Ethical decision making among psychiatric high and intensive care nurses when confronted with moral dilemmas in daily practice, a grounded theory approach

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Abstract

Title

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Background

Acute psychiatry in the Netherlands is currently shaped as secluded high- and intensive care wards (HIC). Crucial to the HIC wards is an emphasis on empathy and contact with the patients, providing a safe and benign environment for recovery. Consequently, the use of coercion and restraint is limited. An environment of empathy and contact, may be at odds with the provision of safety. Nurses are faced with these dilemma's on a daily basis and can hence have a substantial effect on the patient's wellbeing and recovery.

Aim

To provide a theory of ethical decision making of nurses working on HIC wards when they are confronted with ethical dilemmas in daily care

Methods

A constructivist grounded theory methodology was used. A total of fourteen nurses in active duty were interviewed. Participants were recruited from a sample of HIC wards throughout the Netherlands.

Results

A model of ethical decision making emerged comprised of three elements. 1) The values regarding good care as held by the nurse, 2) the context within which nurses have to act, 3) the dynamics between these values and the context of everyday care. This dynamic affects the autonomy to act, limited autonomy is experienced as burdensome. Emotions can motivate to act.

Conclusions

Ethical decision making in daily practice is complex, highly personal and often burdensome. Nurses should be aware of this complexity within themselves to make better decisions and to relieve the burden

Implications of key findings

Ethical reflection, particularly regarding the intricacies of ethical decision making in daily care, remains imperative on the ethically challenging wards that HIC wards are.

Key words

Nursing, acute psychiatry, hermeneutic ethics, ethical decision making, grounded theory

Samenvatting

Inleiding

Acute psychiatrie is in Nederland georganiseerd als high- en intensive care afdelingen (HIC). Een HIC afdeling is een gesloten afdeling waar patiënten in acute psychiatrische crisis worden opgenomen en behandeld. Cruciaal binnen de HIC-visie is om vanuit empathie en contact een herstelgericht klimaat op de afdeling te handhaven. Dit kan echter op gespannen voet staan met het waarborgen van veiligheid. Verpleegkundigen worden dagelijks geconfronteerd met dilemma's waarbij contact en herstel tegenover veiligheid staat. In dit onderzoek is onderzocht op welke wijze verpleegkundigen in dat soort gevallen een beslissing nemen.

Resultaten

Voor verpleegkundigen zijn de eigen waarden over wat goede zorg is leidend in wat voor hun een goede beslissing is. Verder treden veelal ook emoties als medelijden, angst en machteloosheid op. Deze emoties vertellen de verpleegkundigen dat hun eigen waarden worden aangetast en bieden ook een richting voor een beslissing. Vaak worden verpleegkundigen gehinderd in het nemen van een beslissing door het behandelbeleid, de wet of andere regelingen. Dit levert dan emoties op als boosheid en machteloosheid.

Conclusie

Dit onderzoek laat zien dat ethische besluitvorming een genuanceerd proces is en daarom is het belangrijk om hierop te reflecteren. Het is laat zien dat het nuttig is om op de eigen waarden te reflecteren, maar zeker op de rol van emoties die immers altijd een rol lijken te spelen. Het geeft ook aan dat er aandacht op de afdeling voor de soms machteloze posities van verpleegkundigen moet zijn. Dit suggereert ook dat de verpleegkundige rol wellicht nog meer emancipatie behoeft.

Introduction

Reduction of coercion and restraint in psychiatry has gained considerable and lasting attention within mental health care practice, and collaboratively, in science as well[12]. In the Netherland, the methodology of high- and intensive care (HIC) in acute mental healthcare has been widely implemented to answer the question on how coercion and restraint can actually be reduced[3]. HIC is a methodology shaping treatment and care on acute general mental health care wards. At the core of HIC is a set of values derived from care ethics directing development of interventions, culture, attitude of professionals and the built environment[1,3]. Basic concepts of the ethical core are contact with the patient, hospitality and focus on recovery[1,3]. Adherence to the HIC methodology results in constructive therapeutic alliances, even in intense emotional situations, reducing the need for coercion and restraint. Furthermore, coercion and restraint are explicitly counter the ethical core of HIC, motivating health care professionals and scientists alike to uphold the core principles of HIC[3].

Nurses can be regarded as the main providers of care within the HIC framework[3]. It is their task to establish and 'be' the climate necessary to engage in sustainable and recovery oriented relations with patients[3]. This task is however challenged by the unpredictable and potentially harmful behaviour of patients in crisis, causing potential tension between the HIC principles and actual practice[1,4,5]. I.e. the values of contact, cooperation and hospitality may be challenged in the face of crisis when the nurse may uphold values such as the provision of safety and non-maleficence. This conflict in itself may result in moral and emotional stress and when not properly addressed in application of coercion and restraint.

In this article the HIC ward is assumed to be a forcefield of paradoxical moral values in an unpredictable and potentially harmful environment. Nurses are hence daily confronted with smaller and bigger ethical dilemmas. Decisions in these situations should be swift due to the nature of the ward, yet should also uphold the core principles of HIC. Moreover, the true value of the HIC framework must also show in the 'messiness' of the moral forcefield of daily practice.

The reduction of coercion and restraint is not merely an instrumental issue, it is profoundly ethical[1,2,6–910], moreover, ethical reflection has shown to function in projects reducing coercion and restraint[2,11–13]. In this research, the HIC-ward is understood as being a forcefield of moral paradoxes with daily practice being drenched with these paradoxes. It is consequently hypothesized that ethical reflection on daily practice may improve decision making, increase quality of care and ultimately reduce the use of coercion and restraint. A void in the literature regarding nurse ethical decision making in acute mental health daily

practice urges elucidation of this process. Under the assumption that nurses are being confronted with a breadth of ethical dilemmas and actual decision making in daily practice being complex, the process of ethical decision making in daily practice is the focal point of this inquiry.

The results of this inquiry may be of use in ethical reflection in the broad sense. It could provide a novel approach to the process of moral case deliberation. It could furthermore provide an evidence based approach to any other implicit or explicit form of reflection either in practice or education. The findings may aid in a raised moral literacy and consequently a reduction of the use of coercion and restraint. In turn, being a fundamentally empirical ethics inquiry[9,14], the results may add to the body of knowledge of care ethics related to psychiatry[15].

Aim

To provide a theory of ethical decision making of nurses working on HIC wards when they are confronted with ethical dilemmas in daily care

Methods

Design

This study follows a constructivist grounded theory methodology as outlined by Charmaz (2014)[16]. Constructivist grounded theory is appropriate for the analysis of any process within social contexts[16] and in this study moral motives and, which is the primary aim, are assumed to be socially constructed. Additionally, the constructivist approach acknowledges that the inquiry and the development of the theory itself take place within the social context[16]. This is also in line with the principles of hermeneutic ethics which considers direct experience as a source of moral wisdom[14] and nurses being faced with moral dilemmas in daily practice are the main source of data.

Study population

The domain is comprised of all nurses working on HIC wards in the Netherlands. Interview participants were recruited by means of purposeful sampling[17]. This research was conducted within the research group already involved in HIC research. Recruitment took place through the established contacts with all HIC wards of the research group, thus the study population coalesces with the domain. Participants volunteered upon a request within the nursing teams.

Inclusion criteria:

- Must be a registered nurse or have another relevant bachelor's degree
- Must currently be in active duty in clinical practice on a HIC ward
- Must have been employed on a HIC ward for at least one year

Exclusion criteria:

- Has an advanced degree in nursing
- Is part of management or treatment staff
-

Due to the qualitative researches demand for rich data and the iterative process in data analysis of the grounded theory approach, a wide variety of perspectives is called for[16,17]. This variety was achieved by theoretical sampling[16]. Feasible variables appeared to be the level of implementation of the HIC methodology on the ward and years of work experience of the individual participant.

All participants (n=14) were registered nurses on active duty on seven different HIC wards throughout the Netherlands. Demographic details below (table 1) show the diversity among the population, albeit rather crude to secure anonymity.

(table 1)

Data collection

Data collection took place by means of intensive interviewing which is deemed appropriate for in-depth exploration of the participants' experience of participants with first- hand experience[1617]. Participants were interviewed using an interview guide (appendix 1). Content of the interview guide was provided by interviewing key figures (n=3) in the HIC field, identifying current prevalent ethical themes. The interview guide was adapted during the period of data collection based on intermittent analysis of the interviews being held, this is in line with the iterative process of data collection characteristic for grounded theory[16]. The interviewer being a nurse in acute psychiatry easily provided mutual understanding and trust among the participants adding to the explorative nature of the intricate and often delicate processes at stake. Interviews were recorded and transcribed verbatim. Data collection last until data saturation[16] had been reached, a total of fourteen interviews were executed.

NVivo[18] was used to manage and analyse the data. Voids and questions raised in the emerging theory was elaborated on by means of theoretical sampling, advancing data collection based on the analysis so far[16]

Data analysis

Initial coding

Interview transcripts were initially read line by line and coded for minimal meaningful fragments[19]. According to Charmaz 2014[16] coding reflected action within the text, not only does this prevent the application of pre-existing categories, it also suits the action focused aim of this research. Sensitizing concepts concerning the process of ethical decision making aided in initial coding, but did not determine the content[16]. Initial codes gained prominence with the initial coding and constant comparison of subsequent transcripts, ultimately leaving other initial codes redundant.

Focused coding

Initial codes that came to prominence directed the emergence of focused codes. Focused coding identified the concepts entailing ethical decision making as reported by the participants. Constant comparison of the focused codes and acquired data added to the robustness of the focused codes[16,19]. Coding the las two interviews did not yield any new focused codes, hence it was concluded that data saturation had been reached[16,19].

Theoretical coding and theory formation

Theoretical coding was aimed at identifying relationships between the focused codes[16]. Temporalization within the deliberative process and the relative weight of the focused codes were a major focus. Constant comparison of raw data, initial codes and focused codes aided in the emergence of theoretical codes. Pre-conceived concepts were kept to a minimum aiming at a emergent theory. Theoretical coding provided consistency between the focused codes and meaning to the concepts with the focused codes. A theory of ethical decision making as grounded in the data, was consequently formulated.

Trustworthiness

Initial coding had been done by the first author. Focused coding and theoretical coding has been done within the research group on the basis of consensus. Understanding of the experiences of participants have been verified by member checking summaries of the interviews of all participants. The COREQ guidelines[20] were followed in reporting this research.

Ethical issues

The study was conducted according to the principles of the Declaration of Helsinki. In accordance with the Medical Research Involving Human Subjects Act (WMO), this study requires non-approval from the medical ethics committee concerning this act since no humans will be subjected to any kind of experimentation or any sensitive interviewing. This non-approval was obtained from the medical ethics committee of the VU medical centre. Provision of consent was obtained according to guidelines as set by the the medical ethics committee of the VU medical centre.

Results

The emerged grounded theory explains the deliberative process when a nurse is confronted with an ethical dilemma. Three main themes were found that comprise ethical decision making. 1) the values regarding good care as held by the nurse, 2) the context within which the nurse has to act, 3) the dynamics between these values. This dynamic results in either decision making, or the conclusion that a decision can actually not be made by the nurse.

The values regarding good care as held by the nurse

All participants reflect on their own values concerning good care. All claim the ambition to provide good care. However participants differ in what they think is good care. Empathy is most often mentioned. Contact with the patient, respect for autonomy, relieving suffering and honesty are mentioned commonly. Some participants seem to emphasize caring and others respecting autonomy, without being mutually exclusive. Bottomline is that all nurses are eager to give care according to their own values. In fragment 1 (table 2) a participant expresses the process of internalization of empathy over the years past.

The context within which the nurse has to act

The context within which the nurse has to act is comprised of all external factors affecting autonomous nurse agency. The medical staff is considered as being the most influencing external factor. In addition to the organization of care with its economical and legal constituents.

The medical staff is highly influential by determining the treatment to be provided and hence providing the framework for the nurse. Administration of medication, use of coercive measures or on the contrary, limiting intervention, are determined by the medical staff. Specifically these factors were mentioned as being highly influential regarding the freedom of the nurse to act.

The organization of care affects the nurse predominantly by managing admission and discharge. This means effectively which patients are present on the ward. HIC wards have few admission criteria so admission can be low level. The HIC ward may actually not be the best place for some, and additionally discharge may be problematic. This may result in a deadlocked treatment and consequently any provided care may be experienced as futile or even harmful.

In fragment 2 a participant expresses being guided by the medical staff despite having mentioned the view on a patient by the nursing staff.

Dynamics between own values and the context

The context provides the boundaries for the nurse to act within. These boundaries may be such that the nurse can actually provide care according to their own values, no tension is consequently experienced. Most participants however report the contrary, i.e. there is a conflict between their own values and the limitations from the context. The nurse feels restricted and can not act according the own values, the medical staff may also order an intervention counter the own values of the nurse. Both situations result in moral tension that is experienced emotionally. Common emotions are anger towards this external guidance, frustration of having to ignore their own values, violating the patients' values and the suffering of the patient as a result. This moral tension seems to perpetuate nurse agency on HIC wards.

In summary, three levels of freedom of agency can be distinguished 1) the nurse has the freedom to act according their own values, 2) the nurse is refrained from acting according their own values , 3) the nurse has to act against their own values. All three levels differ in their dynamics and hence ethical decision making, this will be outlined below.

<u>Nurse has the freedom to act according their own values</u>

The nurse has full professional autonomy to make a decision, not guided by external factors. Ethical decision making appears to have three major constituents. The own values regarding good care, the emotions involved and assessment of consequences.

Experienced emotions are mostly the result of suffering of the patient or any risks involved emanating from psychiatric crisis. Fear, pity and sympathy are common emotions in these situations. These emotions seem to fulfil at least two functions. It sensitizes the nurse that any of its values are violated and it motivates the nurse to act accordingly. Emotions may, or may not be in balance. Strong emotions may overwhelm the values.

Consequences are always taken into account. A decision based on values is more likely when consequences are limited. Conversely, avoidance of (potential) harmful consequences may ignore other values such as autonomy and/or integrity. More experienced participants report to uphold values of contact and autonomy in the face of any imminent risk of adverse outcomes.

In fragment 3 a participant expresses a decision made involving an acceptable risk in favour of recovery.

In fragment 4 a participant expresses a decision made violating the integrity of the patient in favour of breaching an enduring crisis.

Nurse is refrained from acting according their own values

The next step in the decline of freedom to act is when the nurse is confronted with a conflict with their own values, with acting barred by external factors. Either the medical staff, the law, or the organization of care cause a situation in which this dynamic occurs. This results in emotions of anger towards the external factors barring agency and frustration and powerlessness regarding their own situation. This is accompanied with emotions of pity and sympathy towards the patient, whose situation the nurse wants to improve, but cannot do so. Experienced emotions are strong and are consequently strong motivators in acting. In fragment 5 a participant expresses anger towards being withheld from acting.

However, options are limited and initially do not meet their own values. The nurses' own values might actually play a role by making the best of the situation, albeit rather constrained. This could towards the patients be by dealing with the situation despite its confines or by negotiating with the external factors. Another option is to claim autonomy and act according their own values anyway. Thereby breaching the external factors that initially barred agency, i.e. ignoring directions of the medical staff, the law or any other rules and regulations. Inherent to this situation however is the impossibility to act according to the own values which entails a perpetual tension that nurses report to find hard to cope with. Perpetuation of this dynamic does not seldom result in decline from the profession.

Nurse has to act against own values

The playground of the nurse has now shrunk as far as being left in a mere executive role. Effectively the medical staff orders a certain intervention, and the nurse has to comply. Significantly, these orders are counter the nurses' own values. Nurses generally oppose these orders referring to a perceived (by the nurse) negative impact on the patient at stake. Emotions of anger, frustration and powerlessness are now dominant over emotions of pity and sympathy towards the patient. In fragment 6 a participant expresses the tension within herself when she might had to administer medication forcefully to an otherwise cooperative patient.

Often this bridge is not gapped and the nurse complies, reinforcing these emotions. Others may claim authority by neglecting the orders given. This is however potentially at the expense of the professional relationship within teams, disciplinary measures or ultimately

discharge. In fragment 7 a participant expresses the intention to ignore a given order by the psychiatrist and additionally the willingness to face any consequences:

These situations typically reinforce the feeling of the nurse as being merely executive. This might be accepted as a fact and hence alleviate tension. On the contrary it might perpetuate a sense of powerlessness resulting in decline from the profession.

(table 2)

Discussion

Main findings

As apparent from the literature, this research provides the first account on nurse ethical decision making in daily practice in acute mental health. Grounded theory puts "action central, and creating abstract interpretive understanding of the data"[16]. Thus the emerged theory does not merely describes ethical decision making, it explains why nurses act as they do. Nurses are primarily guided by the own values concerning good care. These own values act as a reference point on which the patients' situation and the actual care they have to provide are being judged. Dissonances occur when the patient is in misery or when nurses cannot act according their own values. These dissonances are experienced emotionally. Misery of the patient is inherent to psychiatric crisis. The impossibility to act according one's own values appeared to be explained largely by directives from the medical staff and regulations. This provides a perpetual moral tension. All core elements of this model can be related to the literature on (nurse) moral agency as will be shown next.

Comparison with literature

The process of ethical decision making starts with the nurses' own values regarding good care. The willingness to care, contact with the patient and empathy are all fully in line with the normativity of care ethics[21]. The prevalent principles of non-maleficence and autonomy are in line with 'classical' medical deontological ethics as formulated by Beauchamp and Childress[22]. These values and principles could be thought of as the static reference point of ethical decision making. Being confronted with an ethical dilemma triggers a response, the nurse has to act. Two models have been put forth to explain the subsequent deliberative process which will be assessed in the light of the findings in this research. The first is the situationist intuition model[23](SIM), the second the theory of moral emotions as formulated by Nussbaum[24].

The SIM has been proposed to model moral judgement in psychiatric nursing[9]. This model assumes moral judgement to be primarily a matter of intuition upon exposure to any moral problem. A rational explanation of the decision made is provided afterwards[23]. The proposed model in this article adds to the SIM by taking moral intuition into account by the identification of the role of emotions. Moreover, the proposed model in this article also provides an explanation why emotions occur. The background of this explanation is brought up by Nussbaum in her theory of moral emotions[24]. A moral emotion is aimed at another person

who in this case is in distress. Through empathy the nurse senses this distress and contrasts this with the own values, i.e. the intention to relieve suffering and to do good, i.e. to care[21]. The emotion thus risen could be thought of as having a cognitive-evaluative content according to Nussbaum, i.e. the emotion is a form of thinking[24]. This dynamic explains the process of ethical decision making as emerged in this grounded theory. It also explains the occurrence of moral tension when confronted with ethical dilemmas, which had been documented thoroughly as an innate phenomenon of nursing, i.e. moral distress.[25]

Moral distress has been defined as suffering when one has to act in a way that is inconsistent with one's deeply held values, principles or commitments[2625]. This is evident from the results of this study. Moreover, it seems that the practice of acute mental health medicine may be at odds with a nurse ethic. I.e. coercion is a key theme as expressed by the participants, but coercion seems to be inconsistent with empathy, contact and integrity. Psychiatric nursing has some tragic tendencies in that respect. Moral agency (autonomy to act), moral imagination (acknowledging the patient's needs) and moral community (being part of a morally conscious community) have been proposed as antidotes to moral distress[27,28]. Particularly the lack of moral agency and moral community seems to explain the moral distress as expressed by the participants. These themes also provide a direction to mitigate moral distress on HIC wards in general.

Strengths and limitations

In data gathering it appeared beneficial that the interviewer is also a nurse in acute psychiatry, in depth exploration of the subject was thus feasible. A demographically diverse sample was achieved. This may in general be efficient in qualitative research[29], it is however merely assumed that demographic diversity translates into diversity on viewpoints at the process at stake, ethical decision making. All participants do have however thorough experience with this process.

Weaker points of this research are the participation upon a request dropped in teams. Nurses sympathetic towards the subject are probably more prone to apply, likely causing a bias in the results. However, the impression of the author is that most nurses are sympathetic towards ethical reflection anyway.

Implications for clinical practice and/or future research

Ethical reflection has shown to result in an increase of the moral conscience and also in the reduction of distress regarding ethical dilemmas[3022717]. This research show the intricacies involved and could therefore provide a novel approach to ethical reflection. This could be by the use of moral case deliberation or other forms of support. Consequently, moral distress is to be decreased and ethical decision making may improve.

The findings of this research also suggest the HIC ward to be a truly multi-disciplinary effort. Adoption of any intervention is likely higher when nurses have had a fair share in the decisions made. They are the ones to assess their own strengths and weaknesses when dealing with patients twenty-four hours a day. Nurse practitioners could be particularly well able to relay between nurses and the medical staff.

Future research may show the effects of ethical reflection on both nurse directed outcomes (burden) and patient directed outcomes (e.g. reduction of coercion and restraint, satisfaction).

Conclusion

The findings of this research shows that ethical decision making is complex, highly personal and often burdensome. It is a complexity of the own values, emotions and ultimately one's own course of life. Nurses should be aware of this complexity within themselves to make better decisions and to relieve the burden. This underlines the importance of moral competency of the nurse and the moral climate of the ward.

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Tables

Table 1. Demographics of participants

Gender	Age	Years of service
Male	30-40	>10
Male	50-60	>30
Female	20-30	5-10
Male	20-30	<3
Female	40-50	<3
Female	40-50	>20
Male	20-30	<3
Male	40-50	>20
Female	50-60	>20
Male	40-50	>10
Female	20-30	<3
Female	20-30	<3
Female	50-60	>20
Male	40-50	>20

Table 2. Quotes as referenced to in the results section

Fragment*	Quote
1	*"Because it is just so much more friendly, and I also, I grew older myself, I much more thought like what if this would be my brother/sister/father/mother/child, then I would someone to be nice to them, even if that person is completely mad"*
2	*"Yes, that is where the decision is ultimately made, which direction to take, and even though we referred to our own experience [with that patient] multiple times, the discussion ceases at some point, I will not cross that line by acting against that decision"*
3	*"… and know it's healthy for you to take responsibility for yourself, and I am for 95% certain that it'll go well, you obviously take a small risk, and that was also based on the good contact we had before…"*
4	*"Yes, to prevent worse from happening so to say, but you actually act against his will, he asks us to get the hell out…"*
5	*"Euhm, mosty I was angry, because I was convinced that we could have avoided it by working more thoughtful, which also makes me motivated in seeking means to make this process more efficient"*
6	*"…a sort of conflict of conscience, we have cooperated fine for weeks, had a nice contact, nothing bad happened between me and him and then I should forcefully administer medication…"*
7	*"Yes, so why I would stand up and why I would engage a conflict with the psychiatrist, well, yes, because I think it is the only way to get out of the minefield we entered together"*
8	*"She was so vulnerable and the abu…, it was obvioulsy abuse, that, my healthcare heart, but also just my human heart, is very… a feeling, I couldn't stand it. I thought I had to protect her, against that."*

*Fragments are not visibly linked to individual participants to secure anonimity

Appendix 1 Interview guide

Can you describe a situation in which you felt confronted with an ethical dilemma?

What comprised the dilemma?

Which values were at stake?

Can you describe how you eventually made a decision?

Which pro's and cons crossed your mind?

What was the deciding argument for you?

What made the other arguments to be less important?

Back to the deciding argument, what was the reason why this argument had to be the final argument?

Can you describe a situation in which you had the impression that a moral boundary was crossed?

Which values were at stake?

From what was apparent that a moral boundary was crossed?

How did you react?

Can you explain your reaction?

Ethical themes:

- Seclusion
- Forced medication
- Compliance to rules
- The power of the nurse
- Taking risks