less ethical dilemmas compared to those aged 35 years and above. This could be explained by the fact that majority (65%) of the nurses working in the critical care units were aged 35 years and above group hence they (those aged below 35) formed a minority of those who experienced dilemmas.

There was no significant relationship observed between the length of working experienced and the experience of dilemma by the nurses. This could be explained by the fact that these dilemmas occur to all nurses regardless of their level of qualification as observed in previous researches conducted in other countries.

The study results revealed the level of professional qualification had a significant relationship with experience of ethical dilemmas. Respondents with post basic diploma reported to have experienced more ethical dilemmas compared to those with basic diploma. This may be explained by the fact that as the nurses become more knowledgeable in the area of critical care they are in a better position to identify a dilemma once encountered. What a person with a basic diploma may consider an ordinary situation may pose a dilemma to a more knowledgeable person with a better understanding of ethical issues.

When it came to assessing the amount and nature of ethics content integrated in both regular training and training and CPD, majority (89.2 %) of the nurses surveyed reported having ethics content integrated into regular nursing courses within their curricular. In addition, 79.2 % reported having ethics content taught in continuous professional development courses. In both cases the content was taught by nursing faculty.

Although most (98.3%) of respondents reported they were knowledgeable about ethics/human rights issues in nursing practice, 97.5% (97) of them believed they had a great/ very great need for more education on ethical issues. Only 2.5% (3) felt only a 'slight or no need' for such education.

It was observed that nurses who were not knowledgeable on ethical issues experience fewer dilemmas than those who were knowledgeable. The relationship between nurses' knowledge and experience of conflicts related to ethics and human rights issues in practice is particularly noteworthy. A research conducted earlier, (Johnstone 1999, 1998) showed that the ethics education of nurses (and their associated improved knowledge of ethical and human rights issues in practice) can paradoxically compound the frequency and intensity of ethical and human rights issues experienced by nurses in practice. This could occur due to their improved ability to identify ethical issues in places of work more readily than they did prior to their learning.

Looking at the work place resources available to support ethical decision making majority of the respondents cited inadequate work place resources. The respondents who said the resources were inadequate or totally inadequate reported to have experienced more ethical dilemmas compared to those who reported to have adequate

resources. This may be explained probably by the fact that knowledge of availability of resources for instance ethics committees would enable one to utilize them in dealing with issues at work hence lessening their experience of dilemma.

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. When faced with dilemmas most of the nurses reported that they would report to the physicians or the nurse managers. A small percentage would make decisions without consulting. This means that though the profession is still showing some elements of subordination to the medical profession, nurses are developing trust in their ability to make ethical decisions independently. 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 ethics education.

Although the findings of this study may not be broadly generalized for instance to cover the issues affecting nurses working in critical care units in private hospitals they nevertheless highlight the need for a critical examination of the:

1. accredited ethics education programs for nurses and whether these are effective in terms of assisting nurses to achieve the stated and agreed ethical competencies expected of registered and enrolled nurses with respect to professional and ethical nursing practice;
2. The nature and availability of continuing education/professional development programs on ethics and human rights for nurses, and whether these address the issues that are of most concern and are most relevance to nursing practice, particularly in regard to: improving interdisciplinary ethical decision making; improving knowledge of emerging issues; meeting the needs of care givers and care recipients.
3. The availability and adequacy of resources in the hospital to help nurses identify and resolve ethical issues.

5.3. Recommendations

As noted earlier, although 98.3%(118) of respondents (nurses) reported that they were knowledgeable about ethics/human rights issues in nursing practice, 97.5% (97) of them believed they had a great/ very great need for more education on ethical issues. Only 2.5% (3) felt only a 'slight or no need' for such education (table 4).

From the findings of this study I would recommend that the regulatory body reviews the ethics content included in the program of the nursing training syllabi to broaden it.

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.

The hospital can also ensure that the ethical content included in the continuous education programs for the nurses working in the critical care unit is relevant and adequate to help them address their work related issues.

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.

BUDGET

ITEM	UNIT	Cost per unit KShs	Total cost
Typing and printing services			
Laptop & software	1	45,000	45,000
Printing concept paper	2 copies	10	200
Photocopying the concept paper	2 copies	2	40
Printing the proposal	55 pgs	10 x55	550
Photocopying the proposal	2 copies	55 x 2 x2	220
Printing consent forms	1 pg	10	10
Photocopying consent forms	150 copies	2 x 150	300
Printing the final report	75 pgs	10 x 75	750
Photocopying the final report	8 copies	2 x 75 x 8	1200
Binding the final report	8 copies	8 x 300	2400
Stationery			
Notebooks	2	30	60
Calculator	1	1,200	1200
Stapler and staples	1	1,000	1,000
Paper punch	1	500	500
Flash disk	1	1,500	1,500
Pens	1 dozen	20 x12	240
Pencils	2	15	30
Erasers	2	25	50
Personnel/ human resource			
Wages for the research assistants (pretesting of the questionnaires)	2	700 x 2 x1day	1,400
Wages for the research assistants (execution of the research)	2	700x2x5days	7,000
Principle investigator	1	2000x7days	14,000
Submission to the ethics committee	1	1000	500

Submission to the Ministry of higher education	1	1000	1,000
Sub- total			79,650
5% contingency			3,983
Total			83,633

WORK PLAN

TASK	WEEKS																					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
preparing the concept paper																						
Proposal writing																						
Presentation to KNH- REC for approval.																						
Training of research assistants & pretesting of questionnaires																						
Data collection																						
Data cleaning, analysis and report writing.																						

5.4 REFFERENCES

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5.5. APPENDICES

5.5.1. Appendix 1: questionnaire

Instructions:

Read and sign the consent form before filling in the questionnaire.

The questionnaire has 5 parts. Kindly fill all of them.

Follow instructions on how to respond as given in each section.

Section A: Nurses' socio- demographic factors.

For this section circle the appropriate response

1. Indicate your gender

   Male

   Female

2. Indicate your age in complete years……

3. What is your highest level of educational qualification?
   a. Diploma
   b. Higher national diploma
   c. Degree
   d. Masters.

4. Indicate the number of years you have worked in this critical care unit since you qualified as a nurse.
   a. zero to five years
   b. Six to ten years
   c. Eleven to 15 years
   d. Over 15 years

Section B

The following items request information about nurses' knowledge of ethics or ethical issues.

Circle 0, 1, 2, or 3.

1. What is your general knowledge of ethics or human rights issues in nursing practice?

   0=Not at all knowledgeable, 1 knowledgeable,

   0 1

2. To what extent do you need ethics or human rights education for your area of practice?

   0= no need, 1= Little need, 2= great need and 3= very great Need

   0 1 2 3

For question 3 and 4 circle the most appropriate response.

3. What type of ethics content or coursework did you have in your educational preparation?
   a) Ethics content integrated throughout the program(s) of study
   b) Ethics course taught in a specific course
   c) Ethics content taught by nursing faculty
   d) Ethics course taught by non-nursing faculty
   e) No ethics content or course work

4. What type of ethics content have you had in continuing education programs?
   a) Ethics content integrated throughout continuing education program.
   b) Ethics content in an ethics program
   c) Ethics content taught by nursing faculty
   d) Ethics content taught by non-nursing faculty
   e) No ethics content in continuing education programs

5. To what extent does your place of employment provide resources to help you with ethics and human rights issues in nursing practice?

CIRCLE: 0, 1, 2 or 3.

0=Totally inadequate resources, 1= inadequate, 2= adequate, 3=Very adequate resources

0 1 2 3

Section C: Nurses' experience of Ethical dilemmas.

Have you ever experienced ethical dilemmas while practicing nursing in your area of work? Circle the correct response.

Yes 2. No

If YES proceed to answer the rest of the questions. If NO skip questions 1 to 11 and answer questions 12 to 15.

Component 1: on end- of- life issues.

Put a tick against the number that describes your answer.

Key: 1 = 0 times; 2= 1- 5 times; 3= 6- 10 times; 4= over 10 times.

Indicate in the last one year how many times you experienced conflicts with:

		1	2	3	4
1	Prolonging the dying process.				
2	Withdrawing/ withholding treatment.				
3	Resuscitation (DNR) orders				
4.	Patient's religious values versus your duty to save life.				

Nurses' Ethical decision making in resolving the end- of –life issues.

Please put a tick against the action you took in resolving the above dilemmas once encountered.

1. Prolonged dying process

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Ignored the order ( )

iv) Complied ( )

v) other actions taken(kindly specify)…….

……

2. Withdrawing/ withholding treatment.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Ignored the order ( )

iv) Complied ( )

v) Other actions taken (kindly specify)…….

……

3. Resuscitation (DNR) orders

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Ignored the order ( )

iv) Complied ( )

v) Other actions (kindly specify)……

……..

4. Patient's religious values versus your duty to save life.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Ignored the order ( )

iv) Complied with the treatment ordered ( )

v) Other actions (kindly specify)……

……..

Component 2: Patient care issues

Put a tick against the number that describes your answer.

Indicate in the last one year how many times you experienced conflicts with:

1 = 0 times; 2= 1- 5 times; 3= 6- 10 times; 4= over 10 times.

		1	2	3	4
5	unsafe nurse- patient ratios				
6	Allocation of scarce medical resources				
7	Breaches of patient privacy/ confidentiality				
8.	Ignoring patient autonomy				
9.	Irresponsible/unethical/impaired/incompetent colleague Kindly specify the condition(s)……..				
10	Discriminatory treatment of patients				
11	Patients/ relatives uninformed about treatment/ prognosis				

Nurses' Ethical decision making in resolving the patient care issues.

Please put a tick against the action you took in resolving the above dilemmas once encountered.

5. Inappropriate nurse- patient ratios

i) Consulted with the nurse in- charge ( )

ii) Reported to the nursing team leader ( )

iii) worked under strain ( )

iv) sought for help ( )

v) Other actions (kindly specify)……

……

6. Allocation of scarce medical resources.

i) based allocation on patients' age ( )

ii) Reported to the nursing team leader ( )

iii) Improvised ( )

iv) Based allocation on patients' condition ( )

v) Other actions (kindly specify)……

……

7. Breaches of confidentiality due to pressure from relatives.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Ignored the relatives ( )

iv) Complied ( )

v) Other actions (kindly specify)……

……

8. Ignoring patient autonomy e.g. during an emergency.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Just carried out the procedure ( )

iv) Contacted the proxy ( )

v) Other actions (kindly specify)……

……

9. Irresponsible/unethical/impaired/incompetent colleague. Kindly specify the condition(s)……

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Reported to the personnel ( )

iv) Ignored their actions ( )

v) Other actions (kindly specify…….

……

10. Discriminatory treatment of patients

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Reported to the administration ( )

iv) Ignored the actions ( )

v) Other actions (kindly specify)……

……

11. Patient/relatives uninformed about the patient's treatment/prognosis.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Referred the case to the counsellor ( )

iv) Explained to the client the facts ( )

v) Other actions (kindly specify)……

……

Component 3: human rights issues:

For questions 12 to 15 please tick the number that best represents your response.

1.Strongly disagree 2.disagree 3. Agree 4. Strongly agree.

		1	2	3	4

12	Advance directives are a source of moral conflict involving care of the critically ill.				
13	Informed consent can bring about conflicts in critical care.				
14	Rights of pediatrics patients are sometimes violated				
15	Nursing critically ill patients can pose a risk to the nurse.				

Nurses' Ethical decision making in resolving human rights issues.

If you have ever experienced conflicts with the above human rights issues tick where appropriate to indicate how you resolved the dilemma.

12. Advance directives.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Discussed the matter with the proxy. ( )

iv) Talked to the relatives ( )

v) Other actions (kindly specify)……

……

13. Informed consent.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Referred the case to the administration ( )

iv) Explained the procedure to the patient/ proxy ( )

v) Other actions (kindly specify)……

……

14. Rights of pediatric patients

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Talked with the parents ( )

iv) Reported to the social worker ( )

v) Other actions (kindly specify)……

…….

15. Providing care with a possible risk to your health.

i) Consulted with the physician ( )

ii) Reported to the nursing team leader ( )

iii) Requested to be allocated another patient ( )

iv)Took precautions ( )

v) Other actions (kindly specify)……

……

5.5.2 Appendix 2

INFORMED CONSENT FORM

STUDY TITLE: ETHICAL DILEMMAS EXPERIENCED BY NURSES WORKING IN THE CRITICAL AREAS AT KNH.

INVESTIGATOR: Jostine Ndunge Mutinda – 0722214819.

INSTITUTION: School of Nursing Sciences- University of Nairobi.

This informed consent form has two parts: Part1- Information sheet (to share information about the study with you) and Part 2- Signature sheet (to indicate whether you agree to participate or not).

Part1: Information sheet

Introductory statement: I am undertaking a research project to determine the ethical dilemmas experienced by nurses working in the Critical care areas at Kenyatta National Hospital. The research is in fulfillment of the requirement of the award of a degree in Master of Science in Nursing (critical care). The reason for giving you this information is because I want you to participate in the research. If you agree to participate you will be required to sign the signature sheet provided as a sign of your consent. If you prefer not to participate you are free to do so. If there is anything which you do not understand in the questionnaire you are free to seek for clarification from the investigator.

Importance of the research: This study is aimed at determining the ethical dilemmas experienced by the nurses working in the critical care areas at KNH. Any gaps knowledge gaps/problems identified in their ethical decision making process will help in making recommendations for improvement of the hospital's policies on ethical decision making. Recommendations may also be made for further training of the nurses on ethical decision making if need is identified.

Who can participate? All the nurses working in the critical care, burns and the renal units who will agree to participate and sign the consent forms will be eligible to participate. The participants will be employees of KNH who will be on duty during the time of the research. Participation is voluntary.

Permission and ethical approval: Permission to conduct this study has been granted by the KNH administration and ethical approval by the KNH/ UON ERC. The assistant chief nursing officer in charge of this unit has allowed the study to be conducted on the nurses working in this unit. A research permit has been obtained from the Ministry of higher education science and technology.

What the study involves: This study will take seven weeks starting from the day data collection commences. It involves interviewing nurses working in the critical care units (ICU, renal and burns Units). Participants will be recruited randomly from the three departments. If you agree to participate in the study you will be required to sign an informed consent form. You will be issued with a forty five item self administered questionnaire requesting you to give information on the ethical dilemmas you face while working in your area of deployment and how you resolve them. Pretesting of the questionnaires which will take one week will be done on nurses working in the emergency ward of the Accident and Emergency department of KNH. Participants will be required to provide the information required by filling in the questionnaire as truthfully as possible.

Confidentiality: Any information collected from you will have a number and you are not required to indicate your name on the questionnaires. The number will only be known to the investigator and no information should be shared among participants. Ever information given will be treated with confidence and there will be no victimization.

Handling of the results: The results of the research will be shared with you upon request and the stake holders. The results will then be published so than those interested can learn or do further research in the field.

Risks and benefits of participation: There are no direct benefits to you as a participant and you will not be given any compensation. The study may however benefit KNH and the nurse training institutions. The results of this study may aid in making recommendations for shaping of the syllabus for training of the critical care nurses on handling of ethical issues in critical care. If any gaps are identified in the ethical decision making process recommendations will be made for improvement on the procedure as well as continued professional development for the nurses on ethical decision making. There are no risks associated with participating in this research and confidentiality is guaranteed. Any issues arising in the process of the study will be appropriately addressed where possible and confidentiality guaranteed.

Rights of the participants: Your participation is voluntary and you may agree or refuse to participate in the research. You are at liberty to withdraw at any stage without any coercion or victimization.

Contact person: For further clarification or if in doubt kindly contact:

The secretary KNH/UON – ERC

P.O. Box 20723

Nairobi.

Tel. 2726300-9 (ext. 44102).

Part 2: signature sheet

This is to certify that I…… …….. have read and understood the contents and implications of the consent I am required to give and do agree to participate in the research study of Jostine Ndunge Mutinda on ethical dilemmas experienced by nurses working in the critical care units of KNH.

I understand that the research will take seven weeks (one week for pretesting of the questionnaires) and will involve filling in of questionnaires. It is voluntary and there will is no compensation for participating, no risks will be involved in the study and I may withdraw any at any point.

I hereby append my signature as a sign of my agreement to participate in the research titled, Ethical dilemmas experienced by nurses working in the critical care areas at KNH.

…… ……

Signature of the participant. Date.

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
(254-020) 2726300 Ext 44355
Ref: KNH-ERC/A/142

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KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi
30th May 2012

Jostine Ndunge Mutinda
School of Nursing Sciences
College of Health Sciences
Kenyatta University

Dear Jostine

Research proposal: "Ethical Dilemmas experienced by Nurses in the Critical Care Units in Kenyatta National Hospital" (P78/02/2012)

This is to inform you that the KNH/UoN-Ethics & Research Committee (ERC) has reviewed and **approved** your above revised research proposal. The approval periods are 30th May 2012 to 29th May 2013.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH/UoN ERC before implementation.
c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH/UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH/UoN ERC within 72 hours.
e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f) Clearance for export of biological specimens must be obtained from KNH/UoN-Ethics & Research Committee for each batch of shipment.
g) Submission of an *executive summary* report within 90 days upon completion of the study
This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

For more details consult the KNH/UoN ERC website **www.uonbi.ac.ke/activities/KNHUoN**

Yours sincerely

PROF. A.N. GUANTAI
SECRETARY, KNH/UON-ERC

c.c. The Deputy Director CS, KNH
The Principal, College of Health Sciences, UoN
The Director, School of Nursing Sciences, UON
The HOD, Records, KNH
Supervisors: Miriam A Wagoro, School of Nursing Sciences, UON
Mrs. Theresa Odero, School of Nursing Sciences, UON