

***ETHICAL DECISION MAKING BY REGISTERED NURSES
IN A BUREAUCRATIC CONTEXT***

by

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DECLARATION

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I declare that **ETHICAL DECISION MAKING BY REGISTERED NURSES IN A BEURACRATIC CONTEXT** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

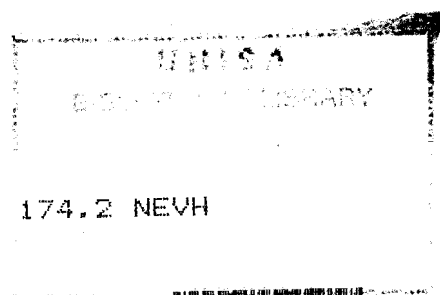
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SUMMARY

ETHICAL DECISION MAKING BY REGISTERED NURSES IN A BUREAUCRATIC CONTEXT

| | | |
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The purpose of the study was to highlight the impact of bureaucracy, ethical principles, socio-cultural, religious and occupational factors, and selected demographic variables (such as age, gender, status, and education) on ethical decision making.

A quantitative survey was used to investigate the factors which influence ethical decision making in a bureaucratic context. The study was limited to all the hospitals in the Northern Region of the Northern Province in the Republic of South Africa.

The structured results indicate that registered nurses are aware that bureaucracy and occupational factors affect their ethical decision making. Culture and religion also influence their ethical decision making, but educational status and position do not influence ethical decision making. Recommendations based on the findings are given. The need for bio-ethic committees in hospitals to guide nurses in ethical decision making is highlighted.

KEY TERMS

Autonomy, beneficence, bureaucracy, ethical decision making, ethical principles, fidelity, justice, non-maleficence, registered nurse.

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“To our God and Father be glory for ever and ever Amen” (Philippians 4:20)

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LIST OF ABBREVIATIONS

| | | | |
|---|----------|---|--|
| ❖ | AIDS | : | Acquired Immuno Deficiency Syndrome |
| ❖ | AFM | : | Apostolic Faith Mission |
| ❖ | AME | : | African Methodist Episcopal |
| ❖ | ANA | : | American Nurses Association |
| ❖ | DENOSA | : | Democratic Nursing Organization of South Africa |
| ❖ | f | : | frequency |
| ❖ | HIV | : | Human Immuno Deficiency Virus |
| ❖ | HOSPERSA | : | Health and Other Service Personnel Trade Union of South Africa |
| ❖ | ICU | : | Intensive Care Unit |
| ❖ | n | : | The number of different categories that responded to an item |
| ❖ | N | : | Total number of respondents |
| ❖ | NEHAWU | : | National Education Health & Allied Workers Union |
| ❖ | OPD | : | Out Patients Department |
| ❖ | TOP | : | Termination of Pregnancy |
| ❖ | UAAC | : | United African Apostolic Church |
| ❖ | ZCC | : | Zion Christian Church |

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CHAPTER 1

ORIENTATION STATEMENT OF THE PROBLEM, OBJECTIVES AND THEORETICAL FRAMEWORK

1.1. INTRODUCTION

There has been a rapid increase in the utilization of science and technology in health care. Pera and Van Tonder (1996:29) assert that nurses have to cope with various ethical issues and dilemmas which arise from scientific and technological progress, and that nurses are faced with a high level of responsibility for ethical decision making. Scientific and technological progress has also changed the patient's expectations.

Traditionally, doctors were viewed as sole decision makers regarding the treatment and care of patients but nurses, administrators, unions, families, patients' rights representatives and lawyers now claim a voice in making health care decisions (Bandman & Bandman 1995:98). With the twelve-point document regarding patients' rights in South Africa, ethical decisions to protect the rights of patients have become even more important. Especially so, as patients' rights to participation in decision making in matters affecting their health is mentioned specifically (Nursing Update 1999/2000:36).

The role of the nurse is also being redefined. The paternalistic attitude of health care professionals who view themselves as authoritative figures with the best knowledge is no longer appreciated and is now less acceptable. Patients and families expect that professionals will share their knowledge regarding the nature of illness, diagnostic procedures, proposed treatment and costs involved, with them as the basis of informed consent.

There might be problems in assuming an increasing responsibility for ethical decisions if nurses are functioning in a bureaucratic hospital hierarchy where they are caught in the middle of two quite different role models, the professional and the bureaucratic models. It appears that nurses would have loyalty problems in relation to their bureaucratic and professional functions.

1.2. STATEMENT OF THE PROBLEM

Registered nurses who work in state health institutions are confronted with ethical dilemmas and it seems difficult to make ethical decisions in a bureaucratic context.

Nurses have an ethical obligation to the patient, the physician and the institution. In a bureaucratic environment of health services they, however, find it difficult to function as professional practitioners when making ethical decisions, at the same time heeding the expectations of the employer. This results in the nurse coming into conflict with the pledge of putting the patient's total health first. To highlight this problem the views of some authors on this matter are given below.

According to Sullivan and Decker (1992:7) the hierarchical nature of hospitals often provides a work environment in which nurses find it difficult to function simultaneously as both professional practitioners and employees. This could be because the primary focus in a bureaucratic organization is individual productivity and proper allocation of work to people. Nurses have an ethical obligation to the patient, to the physician, and to the institution in which they work (Davis & Aroskar 1983:50). In a bureaucratic structure nurses are expected to place the organization's goals before their own; the nurses' loyalty to patients, employers and themselves may be divided because of pressure from their conflicting obligations (Ellis & Hartley 1992:217 and Morrison 1993:202). These conflicts between patients, health care professionals and / or institutions have resulted in ethical dilemmas in bureaucratic health care institutions because the emphasis is on the rules and regulations of the institution (Chitty 1993:373). The above mentioned statement has also been supported by Rumbold (1993:105) who asserts that more problems arise because most nurses are employees of a hierarchical Health Authority and they have obligations to their employer.

It will only be possible for nurses to make ethical decisions in a bureaucratic context if the goals of the institution, the values and beliefs of nurses, other health professionals and patients can come to some compromise. The main objective should always be to make decisions, which will

be to the benefit of the patient first of all, then to the institution. The high cost of health services to both the patient and the health authorities cannot be ignored.

1.3. BACKGROUND OF THE PROBLEM

According to Rumbold (1993:153) nurses were seen as not having the slightest hint of what ethical autonomy entails. Previously, nurses were seen as subservient to doctors and agents of bureaucracy. They were seen as good if they obeyed the doctors' instructions without question and were expected to carry out decisions made by others. They could not challenge the decisions made by others (Bandman & Bandman 1995:98). Nurses are now becoming more aware of their professional status as advocates to patients and want to be part of ethical decision making in caring for their patients. Conflicts exist between the authority of nurses as professionals and the professional authority of physicians because many physicians are reluctant to accept other professionals, and particularly nurses, as colleagues (Maas & Jacox 1977:172).

Jolley and Brykczynska (1993:62) assert that nurses have a low status, because caring as compared to medicine is seen to be non-scientific and non-technical work. Nurses are found somewhere near the bottom line of professional and institutional responsibility. Because of nurses' relatively low status in the bureaucracy, they have often been called upon to carry out decisions made by others without the benefit of participating in the process and understanding why such decisions were ordered (Thompson & Thompson 1990: 63-64).

Kramer and Schmalenberg (1976:19-23) have described conflict as destructive if those with authority attempt to maintain or change things through the use of threats or coercion. Conflict comes from a bureaucratic source if the superior attempts to influence the autonomous behaviour of the subordinate using authority which is based on the occupation of a senior position in a bureaucratic system (Mauksch & Vessen in Snyder 1982:301).

Since hospitals and health authorities are hierarchical and bureaucratic institutions, “The relationship between employee and employer is one of contract obligation, not one of consensus; it is formal, not friendly” (Tschudin 1992:112). All of these issues influence the nurses’ ability to make ethical decisions in the best interest of the patient, as division of labour, hierarchical structure, rules and regulations have to be adhered to.

Problems do exist when nurses are employees of bureaucratic structures since they have many responsibilities towards patients, doctors, and employers. Regardless of these multiple obligations, nurses are expected to have the responsibility to cope with numerous ethical issues and dilemmas in the health care situations (Pera & Van Tonder 1996:29). If nurses are not guided to, or not allowed to, make ethical decisions in this bureaucratic environment, they are not able to competently perform their duties.

It has been the researcher’s experience as a professional nurse in one of the public hospitals in South Africa that the image of the nurse as subservient to doctors, as having a low status in the hospital’s hierarchy, as one who obeys the doctors’ instructions without questions, has not changed to the extent that one could say that nurses in a bureaucratic context or institutions are autonomous independent practitioners who are freely involved in ethical decision making.

Most decisions are still made at the top of the hierarchy by those with authority. Nurses are still regarded as good if they do not question the doctors’ decisions. Some nurses are even disciplined or regarded as aggressive if they question the decisions made by those with authority. Some are afraid to question the decisions for the sake of protecting or securing their jobs or positions.

1.4. OBJECTIVES OF THE STUDY

The objectives of the study are to:-

- determine the bureaucratic factors which influence ethical decision making in a bureaucratic context;
- identify ethical principles affecting ethical decision making;

- identify socio-cultural, religious, and occupational factors which influence ethical decision making; and
- determine the influence of the selected demographic variables (age, employment status, and education) on ethical decision making.

If the above-mentioned objectives are met, the bureaucratic, socio-cultural, religious and occupational factors, which hinder ethical decision making, could be avoided or controlled, and those that enhance it could be promoted. Nurses could also make use of ethical principles as guidelines for making ethical decisions.

1.5. RESEARCH QUESTIONS

The research questions are as follows: -

- To what extent does bureaucracy influence ethical decision making?
- What is the impact of ethical principles on ethical decision making?
- How do socio-cultural, religious, and occupational factors influence ethical decision making?
- To what extent do demographic variables (age, status and education) influence ethical decision making?

1.6. DEFINITION OF CONCEPTS

It is necessary to define concepts applied in the context of the study in order to enhance the common understanding of the subject.

1.6.1. Autonomy

Autonomy implies the freedom to make choices and decisions about one's care without interference, even if those decisions are not in agreement with those of the health care team (Husted & Husted 1995:57, and Zerwekh & Claborn 1997:353).

1.6.2. Beneficence

The principle of beneficence implies the duty to actively do good for patients (Searle & Pera 1995: 140-141).

1.6.3. Bureaucracy

Bureaucracy is an organizational structure characterized by division of labour, hierarchy, rules and regulations, emphasis on technical competence, appointment by seniority and impersonal relationships between management and workers (Marquis & Huston 1994:32).

1.6.4. Ethical decision making

Ethical decision making in nursing is the purposeful mental and spiritual judgement of the nurse/midwife in order to perform a moral act and to justify or account for such an act according to her/his moral values, responsibilities and obligations (Muller 1996:90).

1.6.5. Ethical principles

Ethical principles are action-guides for normal decision making and are important elements in professional practice. They provide guidance for thinking or acting in order to determine what should or should not be done in particular situations (Pera & Van Tonder 1996:21).

1.6.6. Fidelity

Fidelity implies the duty to be faithful to commitment, and it incorporates keeping promises, keeping secrets and truth telling (Hall 1996:338, and Zerwekh & Claborn 1997:354).

1.6.7. Justice

The principle of justice in health care relates to allocation of resources and fairness. It is an obligation to be fair to all people (Ellis & Hartley 1992: 209, Rumbold 1993:177, Chitty 1993: 36, Searle & Pera 1995:142, and Pera & Van Tonder 1996:24).

1.6.8. Non-maleficence

The principle of non-maleficence implies the duty to prevent or avoid doing harm, whether intentional or unintentional (Zerwekh & Claborn 1997: 353-354, and Searle & Pera 1995: 140-141).

1.6.9. Registered nurse

A registered nurse is a person registered under the section 16 of Act 50 of 1978 as amended (Searle & Pera 1995:91).

1.7. SIGNIFICANCE OF THE STUDY

The proposed study will summarise present knowledge through the literature study, which will contribute to the body of knowledge in nursing, since registered nurses on a daily basis encounter situations in which they must make judgements, decisions and act on them (Oermann 1991:228). The study will empower registered nurses to make ethical decisions in an autonomous manner, since they are increasingly viewed by the public and themselves as patients' advocates, who help patients gain better understanding, better health and more control of their participation in health care (Bandman & Bandman 1995:109).

The study will also look at the strategies that can be used to enhance or improve ethical decision making by registered nurses in a bureaucratic context. The study will emphasise the formation of ethics committees that could guide nurses when making ethical decisions.

1.8. THEORETICAL/CONCEPTUAL FRAMEWORK

The organizing framework on which the study is based is the perspective of principlism. Principlism according to Deloughery (1995:230) is the orientation which incorporates duties, rights and principles emanating from deontological theories. Deontology embraces “the concepts of duty and the inherent rightness or wrongness of actions” (Oermann 1997:218). Respect for persons and confidentiality is also deontologically based. Hanford (1993) in Tschudin (1994 (a):129) describes principlism as “the practice of using principles to replace moral theory, rules and ideals in dealing with moral problems arising in clinical practice”.

The principles which are accepted in the field of bio-ethics include autonomy, beneficence, non-maleficence and justice. When ethical decisions are made the autonomy of the patients to decide on their own destiny in matters of health and illness must be kept in mind, as they have the right to make choices based on their own values and beliefs.

The nurse, however, is responsible to provide the patients with the information they need to make an informed decision. The national patients’ rights charter for South Africa emphasises this right to information (Nursing Update 1999/2000:36). Searle (1991:279) asserts that nurses should be in possession of clear information as to their duties and obligations towards society, their employer, the patients, co-workers, subordinates and students or other learners in the health profession, to enable them to give full and accurate information to all involved in decision making.

With regard to beneficence, the primary obligation of the nurse is to provide benefits to the patients, considering benefits against the harm that could be incurred by the patient. All decisions should be assessed as to whether the benefits outweigh any harm that could result. Doing no harm is a priority over and above beneficence and therefore, non-maleficence is seen separately from doing good. The equal distribution of health care, according to the needs and rights of patients, relies on the principle of justice (Deloughery 1995: 230-232). Access to health care is another right of patients which can lead to increased numbers of ethical decisions by nurses,

especially as patients should receive timely emergency care, regardless of the patient's ability to pay (Nursing Update 1999/2000:36).

Respect for patients and confidentiality is also entrenched in the national patients' rights charter. All information concerning a patient's health and treatment can only be disclosed with informed consent. Patients are also free to refuse treatment and ask for a second opinion and nurses should respect the patient's choice (Nursing Update 1999/2000:36).

If nurses want to be autonomous and patient-centred, they should take risks and not go and ask other people what to do, and they should avoid making decisions that will not suit the patient (Mashaba & Brink 1994:134). Nurses will have to be guided by the principles of bio-ethics in making ethical decisions to protect the rights of patients.

1.9. SUMMARY

The aim of this chapter is to present a clear background to the problem under investigation. It has included the introduction, statement of the problem, background of the problem, objectives of the study, research questions, theoretical framework, and the significance of the study.

The majority of nurses work in a bureaucratic setting, and they should be prepared to participate in ethical decision making and debate in order to constantly advocate the wellbeing of the patients. The guidelines on patients' rights as launched by the Minister of Health in South Africa, will increase the responsibility of making ethical decisions in the health services.

1.10. PLAN OF THE STUDY

- Chapter 1: Concentrates on the exposition of the problem, the research objectives and questions, and explanation of the concepts.
- Chapter 2: A literature review was undertaken to examine the bureaucratic factors which influence ethical decision making, the impact of ethical principles on ethical decision making, and the socio-cultural religious and occupational factors which

influence ethical decision making. This served as a basis for the research instrument.

- Chapter 3: Concentrates on research methodology and the gathering of data; the development of the research instrument is discussed and ethical aspects of data gathering highlighted.
- Chapter 4: The data analysis and findings are displayed in graphs and tables. Findings are verified using a literature control.
- Chapter 5: The conclusion of the study is presented and checked against literature using the objectives of the study. Recommendations are made as to how ethical decision making in a bureaucratic context can be enhanced.

CHAPTER 2

REVIEW OF LITERATURE

2.1. INTRODUCTION

This chapter reviews the literature relating to ethical decision making by registered nurses in a bureaucratic context. The literature is divided into three major sections. The major areas are the bureaucratic factors which influence ethical decision making; the impact of ethical principles on ethical decision making; and the cultural, religious and occupational factors which influence ethical decision making.

Making difficult complex ethical decisions is an inherent part of the practical nurse's role. Ethical conduct is an individual and personal matter and nurses should therefore, be aware of their own values and must be non-judgmental in making ethical decisions about their patients (Harrison 1992:102-103). In order to make these complex, ethical decisions, nurses should have autonomy, authority and knowledge. Nursing autonomy implies an increasing degree of scope for independence of judgement, decision making and action; authority means increased power for good or for bad; and knowledge requires a great deal more than nurses acquainting themselves with biomedical knowledge, but also enables nurses to intervene in the ethics of research and to push for representation on local research ethics committees (Hunt & Weinwright 1994:30-33).

The ability to make ethical decisions independently and with autonomy may be hindered by factors such as religious beliefs, patient rights, cultural beliefs, technological advances, finances, legal implications and employment status (Harrison 1992:104-106). Hoffman (1984:5) identified three factors that are preventing nurses from attaining professional autonomy: doctors, nurses and hospitals. She believes nursing does not have much autonomy because doctors and administrators run the show.

According to Pera and Van Tonder (1996:9) nurses are constantly making ethical decisions about what should or ought to be done for a particular patient. Since the primary goal of nursing is the provision of the best care for each individual, nurses have a duty to know, themselves, what they believe in, and what they value most. This knowledge of self contributes to ethical decision making in nursing practice.

2.2. BUREAUCRATIC FACTORS WHICH INFLUENCE ETHICAL DECISION MAKING

Bureaucracy has been defined as an organizational structure characterized by division of labour, hierarchy, rules and regulations, emphasis on ethical competence, appointment by seniority and impersonal relationships between management and workers (Marquis & Huston 1994:32). Nurses are salaried professionals who function in a bureaucratic hospital hierarchy, where they are caught in the middle of two quite different role models, the professional and bureaucratic models. It appears that they would have particular loyalty problems in relation to bureaucratic and professional functions (Johnson 1971:31).

Hospitals and health authorities tend to be hierarchical institutions. The relationship between employee and employer is of contract and obligation, not one of consensus, it is formal not friendly (Tschudin 1992:112).

The characteristics of bureaucratic institutions will each be discussed below.

2.2.1. Hierarchy and division of labour

Cloete (1994:92-93) asserts that every institution consists of a hierarchy of functionaries who are regulated by policy statements such as legislation, regulations, proclamations of the legislation and directives issued by superiors. "Workers were rigidly controlled to promote high levels of production" (Morrison 1993:191). Nurses should be knowledgeable about legislation and regulations controlling their practice, as they are accountable for all decisions made by them. Legal aspects are closely related to ethical concerns. An example can be informed consent.

Nurses as professionals are responsible for their own acts and omissions. "While this responsibility is ethically based on personal and professional values, it is also a legal responsibility" (Doheny, Cook & Stopper 1997:234).

According to Jolley and Brykczynska (1993:74) there is a concentration of power at the top of the pyramid and this will guarantee the stability over time of inequalities in authority and rewards, and in particular, the continuing subordinate status of nurses who are tied to medical and managerial versions of caring. Sullivan and Decker (1992:7) maintain that the hierarchical nature of hospitals often provides a work environment in which it is very difficult for nurses to function simultaneously as both professional practitioners and employees.

Employees are organized and ranked in a hierarchical manner according to their degree of authority within the organization. For example, the people at the top of most hospital hierarchies are the superintendent and the chief nursing service manager while nursing auxiliaries and cleaning personnel are at the bottom (Booyens 1993:184). Tappen (1995: 375) asserts that people in a hierarchy are also ranked according to their status and salary. The implication of the above is that people at the bottom of the hierarchy will have a limited role or none to play in ethical decision making, while on the other hand those at the top will be directly involved in decision making at different levels.

Division of labour simply indicates that the specific parts of the job which must be done are assigned to different individuals or groups of the health care team. For example, nurses, doctors, dietitians, laboratory technicians and others, all provide a part of the care which is needed by the patient (Booyens 1993:184).

A problem could be that extreme division of labour may make it impossible to identify who is really responsible for successful or unsuccessful results of care. Since in the bureaucratic structure the top management is the one which makes important decisions in the current climate, it has become impossible for the management team to maintain the level of knowledge required for sound decision making. The employees who are most knowledgeable in different areas of a speciality are those specialized lower-level workers who are carrying out their functions on a

daily basis. These are the employees who should use their expert knowledge to make the necessary decisions for their field of speciality, but Fuszard (1993) in Booyens (1993: 187) asserts that this is not done in most bureaucracies.

Bowman (1995:12) in his study on the role of professional nurses has identified the limitations and problems associated with their roles. For example, nurses were found to be attempting to maintain an effective nursing service in an environment that presents a vagueness of role, function and parameters, without knowing the area of legitimate clinical freedom and practice. The other paramount issue that has been identified by Bowman was that authority, responsibility, autonomy and development of nurses did not match the demands of their roles, function and expectations.

Registered nurses are also seen as specialized lower level workers who are at all times working with patients in their units, but because of their low status in the hierarchy they are unable to make autonomous ethical decisions on matters that affect their patients. Decisions are made by doctors who are the 'captains' of the health care team, regardless of the fact that they spend less time with patients in the units.

2.2.2. Technical competence

A bureaucratic structure, according to Booyens (1993:184), puts an emphasis on technical competence. People possessing certain skills and knowledge are employed to carry out specific parts of the total service of the institution. For example, in a hospital there are nurses who deliver patient care, doctors who examine and treat patients, pharmacists who dispense medicines, clerical staff who do the filing and typing.

Competence in nursing is based on the comprehensiveness of nurses' knowledge and their ability to perform skills in an effective and efficient manner. Professional nurses have obligations to society to maintain their competence. Nurses who are found guilty of incompetence have to face sanctions or penalties such as civil actions, discipline by the registration authority and dismissal from service (Searle & Pera 1995:138-139). These competencies refer to inter-alia collecting

data to assess the patient's needs, making a nursing diagnosis and developing and implementing a nursing care plan and noting the patients' response to treatment. In each of these competencies ethical decisions are entrenched, doing what is best for the patient.

The implication of the above is that registered nurses in the bureaucratic institution should have the competence in order to act in an autonomous manner and to make decisions independently, as well as collectively with the patient and other health care personnel.

According to the findings by Bowman, the main constraint perceived by ward sisters in exercising their authority and autonomy included the fact that doctors had prescriptive care, which prevented them from using their expertise and description in the management of patient care (Bowman 1995:80).

Nurses should realise that they can gain expert power over those who need the knowledge and expertise they have required. This could assist them in taking the lead when an ethical decision has to be made in their field of expertise, because of the technical knowledge they have required.

2.2.3. Bureaucratic authority

In a bureaucratic structure, people are ranked according to their function and the amount of authority which they have (Booyens 1993:206). This could imply that nurses would have varying decision making power according to the level at which they function, as bureaucracy has a rational, clear chain of command. Those at the top of the hierarchy have the greatest decision making power. The authority and responsibility of each level as well as the span of control is defined for each one person.

2.2.3.1. Hierarchical structure

The hierarchy in the bureaucratic institution can best be viewed as a pyramid, where the top is formed by the smallest number of people, possessing the greatest amount of authority, and the

bottom of the pyramid is formed by the largest number of people with the smallest amount of authority (Booyens 1993:206).

According to Sullivan and Decker (1992:253) status is the social ranking of individuals relative to others in a group, in such a way that higher status members of the team have more influence than lower status members in group decisions. Jolley and Brykczynska (1993:67) assert that nurses constitute a servant or lower class within the professional hierarchy and that they should ensure that bureaucratic objectives are achieved and that tasks of patient care are accomplished. Nurses as hospital employees are placed in a hierarchical network of power where they carry multiple responsibilities to patients, employer and co-workers, and demands from any of these may conflict with both ethical and legal obligations to others (Thompson & Thompson 1990:63).

The diagram that follows represents a chain of command in a hierarchical order, within a hospital context.

TOP LEVEL

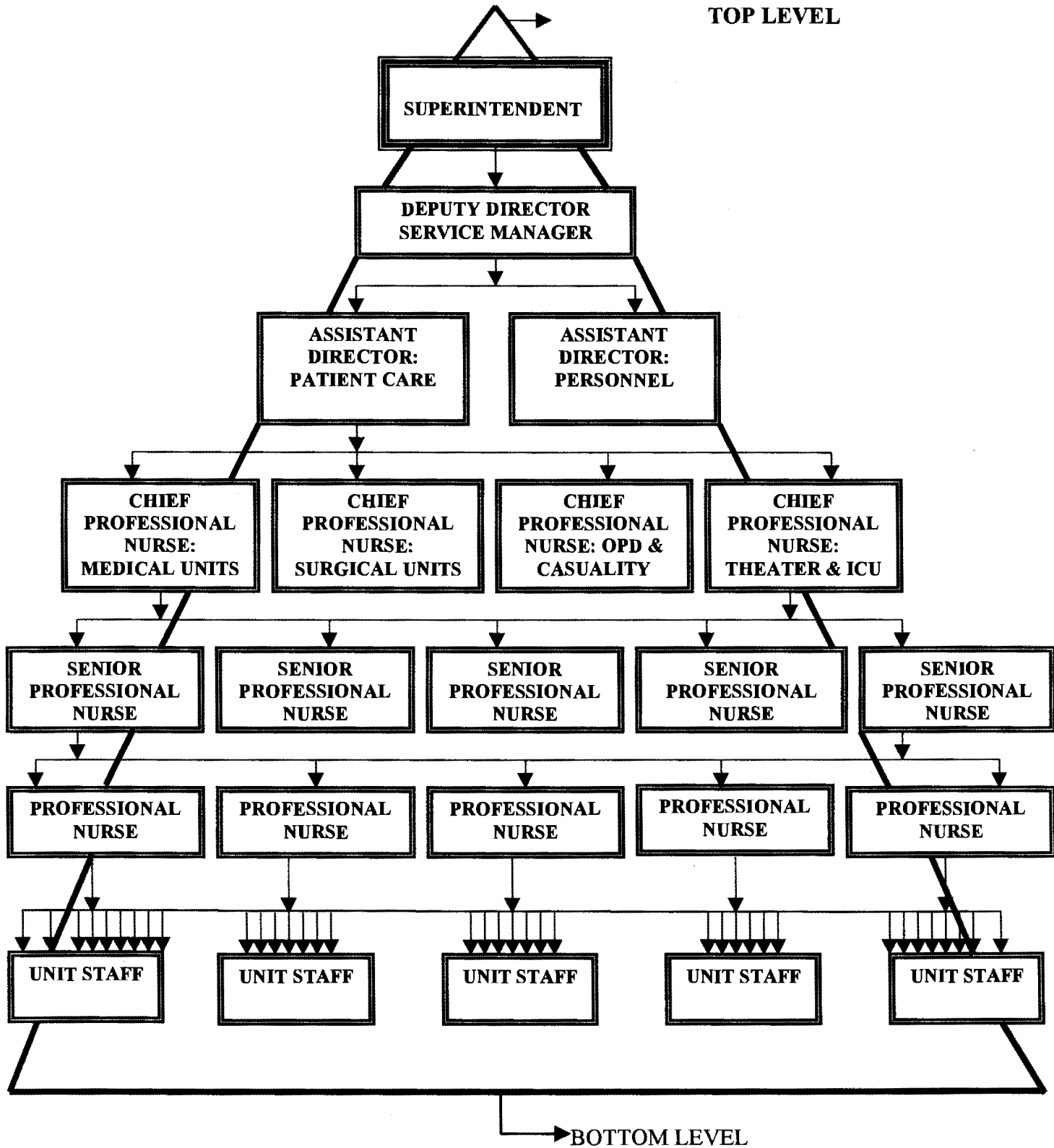


Figure 2.1. Chain of command

Kelly (1987:278) asserts that most decisions occur at the top hierarchical level, and the goals of bureaucracy are those that receive first priority. The problem is that nurses are usually expected to accept goals that are not necessarily in the best interests of the patient, to make sure that the work should suit the hospital schedule, rather than nursing to meet the patient's needs.

Because of nurses' relatively low power status in the bureaucracy, they have often been called upon to carry out decisions made by others without the benefit of participating in the process and understanding why such decisions were ordered. There are four major sources of ethical conflict in a bureaucratic setting, namely the setting of the institution, other players on the team, nurses' employee status and ethical dimensions of practice and the ethical reasoning process (Thompson & Thompson 1990:61). The setting of the institution is the hierarchical bureaucratic structure. Other players on the health team could include the patient, the patients' next of kin, doctors, para-medical personnel and the nurses. The employee status of nurses will to a certain extent depend on the hierarchical structure but the nurse's ability to apply ethical reasoning and her ethical dimensions of practice as prescribed in her nursing code will have a direct influence on how she/he makes decisions in a bureaucratic context.

2.2.3.2. *Vagueness of roles*

The bureaucratic setting is an environment that presents vagueness of roles, which are unmeaningful and unproductive. One could easily conclude that nurses in such an environment would have difficulties in making ethical decisions. From this it can be deduced that nurses need a clear and precise role description within the working environment, to enable them to be competent and productive.

Because nurses find themselves in an environment that presents a vagueness of role, they are unable to know the area of their legitimate clinical freedom and practice. In essence, their imprecise role is relatively unproductive and unmeaningful in meeting the demands placed upon them (Bowman 1995:12).

The other players in the health team are also sources of potential conflict of obligations and loyalties for the nurse in the hospital; nurses may receive conflicting demands of loyalty and service from patients, patients' families, administrators, doctors and significant others. Thompson and Thompson (1990:62-63) give an example of a doctor who disagrees with the patient on the treatment plan and nurses are asked to take sides. The doctor as the leader of the health team expects nurses to be loyal to him but their employer and the patients on the other hand expect nurses to act as advocates of patients.

According to Jolley and Brykczynska (1993:62), "Nursing care in health is regarded as essentially patient care. It is low status because it is not seen to have a benefit independent of those who share proprietorship of the patient. Accordingly they are found near the bottom line of professional and institutional responsibility. Their actual responsibilities are not directly to patients but to the medical and health authorities". If this statement is still found to be true in the year 2000 it will impair ethical decision making by nurses.

Steel (1986:81) asserts that nurses tend to blame physicians for their inability to make ethical decisions because of their low status in the bureaucratic hierarchy, as a means of reducing the anxiety brought about by recognising that they are victims of bureaucratic problems and difficulties. Nurses who have been educated to give enlightened, tender, judicious care find themselves depleted by their struggles against the bureaucracy. Physicians who are not trapped in these bureaucratic problems and difficulties respond with anger and reciprocal blame.

2.2.3.3. Divided loyalties

The problem of nurses' divided loyalties has also been identified by Davis and Aroskar (1983:50) who assert that nurses have an ethical obligation to the physician and to the institution in which they work. As professionals, nurses' primary ethical obligation is to the patient, however, as employees, nurses also have ethical obligations to the institution and to the physician. An example would be that of the hospital authority which has withheld or distorted information, to prevent a legal suit by a patient's family when a mistake has been made in surgery. In this situation nurses are expected by the hospital authorities to be loyal to them and to

go along with the authority's decision if they are to stay as loyal employees but at the same time they are denying the patient and the family their rights to know the truth.

The bureaucratic organization is interested in standardisation and routine, while professionals focus on patients as individuals who need unique attention. It is therefore implied that professional, and bureaucratic principles provide competing sources of loyalty and opportunity for potential role conflict (Johnson 1971:33). Although nurses often encounter ethical and professional dilemmas, they are deemed responsible for the activity of nursing care but are not allowed to exercise that responsibility or they must exercise it in partial ignorance (Hunt 1994: 81). Problems arise when they are held responsible when things go wrong, even though they were at the time in question, not expected or encouraged to understand or to query in the situation. This position in which nurses find themselves could make it difficult or even impossible for them to function in a professional manner, not least in making ethical decisions. Nurses actually find themselves being pulled in several directions, for apart from owing loyalty to the doctor and their nursing hierarchy they also owe loyalty to the patient and nursing colleagues. All in all, the employing authority probably has the most power, since they have the power to instigate formal disciplinary procedures and ultimately to dismiss nurses.

2.2.3.4. Ethical reasoning

The ethical dimension of practice and ethical reasoning process has been identified by Thompson and Thompson (1990:65) as another area of potential conflict for nurses who are hospital employees. The conflict is in nurses themselves about their own personal beliefs and their professional commitment to provide nursing services in an ethical manner. According to Benjamin and Curtis (1992:12-19) ethical analysis and reasoning involve:

- determining relevant factual information,
- careful analysis of the concepts and recognition of important distinctions,
- constructing and carefully evaluating arguments for and against various positions,
- developing a systematic framework for the purpose of provision of a common ground for resolving moral disagreements, and

- anticipating and responding to objections in order to detect if the analysis and the reasoning process was defective or that important factors may have been overlooked.

For nurses to be able to make effective ethical decisions they will have to acquire skills in analysis and reasoning which will enable them to construct these evaluative arguments to come to right decisions.

According to Thompson and Thompson (1990:65-66) nurses are not in control of their practice because they choose, consciously or unconsciously, not to be in control. The other major reason given by the authors why nurses compromise their care giving activities and give less than optimum service to clients and employers, is ignorance of the ethical dimensions of practice and ethical reasoning in conflict situations. Many nurses may not have had formal preparation in their topics of ethical analysis and reasoning process during their nursing programmes or in continuing education programmes. This could inhibit these skills in ethical decision making.

2.2.3.5. Conflict

Many nurses recognize the signs of conflict as they practise, but most of them ignore the symptoms or choose to follow the directions of others, especially the more powerful team members like physicians and administrators. Some nurses choose to avoid a particular patient or a physician with whom they sense disagreement. If the conflict seems too big to handle, other nurses resort to quitting that job and look for another. Another reason why nurses are not taking an ethical stance is that they are afraid to find themselves in positions where they are not keeping with the powerful, that is the physician or the institution or the patient. The other reality is that nurses probably lose their jobs for taking an ethical stance more often than for incompetent practice (Thompson & Thompson 1990:65-66).

Mauksch and Wessen in Snyder (1982:301) define conflict as coming from a bureaucratic source if the superior attempts to influence the autonomous behaviour of the subordinate by use of any authority based on the occupation of a superior office in the hospital's bureaucratic system, that is bureaucratic authority. To further explain this type of bureaucratic conflict, let us consider an example given in Verschoor, Fick, Jansen and Viljoen (1997:40) where nurses are repeatedly

told to perform duties for which they lack adequate knowledge or skills. Even though they might raise concerns or objections with their seniors, they are always told to follow instructions from those with authority.

With nurses, conflict exists between the authority of nurses as professionals and the professional authority of physicians since medicine has traditionally been recognised as an authoritative profession and physicians have exercised much authority over nurses, and many physicians are reluctant to accept other health professionals, and particularly nurses, as colleagues (Maas & Jacox 1977:172). Kramer and Schmalenberg (1976:19-23) have described conflict as often resulting from basic differences between the bureaucratic model and professional model, where there is incompatibility of the expectations produced by professional and bureaucratic roles. This conflict is said to be destructive if those with authority attempt to maintain or change things through the use of threats or coercion.

This type of authority puts nurses in a very difficult situation, a situation where they are unable to function independently with autonomy; lack of authority may lead to inability to make ethical decisions, or if decisions are made, those with authority may simply reject or ignore them. Rumbold (1993:166) asserts that professional bureaucratic conflict can make life more difficult for nurses who feel obligated to comply with requests and instructions from nursing management and, at the same time, have a loyalty towards the doctor alongside whom they work.

2.2.4. Rules and regulations

There are different types of rules and regulations, which influence the nurses' decision making power. For example, the rules and regulations of the South African Nursing Council. There are also statutes of the Republic of South Africa, for example, Choice of the Termination of Pregnancy Act. 92 of 1996. Some rules are laid down in the Public Service Act of 1984, Act 111 of 1984 and those directives that are issued by the supervisors.

According to Booyens (1993:184) a bureaucratic organizational structure is also characterised by rules and regulations where acceptable behaviour and the correct way to perform predictable

tasks are usually specifically set out in writing. No institution which has to play a role in the existence and survival of the state can perform its functions without successive policy statements to direct all its activities (Cloete 1994:92).

Swansburg (1993:167-168) asserts that policies, procedures, rules and regulations are standing plans of a nursing organization, which exist for standardisation and as a source of guidance for nursing staff, and they are mechanisms that establish constraints or boundaries for administrative action and set courses to be followed. According to Marriner-Tomey (1996:153) policies also serve as a means by which authority can be delegated. It is to be expected, if nursing practice is regulated and controlled by rules and regulations, that nurses should have clear guidelines on how to make ethical decisions. In practice, though, this is not always realized, which is a reason why ethical decision making in a bureaucratic context should be investigated. Could it be that rules and regulations are too strictly applied or not interpreted correctly by nurses or their supervisor?

Searle and Pera (1995:273) believe that laws are enacted to regulate and control the practice of health professionals so that the public may be protected against unauthorised, unqualified and improper practice on the part of health professionals concerned. The nursing council or the Board promulgates regulations covering the scope of practice of the registered nurse or midwife. The same council can also take disciplinary action about any member of the profession who disregards any regulation relating to the practice of the registered or enrolled person (Searle & Pera 1995:393).

The nursing profession in Southern Africa expects all its members to practise their profession in an ethical manner. Although nurses may have clear ideas of what their profession stands for, and what their scope of practice is, this does not necessarily mean that it will always be easier for them to practice their profession within ethical parameters. Nurses who are dominated by bureaucracy in the work setting or by sadistic professional superiors, frequently face disciplinary measures for ethical infringements, not because they wanted to be unethical, but because they were not equal to the pressure of their circumstances (Searle & Pera 1995:154).

2.2.5. Impersonal relationships between management and workers

A shortcoming in bureaucracy is the failure to include the human elements in management. Marquis and Huston (1994:32) mention that an important characteristic of bureaucracy is the impersonal relationship between management and workers. It has been shown that when special attention is given to employees, productivity improves, and when employees are given the opportunity to participate in decision making, more effective decisions are made. On the other hand demonizing by management results in passive, discouraged workers.

As human relations have become an integral part of management, “most organizations have modified their structure accordingly to render it less rigid and impersonal” (Marquis & Huston 1994:121). For nurses to make ethical decisions a more flexible, decentralized structure is needed, where the authority to make decisions is derived from the employee’s competence. Professional health care personnel also need to collaborate, to solve complex ethical dilemmas. An understanding of each other’s role and expertise is required to eliminate role conflict (Oermann 1997:152).

2.3. THE IMPACT OF ETHICAL PRINCIPLES ON ETHICAL DECISION MAKING

Ethical principles are conduct-guiding generalizations designating certain kinds of considerations as reasons for acting or not acting in certain ways. They are action guides to moral decision making and are important elements in the formation of moral judgements in professional practice. They provide guidance for thinking and acting in order to determine what should or should not be done in a particular situation (Pera & Van Tonder 1996:21,140). Brown, Kitson and McKnight (1992:3-4) believe that ethical decisions can be made well or badly since people come to have moral problems because they have concerns such as: the concern for others who are suffering, the concern to do something worthwhile in one’s life and the concern for justice.

Anderson and Glesnes-Anderson (1987:25) maintain that a set of ethical principles is needed if members of that profession are to behave ethically. Ethical principles are also needed to guide

behaviour when ethical conflicts arise within a professional or organizational context. Husted and Husted (1995:55) refer to ethical principles as contemporary bio-ethical standards which include autonomy, freedom, veracity, privacy, beneficence and fidelity.

2.3.1. The principle of autonomy

Autonomy implies the freedom to decide about one's care without interference, even if those decisions are not in agreement with those of the health team. The choices and decisions are made by virtue of the fact that one has the power and desire to take actions and to determine one's own destiny (Fowler & Levin Arriff 1987:39; Cogliano-Shutta 1986:29; Husted & Husted 1995:57; and Zerwekh & Claborn 1997:353).

The principle of autonomy is not absolute and it may be challenged when the individual infringes upon the rights of others; therefore limits are placed on the individual's power to act (Hall 1996:220 and Zerwekh & Claborn 1997:353). Some individuals have diminished autonomy because of their physical or mental condition and nurses therefore, have the obligation to protect special categories of patients in the hospital setting, namely the children, the mentally ill, the elderly and the dying as they do not have the capability to decide for themselves (Davis & Aroskar 1983:89; and Searle & Pera 1995:143).

Patients are said to be autonomous if they make decisions based on necessary and clear information. From an ethical perspective, health professionals have the obligation to respect patients' decisions even in those situations where they disagree with them. The law requires that human beings with sound minds have the right to determine what should be done with their bodies. Patients have the right to give or withhold their consent to undergo medical treatment. In order for patients to make sound decisions, they have the right to be fully advised of the risks and consequences of procedures, alternatives to procedures, and the expected results of their refusal. This is in line with the National Patients' Rights Charter as discussed in Nursing Update (1999/2000:36). The nurse acts as an advocate to patients and it is his/her responsibility to provide patients with the necessary information on which to base their autonomous decision. Care should, however, be taken not to coerce the patient in making a decision.

According to White (1989:6-8) informed consent is founded upon three important principles: respect for persons, promotion of best consequences and rights. Nursing is said to be concerned with providing information, assessing competence and recognising and preventing coercion. But for the author, prevention of coercion is challenging since it is often difficult to know when it is taking place. Coercion can come from families, spouses or even health professionals. Nurses who suspect that the patient has been coerced have the responsibility to ensure that the patient has all the information needed to make such a choice.

Not only patients, but also nurses, possess autonomy. Nurses need independence as professionals especially from doctors and employer control when such control conflicts with professional practice. Nurses must make constant efforts towards independence when it benefits their patients (Hall 1996:297). This places a great responsibility on nurses to be competent, knowledgeable and efficient, to enable them to act in an autonomous manner.

Street (1992:37-38) believes that doctors and nurses are key players in the provision of health care but that doctors have achieved a virtually unchallenged professional status, which has enabled them to dominate and control the development of nursing. Doctors have been implicated in the oppression of nurses. According to Riska and Wegar (1993:97) "social scientists have also long recognised that nursing, as a historically subordinated occupation, has been constrained by outside pressure from the medical profession". It is essential that this myth should be proven untrue, as nurses provide nursing care and doctors medical care. The one cannot be successful without the support of the other. Nurses are expected more and more to act as first level consultants, especially in rural areas. Often they have no one to consult when making ethical decisions.

Nurses are known to spend more time with patients than doctors or even families. In a case study cited in Olson (1981:143-144) of nurses' feelings about euthanasia at University of Washington Hospital and Swedish Hospital Medical Centre, it was found that nurses received requests for euthanasia from terminally ill patients and their families more frequently than did physicians, leading to the conclusion that the nurses have more interaction with clients and families than do

physicians. The problem, however, is the contrasting viewpoint that nurses are under the obligation to obey the decisions of physicians.

According to Benjamin and Curtis (1992:23) the nursing context is characterized by a number of constraints that frequently make exercising autonomy problematic. Over 68 percent of nurses must contend not only with the conventional hierarchical structure of medical decision making, but also with restrictions on their behaviour imposed by the bureaucratic system of the hospital. Thus hospital nurses find themselves constrained in various and occasionally conflicting ways by the hospital which employs them, the physician with whom they work, the clients for whom they provide care, and the nursing profession to which they belong.

A problem may arise when nurses realize that patients are not given clear information regarding treatments and nurses are not assertive enough to say so to the doctors who are usually more authoritative, more powerful than themselves in the hierarchical network. In this case the autonomy of patients is not respected. Most often nurses tend to sign the patients' consent for treatment or even witness the patients' signature before they have made sure that patients are fully aware of what exactly is going to happen to them. Patients usually give consent to doctors for what doctors do. Nurses who sign as a witness of the patient's signature merely signify that they saw the signing, not that the consent process was valid. It is the responsibility of nurses to see that the patients knowingly consent to any procedure to be performed. To actually consent, patients must know enough to make informed decisions (Hall 1996:224).

The role of nurses here is to see that the patient's informed consent has been obtained, and to make the patient's physicians aware if patients indicate that they did not understand the information conveyed by the doctor, and lastly to make the physician aware of any changes in patients' conditions or circumstances which could render earlier consent ineffective, or when patients indicate that they are no longer willing to undergo the treatment (Bennett 1981:31). The patients' rights charter see informed consent as a patient's right, which emphasizes accountability for decisions made in this regard.

The facts that nurses possess less authority in the hierarchy of bureaucratic institutions, and that they most often carry out orders from doctors, may make it difficult for them to succeed in making doctors accept that patients were not well informed, or that patients failed to understand the purposes of treatment or even that the consent of patients is no longer valid if their conditions have changed or if they have changed their minds about treatment. Doctors may want treatment to be given quickly if they think that they are going to do more good than harm to patients but this may not respect the autonomy of patients.

Here the problem is the fact that the principle of autonomy conflicts with other principles, especially the principle of beneficence and non-maleficence. Take the example cited in Singleton and McLaren (1995:29-35), where a physician instructed nurses that a middle-aged woman who suffered frequent asthma attacks and had severe multiple sclerosis should not be resuscitated if she suffered a cardiac arrest during an asthma attack at the hospital. Nurses felt that the woman's autonomy was not respected since the woman was not consulted by the physician, whereas the physician may have thought that the decision not to resuscitate would be to the benefit of the woman, that is the principle of beneficence, the principle of doing what is viewed best for the patient. To the physician's view, the principle of beneficence overrides the principle of autonomy.

The implication is that doctors have more authority in the bureaucratic structure than nurses since they occupy higher positions in the hospital hierarchy. This signals that nurses are not regarded as autonomous health care professionals and moral agents but as dependent functionaries whose role is to do the moral bidding of others (Kuhse 1997:200). If nurses are made to believe the theory that they should always be subservient to doctors, their ethical decision making will be impaired.

2.3.2. The principle of fidelity

Fidelity implies the duty to be faithful to commitments, and it incorporates keeping promises, keeping secrets and truth telling (Hall 1996:338; and Zerwekh & Claborn 1997:354). The principle of fidelity is considered to be the most difficult one to maintain or to live, but all in all

no harm should be done even if telling the whole truth, and nothing but the truth, is necessary (Tschudin 1986:39). Many authors believe that being true is a complicated business, it is not a matter of saying yes or no since other moral values or principles such as beneficence, nonmaleficence, or loyalty may appear to conflict with the values of honesty (Tschudin 1986:81, Melia 1989:4 and Searle & Pera 1995:141).

Doctors may decide not to inform patients of their poor prognoses, which they think will cause patients to be anxious, distressed and unhappy; nurses on the other hand feel that patients have the right to know of their terminal conditions. Doctors feel that they are preventing harm (the principle of nonmaleficence) by withholding the truth. Should a situation arise where nurses and doctors send out contradictory messages to patients, the patients' trust in either or both will be affected. The above mentioned situation may be stressful to nurses who may not know whether to tell or not to tell, especially since they work in a bureaucratic institution where senior members with high status and authority are those who are likely to make decisions.

Tschudin (1986:77) realized that nurses are, however, rarely consulted by doctors regarding the treatment to be given to a particular patient; sometimes if issues are discussed with nurses, their opinion or reasoning may not be taken seriously. Has the time not come where consulting with one another has become an essential element in making ethical decisions that comply with the principle of fidelity? The moral voice of nurses must be heard so that members of the health care team can respond sensitively and adequately to the needs and wants of those for whom they care (Kuhse 1997:200).

2.3.2.1. Veracity

Veracity implies the duty to tell the truth (Zerwekh & Claborn 1997:356). Veracity is seen as an important principle to consider in the nurse-patient relationship; nurses in most areas find themselves caught in the middle when other people, for example the family or doctor, request nurses not to tell the patients the truth about their prognoses and at the same time patients wish to know all the facts about their diseases. Veracity and fidelity go hand in hand as both rely on consensus reached between different categories of health care professionals.

Let us consider the case cited in Benjamin and Curtis (1992:3-4) of a recent divorcee in her mid-forties who had just been diagnosed as having cancer of the colon with metastasis involving nodes, a cancer for which there is no proven effective treatment. The nurses realized that the patient had not been informed about the seriousness of the condition or about her very poor prognosis. One of the patient's daughters approached the nurse to assure their mother that everything was under control, to spare her the further pains of learning that no proven, effective treatment was available. The nurses approached the doctor thinking that the patient's request was authentic and that she would handle the truth. The doctor told the nurses that the patient was not told about the poor prognosis in order to spare her unnecessary anxiety and moreover, the doctor added that any act of disclosure on the nurse's part would have to be considered inconsistent with the well being of the patient and inconsistent with their role as nurses. The nurses saw that the doctor was disapproving and they consulted the head nurse who advised them to comply with the doctor's directions in order to avoid a severe confrontation.

According to Curtain and Flaherty (1982:326-328) health professionals are no longer thought to tell the truth. They occasionally tell deliberate lies to patients, which rob them of reality and also serve to destroy human relationships between patients and professionals. The health professionals usually provide private and vital information to family and friends while withholding it from the patient. An example could be one of dying patients who are deprived of saying good-bye, of concluding their affairs, possibly of providing for their loved ones, and finally, of choosing their own attitude toward their impending deaths. Patients have therefore, a moral right to information about themselves and, when they ask questions, they have the right to truthful answers.

Nurses are aware of the fact that they are salaried employees in a bureaucratic hospital and know that revealing the information to the concerned people without approval or consent may ruin their careers, and that they may be charged for not being obedient to their authorities even though they may be respecting the patient's right to know the truth.

2.3.2.2. Confidentiality

Another important aspect of fidelity is the confidentiality of information about patients. It is one of the concepts of ethics of nursing which requires that “the nurse keeps in confidence all confidential information about her patients... It is part of the basis of trust between the nurse and the patient” (Searle & Pera 1995:152). This is to safeguard the client’s right to privacy by judiciously protecting information of a confidential nature. Confidentiality is also related to doing good and not harming the patient. Confidentiality and privacy is one of the rights of patients as set out in the 12 point document launched by the Minister of Health on 2nd November 1999 in South Africa to campaign for patients’ rights (Nursing Update 1999/2000:36).

Confidentiality as an obligation to preserve the client’s privacy and hold certain information in strict confidence has long been part of nursing and medical ethics (Benjamin & Curtis 1992:104). Confidential information can only be given in a court of law; for disclosure of other information, the advice of an authority such as the hospital administration, should be sought. Disclosure to a doctor would be privileged and would not put the nurse under any legal liability (Tschudin 1986:105-106).

Keeping people’s secrets can be justified on two general philosophical grounds: the utilitarian argument states that if patients know that a health care professional will not divulge personal information, they are more likely to give medical and nursing staff a full account of their condition and circumstances (Melia 1989:69). Fitzpatrick (1988:174) asserts that in order to care for their patients, nurses need to have access to the facts about patients’ conditions and prognosis. It is generally agreed that this sort of information should not be public knowledge because it concerns intimate details of patients’ physical and mental condition, details which concern only them and the health professionals who are attempting to promote their recovery. Having the necessary information regarding the patient will assist nurses to make ethical decisions which will be beneficial to patients.

Patient records should also be kept safe to prevent the danger of disclosure to unwanted sources. A study of confidentiality was conducted in a 100 bed acute hospital and included health team

members such as nurse managers, secretaries, and nursing assistants. The study addressed the matter of using the computerized patient care system to access information about neighbours, friends, or patients on their assigned units and the respondents acknowledged that they had obtained information about patients who were not in their assigned area (Douglass 1996:331).

The patient's rights to privacy and confidentiality are not protected if the other members in the hospital, who are not assigned to patients, could have access to the patient's confidential and private information. To make ethical decisions that will be beneficial to patients, patients should themselves have access to their own health records to enable them to make an informed choice.

2.3.2.3.Loyalty

Loyalty implies keeping promises. When professionals and employers are in conflict, the underlying value being tested may be loyalty: loyalty to employer versus loyalty to the patient or other professionals. Fowler and Levin-Arriff (1987:84) assert that loyalty to patients and clients may be considered a primary and fundamental principle in the nurse-patient relationship; other competing loyalties may inject conflict into nursing practice. These conflicting loyalties may include loyalty to oneself and one's personal principles and values, loyalty to physician and nurse colleagues, and loyalty to one's employer.

Loyalty to patients may also conflict with loyalty to other health care professionals. An example would be that of a nurse who values respect for senior colleagues and agrees to lie, as happened in a case cited in Harries, Schirger-Krebs, Dericks and Donovan (1983:121) where a patient with diabetes mellitus and a wound on one of the toes of his right foot was not told about the culture result (of pseudomonas), but only saw a note at the foot of his bed: "Warning:, unusual organism". Nurses were not loyal to the patient, his autonomy was not respected. Withholding the truth caused more harm to the patient than revealing it.

Loyalty to patients may also conflict with loyalty to patient's families. In a case cited in Laufman (1989:924) a nurse chose to protect the patient's autonomy and his rights by not telling the family about his Aids disease, because the patient instructed the nurse earlier on that he intended

to tell his family the truth about his illness when he became more seriously ill and his death was imminent. When the family learned the truth from the patient, they were shocked and accused the nurse of being untruthful because they felt they had the right to know, so as to protect themselves from the infection.

Loyalty to patients and one's employer may conflict when nurses start to blow whistles, that is, when they start to disclose information to the public. Health care workers who become whistle blowers are most often charged if they expose their employers. Ngwena and Chadwick (1994:137) gave an example of Mr. Graham Pink, a charge nurse, who was dismissed in 1991 by Stockport Health Authority following his public disclosure about understaffing at Stepping Hill Hospital and was found guilty of gross misconduct. The problem arises when the system in which nurses have to operate, only crushes those who speak out.

2.3.3. The principles of beneficence and nonmaleficence

The principle of beneficence implies the duty to actively do good to patients while the principle of nonmaleficence implies the duty to prevent, or avoid doing, harm whether intentional or unintentional (Zerwekh & Claborn 1997:353-354; and Searle & Pera 1995:140-141). The principle of beneficence requires the provision of benefits and balancing of harms and benefits. Consideration of risks and benefits by health care members in decision making in treatment and research situations might be considered to be part of the thoughtful and careful action dimension of nonmaleficence. This means therefore, that the health care professionals should, before making decisions, consider both possible harms and benefits that might result from choices to do nothing in a situation of conflict, or to take positions to defend principles in a situation of conflict (Davis & Aroskar 1983:44). An example in nursing practice may be the benefits or harm which may result if patients with terminal illness request information from nurses about their conditions. Beneficence and non-maleficence will require the sensitive balancing of harm and benefits by nurses when they make their final decisions.

The problem that may exist in doing good or preventing harm for patients is not knowing exactly who decides what is good: whether patients themselves decide, or whether it is the responsibility of nurses or physicians. It may be difficult for nurses in a hospital setting, which is bureaucratic and hierarchical in nature, to decide what is good for patients since nurses have lower status than doctors who are the leaders of the health team.

2.3.4. The principle of justice

The principle of justice in health care relates to allocation of resources and fairness. It is an obligation to be fair to all people (Ellis & Hartley 1992:209; Rumbold 1993:177; Chitty 1993:368; Searle & Pera 1995:142; and Pera & Van Tonder 1996:24).

The concept of justice should examine those factors, which will constitute the common good, alongside consideration of the specific welfare of one individual or group. Usually the allocation of resources to one deprives another (Watson 1995:191-1925). It would be ideal if all patients could receive all available treatment for their health needs, but because of the costs involved, it is unfortunately not possible. In South Africa where a large percentage of the population does not even have access to health services, this is often a principle that cannot be applied easily. Rumbold (1993:185) believes that justice in the distribution of health care can seldom be achieved and that it cannot be achieved unless resources are unlimited. To decide who should receive the available resources becomes an ethical dilemma when, for example, it must be decided whether to use the money for high technology which will only benefit a few, against allocating the money for an immunization campaign which could benefit a whole nation.

Justice or fairness is a provocative topic when health care decisions are made, because some individuals enjoy an overabundance of services and others lack even the most basic health care (Pera and Van Tonder 1996:25). Justice in the nurse-patient relationship is covered with treating patients rightly as unique individuals, considering their wants and needs. The principle of justice goes hand in hand with the other principles of veracity, autonomy, beneficence and non-maleficence. If patients are not told the truth, to be honest with, to deceive or withhold truth from

patients is injustice, just as to disallow patients autonomy or to fail to involve them in decision making about their care is also to treat them unjustly (Rumbold 1993:185-186).

Problems that may be encountered by registered nurses are that resources are not distributed by them. The government, especially the health ministry, allocates resources to different health institutions. Doctors decide which patients do not qualify. Nurses as health care providers, respond to requests made by doctors, or members of the health care team with higher status in the hospital hierarchy. Nurses might like to give equal care to patients or to meet all needs of patients, but with scarce resources and lack of authority, to decide this could be practically impossible. This could even hinder them from making ethical decisions regarding patients' care.

2.4. SOCIO-CULTURAL, RELIGIOUS AND OCCUPATIONAL FACTORS WHICH INFLUENCE ETHICAL DECISION MAKING

Ethical decisions are not made in a vacuum since there are many factors which exert pressure and demand response, as people search for appropriate answers to the dilemmas they face. There are occupational and social factors which influence decision making. These factors are not independent or mutually exclusive but act and react on one another in a constantly changing milieu, causing evolutionary changes in all segments of society (Ellis & Hartley 1992:213).

Ethical and moral problems are increasing and this necessitates in-depth knowledge of diverse cultures with their ethical values, codes, norms and standards. A worldwide base of ethical and moral knowledge could prevent intercultural problems, imprudent actions, and inappropriate cultural imposition practices. Knowledge of comparative ethical and moral values of a multicultural society is essential today to help nurses make meaningful judgements, decisions, and actions. Currently only very limited content about the ethical and moral dimensions of culture care is taught in schools of nursing. Cultural factors of ethical care are conspicuously missing in most nursing curricula and it will be virtually impossible for nurses to make appropriate decisions about an individual client, families or groups without respect for the clients' specific cultural values, beliefs and life ways.

The South African society is becoming increasingly multicultural; clients expect that their ethical values and moral beliefs will be respected and acted on appropriately by health personnel. This means that nurses must become knowledgeable about different cultures, discover ethical aspects of human care, and be aware of how different cultures reach ethical and moral decisions. If nurses are not knowledgeable they may have a tendency to impose their values, beliefs and practices on their clients (Leininger 1990:50-55). Cultural, religious and ethnic factors also influence how adults will work through a moral reasoning process. When different cultures with dissimilar moral systems are placed together misunderstandings and conflict may arise. (Deloughery (1995:236).

“When faced with a need to make an ethical decision, nurses will find themselves influenced by their childhood upbringing, their education, and their environment. In terms of the latter, most that are created by each institution’s mission statements, administrative and medical structure, and patient population. Nurses are very much in the middle between patients, physicians, their employer, and their own professional obligations. Though our professional code of ethics clearly indicates that the nurse-patient relationship takes priority, the nurse-physician and nurse-employer relationships will also have a strong influence on the nurse patient relationship” (Deloughery 1995:238).

Decision making in nursing is rooted in a nursing culture where a multiplicity of factors have influenced and continue to influence the profession. The nursing culture gives us directions as to what a practitioner should look for, which observations are important and which are not, how data is to be elicited and priorities established. Nurses function within structures that force compartmentalization of patient care, impose time constraints, and see the elimination of symptoms as being synonymous with good health. According to Jones and Beck (1996:95), “A careful observation culture can prepare nurses to make intelligent decisions and propose new solutions to the many issues that we face.”

Hospitals and clinics, where the vast majority of registered nurses are employed, are constrained by hospital culture, where the concern is daily life in the hospital and where treatment is sought

in response to disease etiology. There is little opportunity for nurses to negotiate care with the patient. The breadth of knowledge obtained from professional education remains largely untapped because of nursing's dependency on the environments in which nurses practice. According to Harrion (1992:104-105) factors affecting ethical decision making include religious beliefs, patient rights, cultural beliefs, technological advances, finances, legal implications and employment status.

2.4.1. Socio-cultural factors which influence decision making

Socio-cultural factors that influence ethical decision making include social and cultural values or attitudes, science and technology, legislation, judicial decisions and funding.

2.4.1.1. Social and cultural attitudes or values

Values are the social principles, ideals or standards held by individuals, classes or groups that give meaning and direction to life. They reflect what people consider as desirable, and consist of subjective assignment of worth to behaviour. Values enable people to make both small day-to-day choices and important life decisions. Values also influence how nurses practice their profession (Chitty 1993:159). The value a society places on the individual or family directly impacts on the standard of care. Some societies may place greater emphasis on individuals' rights to exercise their choices based on individual beliefs and conscience, while other societies may place greater emphasis on the community's good than on that of the individual (Ellis & Hartley 1992:105).

Changes in the attitudes of society as a whole profoundly influence the value systems of people. Some changes include the changing status of women, the shifting roles of women and of the attitudes towards marriage, and these changes have required nurses to reexamine their personal feelings and alter their way of providing nursing care.

It is important that nurses should be secure in their own values and beliefs, but it is important not to lose sight of the fact that values differ from one culture to another and that patients' values

may often be entirely contrary to their own (Pera & Van Tonder 1996:194). Failing to understand the cultural background of patients limits the nurses' ability to provide the best care. Understanding the patient's background facilitates communication and assists in establishing an effective nurse-patient relationship. The shared values and beliefs in a culture enable its members to predict each other's actions (Chitty 1993:325). Patients should be allowed to express their feelings about their conditions. Nurses, as patients' advocates, should assist patients in obtaining answers to their questions regarding prognoses and treatments. Values influence ethical decision making but problems may arise when professional values conflict with religious, social, institutional and personal values.

Incompatible perceptions or activities create conflict. This is particularly evident when nurses hold beliefs, values and goals different from those of nurse managers, physicians, patients visitors, families, administrators and others (Swansburg 1993:360). An example of conflicting values of nurses and patients is given in Chitty (1993:325) where in the Navajo culture, great value is placed on keeping pain and discomfort to oneself since letting others know one's feelings is regarded as weak. Nurses who expect patients to complain and ask for medication when in pain may assume that Navajo patients are comfortable when they are not and on the other hand, nurses who value suffering in silence may underrate the discomfort of patients who come from a culture that proclaims pain loudly. Personal goals usually conflict with organizational goals, particularly with regard to staffing, scheduling and the climate within which nurses work. Nurses who have to violate their personal standards will destroy the system. This is demeaning to them and causes loss of self-esteem and emotional stress. When nurses are not recognised or respected they feel helpless and they feel hopeless, they are unable to control the situation. Nurses' values may boil over into conflict related to ethical issues that include "do not resuscitate" order, abortion, abuse, Aids and other problems.

2.4.1.2. Science and technology

One of the most widely debated issues is the impact of technological advances on nursing, where patients' care is "high-tech", versus "high touch" nursing. Technological advances now allow nurses to monitor their patients' conditions on computer screens at the nurses' stations. Without even entering the patient's room, nurses can gather a large amount of information and make nursing decisions on that information. Nurses are seen to pay more attention to machines than to patients. Communication and record keeping in nursing are changing rapidly owing to the use of computers. Nurses merely have to talk to the computer, and their assessments and nurses' notes are automatically recorded and this frees the nurse to spend more time on direct patient care (Chitty 1993:65). If nurses are spending less time with patients because of "high-tech" nursing, they will be unable to identify ethical issues and problems and therefore, will not participate in ethical decision making.

Nurses are expected to spend more time with patients for the purpose of assessment, nursing care and to enhance good nurse patient relationships. However, the nature of the relationship is dynamic and it may exhibit the characteristics of a child-parent relationship or client-counselor relationship. Nurses therefore have an obligation to spend more time with patients, but technological advances have limited the nurse-patient contact (Curtain & Flaherty 1982:87).

According to Harrion (1992:105) "many significant ethical issues have arisen as a result of the advancement of medical technology. The prolongation of life through mechanical means has confronted the health care profession with 'quality of life' issue". Costly technology such as the implantation of an artificial heart in a human subject has led to many ethical discussions regarding the appropriateness of using artificial hearts or obtaining funding for further research, since the survival of patients after implantation has been limited (Ellis & Hartley 1992:215).

It must be kept in mind that even when high technology is used the patient and his/her family should also be involved in the decision making process. At the same time it must be realised that the decisions made by the patient and family are more focused and emotional compared to that of the nurse which is based on knowledge, attitudes, values and rational reasoning. Burger, Botes and Nel (1999:29) identified the following factors which influence decision making concerning life support systems:-

- availability of resources,
- health needs of patients,
- patient's health status,
- knowledge,
- policy, human rights and legislation,
- values,
- ethical aspects, and
- uniqueness of the situation.

As far as scientific advancement and technology are concerned, nurses have no control over the situation. Since these are developments, they have to adjust themselves to and make sure that patients' dignity, safety and autonomy is respected. The factors identified by Burger et al (1999) can serve as a guide to nurses when having to make decisions in a high tech environment.

2.4.1.3.Legislation

Social change and legislation are constantly in interaction. Legislation may follow changes in society's attitudes, converting new ideas into law. When social change is desired, legislation may be actively sought to require people to behave in new ways (Ellis & Hartley 1992:215-216). Strong societal attitudes have been the impetus to incorporate certain ideas into law, according to Harrion (1992:106). An example of change due to societal influence is the abortion issue. Abortion was against the law in South Africa, but many physicians realized that abortions were done under poor conditions and were moved to the extent that they chose to perform them. The laws were thus changed as a result of public demands and attitudes, as can be seen in the Choice of Termination of Pregnancy, Act no 92, of 1996. In the Republic of South Africa, before 1 February 1997, abortion on choice was prohibited by law. The new Act was passed in 1996. This act is said to "repeal the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive right and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs" (South Africa 1996 (a):1301). This Act, however, can pose a problem to nurses who are pro-life. From their value system,

participating in the procedure of abortion is equal to destroying life. It could be very difficult for them to stand neutral when confronted with such a situation. Their ability to make an ethical decision that will be of benefit to the patient and in line with the norms of a bureaucratic system could be impaired.

Another example is the Constitution of South Africa, 1996 (Act 108 of 1996). Chapter 2 of the Act speaks of the Bill of Rights. On the section of freedom and security of the person 12 (2), it is said that "Everyone has the right to bodily and psychological integrity, which includes the right:

- to make decisions concerning reproduction;
- to security and control over their body; and
- not to be subjected to medical or scientific experiments without their informed consent" (South Africa 1996 (b) :8).

All individuals are expected by the constitution to honour this law and nurses are no exception; when they are to make decisions, these laws bind them. It must also be kept in mind that nursing practice is controlled by the Nursing Act no 50 of 1978 as amended. The nurses' regulations will guide the nurse in making decisions, regarding the case and procedures.

2.4.1.4.Funding

The financing of health care also represents a major area of conflict that has ethical dimensions. The government is involved in allocating funds for health care in public hospitals and clinics. A lot of questions are being asked by the public on how much time, money and energy should be allocated to health care and how that money should be divided. Another cause for conflict is the fact that health care includes controversial procedures, such as abortions and sterilization. Some taxpayers do not ethically sanction these procedures and do not want their tax monies used to fund them (Ellis & Hartley 1992:216-217).

Harrison (1992:105) also asserts that many questions are being asked about the spending of monies for health care provision. Questions asked include what health care should be provided, what fees to be charged, whether everyone should pay for the service and who is eligible for care. The problem arises when the mechanical devices that are used are very costly and most

people cannot afford the services. Most often there is also a limited amount of equipment available and difficult decisions must be made as to who is eligible to receive treatment.

2.4.2. Occupational factors that influence decision making

Ellis and Hartley (1992:217) assert that by virtue of the position nurses hold in the health care system, they have special forces acting on them as they try to make decisions. Such factors include their status as employees, collective bargaining contracts, collegial relationships, authoritarian and paternalistic backgrounds, and consumer involvement in health care.

2.4.2.1. Status as an employee

The status of nurses as employees in government institutions or hospitals has been thoroughly discussed in the previous discussions on the bureaucratic factors, which influence ethical decision making. As indicated, there are pressures that divide the nurses' loyalty among patients, employers, and themselves. The employer pays the salaries of nurses and makes decisions in regard to their work. It is therefore, not unusual for ethical decisions to involve conflict between the best interests of the employer and the patient. If nurses' decisions affect the employer adversely, the results may be job loss, poor references, and a severely curtailed economic and career future (Ellis & Hartley 1992:217). According to Harrion (1992:106) nurses are concerned for personal economic and career loss if their decisions affect their employers in a negative way.

“Status is also influenced by skill, education, specialization, level of responsibility, and autonomy, and salary accorded to a position” (Marquis & Huston 1994:126). Status also refers to the power which can be acquired through knowledge and expertise. Nurses must realize that they can be influential in effecting change in the health care delivery system by using their collective power within an ethical framework. They should be able to clarify an ethical issue, the factors influencing it and determine the role of each participant in the decision making process. Doheny et al (1997:233) confirms this point of view, adding that the beliefs and values of participants, alternatives and conflicts should be identified, before coming to a final decision.

2.4.2.2. Collective bargaining contracts

Ellis and Hartley (1992:217) believe that contracts can protect nurses in making ethical decisions. Collective bargaining has positive effects and unions stimulate better hospital management by fostering formal, central and consistent personnel policies with better lines of communication (Zerwekh & Claborn 1997:331). If nurses are active participants in policy-making, or at least, are consulted and given information, or if the management is open and transparent and accessible to nurses, collective bargaining can indeed help or protect nurses in making ethical decisions.

Nurses want to be recognized, both by salary and by position, for their level of professional expertise. Some nurses work in settings where they have little voice in the quality of care in the institution, are poorly paid, and are required to also cover specialized units for which they have not been trained. These nurses may wish to be represented for purposes of collective bargaining, so that they can negotiate for improved salary and working conditions. Nurses' associations lobby the government to influence laws affecting nursing; they assist nurses in dealing with work place issues such as salaries, working conditions and patient care issues such as staffing ratios (Chitty 1993:84).

Health care organizations and professional bodies for health care workers were slow in accepting collective bargaining. The new Labour Relations Act 66 of 1996 and amendments to the Nursing Act 50 of 1978 made collective bargaining a reality for nurses. These acts opened the doors for increased union activity in health services. These activities within the health services have brought about additional ethical issues that need discussion. Nurses have to decide whether a strike is the best option when dissatisfied and if so, how to go about it. The nurses' code of ethics expects them to look at the best interest of their patients. Marquis and Huston (1994:319) discuss a similar situation in the United States where changes to legislation were made as early as 1962 to lift restrictions on union activity for public employees.

2.4.2.3. Collegial relationships

According to Curtin and Flaherty (1982:126,291) nurses have professional collegial obligations to support, guide, and correct one another. Their moral commitment to the profession and to one another forms a foundation for their professional life.

Nursing as a caring profession involves not only care for and of patients, but also care for and of fellow nurses. Relationships among nurses who work together as colleagues, in which they support one another, share in decision making, and present a unified approach to others can provide an excellent climate for ethical decision making. Most often such relationships are lacking in hospitals. Nurses feel alone and are not experienced in seeking out and supporting one another (Ellis & Hartley 1992:218). In order to provide an excellent climate for shared ethical decision making, ethical committees and weekly discussion groups can be established to deal with ethical issues and problems.

2.4.2.4. Authoritarian and paternalistic background

Historically, the authoritarian and paternalistic attitudes of physicians and hospitals often have relegated nurses, most of whom are women, to dependent and subservient roles. Some physicians still believe that all ethical decisions rest on their shoulders, and once such decisions are made all other members of the health team are expected or obligated to follow such orders. Today's nurses increasingly are speaking out against such an approach, which leaves them out of the decision making process (Ellis & Hartley 1992:218). Since nurses are constantly identifying patients' problems, making nursing diagnoses, planning for their care, implementing the plans and evaluating the care rendered, they would like to be part of the decision making team.

Paternalism, that is making a decision for another person, is only justified when it can prevent harm to the patient (Marquis & Huston 1994:424). Nurses should therefore only assume a paternalistic approach to decision making if they know what is best for the patient or when the patient and his/her family are not able to participate in the decision.

2.4.2.5. Consumer involvement in health care

The consumer movement has become a significant factor in health care. Consumers are demanding a greater voice in all aspects of their own health care delivery. Part of this involvement is at the decision making level (Ellis & Hartley 1992:219). Nurses should be aware of this when making ethical decisions, and include the patient in the decision making process. Patients should be given the necessary information to assist them in the process.

Health care services are starting to be scrutinized by the public although there is a prevailing notion or attitude in health care that providers know best and good patients simply follow directions without asking questions. In most developed countries the rise of the consumer movement has protected the public from inadequate care, experimental drugs, poor nutrition, and many other health-related issues. Most consumer groups have demanded control of spiraling health care costs and have gained participation on boards of health planning agencies, accrediting bodies, and professional licensing boards. The impact of the health care consumer movement has been to promote increased accountability on the part of health professions, including nursing. Nurses are expected to act as patient advocates (Chitty 1993:60-62). As advocates to patients nurses should strive at getting the best benefit for the patients, to assist them in choosing the best decision. The National Patients' Rights' Charter is to inform consumers of health care of their rights, and nurses will have to take note of the contents. "Historically consumers and providers of health care had little incentive to control the amount of care provided or the related costs of care" (Doheny et al 1997:113). Health care costs were paid by the tax payer or medical aid schemes, which indirectly was the tax payer. Because the consumers did not have direct contact with the cost, little control were exercised over unnecessary treatment. High premiums and managed care has made consumers and providers aware of the impact of decisions related to their health.

Many hospitals have had ethics committees for years, which are responsible for monitoring the behaviour of physicians, but today the scope of these committees has enlarged considerably and membership in some instances has included nurses. Problems may arise if nurses make ethical decisions on the basis of the patient's best interests but contrary to physicians' or hospitals'

interests. With consumers involved in decision making, nurses again may face a situation in which they are expected to take action or not, based mainly on the conclusions of others (Ellis & Hartley 1992:219).

2.4.3. Religious factors which influence ethical decision making

Nurses are exposed to many religions in their daily dealings with patients and clients. They may be confronted by unfamiliar religions or with views that are at variance with their personal religious beliefs (Pera & Van Tonder 1996:203). Religious beliefs, for some people, are ultimate values that guide and justify the believer's moral conduct in important matters of living and dying (Bandman & Bandman 1995:295). According to Harrion (1992:104), religious beliefs, for many people, form the basis for making ethical decisions.

Members of both religious groups and health services present prescriptions or prohibitions on what may be done or may not be done in respect of life, body and emotions. Religion and the health service are therefore, continuously engaged in the process of describing and evaluating what is right and wrong ethically. The nurse who is part of both these groups can find herself torn between two value systems when making an ethical decision. Her ethical reasoning ability will play an important role in a situation like this. According to Galanti (1991:35) religious beliefs and practices are common sources of conflict and misunderstanding. When patients exercise their beliefs it can result in tragic interference with medical care. This will in turn impact on the nurses' ability to be unjudgemental and non-coercive in rendering care.

Problems or conflicts may arise when personal religious values of patients are conflicting with institutional values or religious values of professionals. Conflicting ethical issues or aspects may include "controversial procedure such as manipulation of the body (organ-transplants, cosmetic and transsexual surgery), human reproduction (abortions, test tube fertilisation, surrogate motherhood, birth control), the use of drugs (LSD as psychotherapy or cultic rituals) and the care of the dying (prolonging of life, active or passive euthanasia)" (Pera & Van Tonder 1996: 206). It is therefore, essential that health personnel understand different religions better in order to provide better care. This knowledge will enable health professionals to make decisions about

believing patients in an ethical and moral manner. Looking at some of the controversial procedures such as manipulation of body parts (organ transplant), trans-sexual surgery, abortion, test-tube fertilization, surrogate motherhood, birth control and euthanasia, there are religions that are strongly against such procedures.

In Orthodox Judaism the body is held to be divine property and no one, neither the state, the medical profession nor any other human agent has the right to use the body for any purpose, including postmortems and organ transplants. Catholicism, Islam and Hinduism are also strongly against euthanasia (Rumbold 1993:19,25-26). The family who believes in euthanasia may want it done to their patient regardless of whether the health professionals or institution believe in it or not. The implication of these religious issues on ethical decision making by nurses in the bureaucratic context are that there may be conflicts between patients, health professionals and families of patients, or even health professionals and state Acts or laws on controversial procedures such as abortions.

Jehovah's Witness patients may refuse blood transfusion on religious grounds even though it is for their own benefit, in preserving life and preventing unnecessary death. The nurse is not in a position to decide whether blood is to be given or not since most decisions are made by those with authority in the hospital hierarchy, especially doctors.

Nurses with strong Christian or Islamic beliefs may find it difficult to assist patients who are to terminate their pregnancies for reasons not acceptable to the nurses. The policies of the hospitals or state Acts may force nurses to assist in such procedures regardless of their religious beliefs. An example could be that of the Choice of Termination of Pregnancy Act, No.92 of 1996 where "any person who prevents the lawful termination of a pregnancy or obstructs access to a facility shall be guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding 10 years" (South Africa 1996 (a):1307).

The law here does not consider the religious beliefs of nurses or health professionals, but only the interests of patients. In this instance believing nurses are faced with serious ethical dilemmas, they are obligated to follow the law or to face criminal charges or job loss.

A study conducted by Gmeiner and Van Wyk (2000:9) found that nurses who are directly involved with termination of pregnancy need “support on a cognitive, emotional and spiritual level”. These nurses need to share their experiences as they have not all developed a coping mechanism. The nurse in this situation cannot really make a decision on her own. She can only counsel the patient but in the end the patient has the right of freedom of choice. This entails the nurse giving the patient all the necessary information to make an informed decision.

2.5. SUMMARY

Nursing is currently being practiced at a time of rapid change in social and professional values and it requires that nurses consider a variety of approaches to ethical decisions. The treatment of ethics in the context of the nurse’s roles within an institution is limited, though not absent. Nurses work under policies established by others, conflict arises between professional values and institutional values, nurses experience role conflict and conflict with other health care professionals, especially physicians, and nurses generally have either limited, or no, input into decisions that they are responsible for implementing (Thompson & Thompson 1990:5-6).

The impact of ethical principles on ethical decision making by nurses in the bureaucratic context has also been explored. On the question “which principle is most important?”, there is no universal agreement. The nursing profession is being encouraged to consider all ethical issues from the central issue of caring; since caring implies concern for preserving humanity and dignity and promoting well being, awareness of rules and principles is important, but not enough. Reliance on rules and principles alone may not adequately address the ethical issues that confront nurses, such as suffering or powerlessness (Zerwekh & Claborn 1997:356-357).

Socio-cultural, religious and occupational factors that influence ethical decision making have been outlined. These factors may act to impede the ethical practice of nursing. Several interrelated themes have been discussed and they include cultural values, religions, beliefs and occupational factors. Beliefs and values influence how nurses practice their profession. Nurses need to be aware of their beliefs and values to prevent the unintentional intrusion of personal

values into nurse-patient relationships. In chapter three the research methodology of this study will be discussed.

CHAPTER 3

METHODOLOGY

3.1. INTRODUCTION

This chapter describes the research design, the population, sampling techniques, the research instrument and the procedures used to collect and analyse data in order to accomplish the purpose of the research.

3.2. RESEARCH DESIGN

An exploratory quantitative survey was used to investigate ethical decision making by registered nurses in a bureaucratic context. According to Brink (1996:11) the purpose of an exploratory research design is to explore the dimension of a phenomenon, the manner in which it is manifested and the other factors which are related to it. The present study can be seen as exploratory, as it investigated the bureaucratic factors, ethical principles, socio-cultural, religious and occupational factors that influence ethical decision making.

A research design is the set of logical steps taken by a researcher to answer the research problems. The research design forms the blue print for the study and determines the method used to obtain subjects, collect data, analyse data, and interpret results (Roberts & Burke 1989: 144; Polit & Hungler 1993:129).

The design and planning phase is described as including the selecting of a research design, identifying the population to be studied, specifying methods to measure the research variables, designing the sampling plan, finalizing and reviewing the research plan, conducting a pilot study and making revisions. The empirical phase includes collection of data, preparing data for analysis, the analytic phase includes analyzing the data, interpreting results, and the dissemination phase includes communicating the findings and utilizing the findings (Polit & Hungler 1993: 38-41).

For the purpose of this study, the steps used included the following:-

- Designing and compiling a questionnaire,
- Writing a letter to the Department of Health and Welfare in the Northern Province for the purpose of obtaining permission to carry out the research in the Northern Region Hospitals,
- Obtaining permission from the Department of Health and Welfare in the Northern Province after a presentation was made to the research committee,
- Writing a letter to the Regional office for the purpose of obtaining permission to conduct research in hospitals,
- Getting permission from the hospitals to execute the research,
- Deciding on the population and the sample of the study,
- Carrying out of a pilot study and making revisions,
- Handing questionnaires to registered nurses,
- Gathering questionnaires, and
- Data analysis.

3.3. TARGET POPULATION

A target population is a group of individuals or elements from which the investigation is able to select a sample (Brink, 1996: 132; DePoy & Gitlin 1998:164; Polit & Hungler 1993:174; Roberts & Burke, 1989:254; Thomas 1990:34;).

The researcher surveyed registered nurses from all the hospitals in the Northern Region of the Northern Province. The following hospitals were surveyed:-

- A, B, C, D, E, F, G and H (See Annexure H).

3.4. THE SAMPLE

A sample is a subset of the population that is selected for a study (Crookes & Davis 1998: 327). As far as this study was concerned, all eight (8) hospitals found in the Northern Region of the Northern Province were included in the sample.

The sample of this study consisted of:-

- Registered nurses from hospitals: A, B, C, D, E, F, G and H

A convenience sampling was used. All registered nurses who were found on duty on the date arranged with the nursing managers for data collection were given questionnaires. Each hospital was visited on a different date, since it was not possible to visit all hospitals on the same day because of the vast distance between hospitals. See figure 3.1.

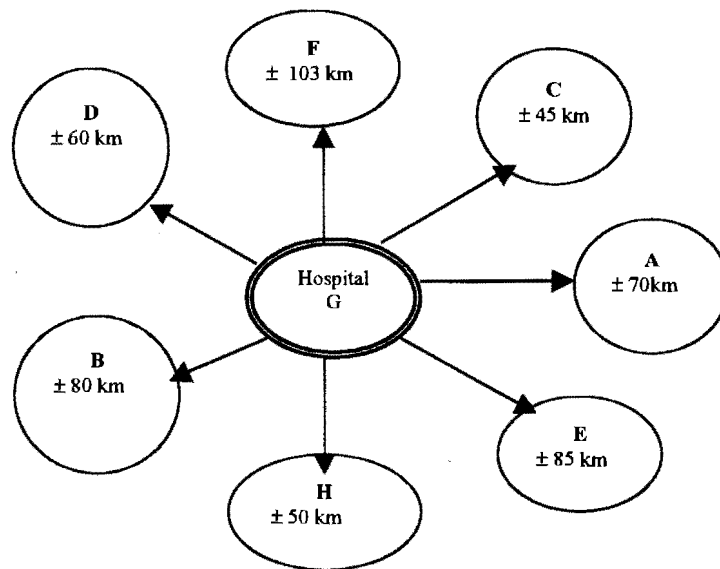


Figure 3.1. Distance between hospital G and other hospitals in kilometers

3.5. THE RESEARCH INSTRUMENT

3.5.1. The questionnaire

A questionnaire is a self-administered tool, in which the respondent reads the question and gives an answer in writing (Polit & Hungler 1991:193; Mateo & Kirchhoff, 1991:158). Questionnaires allow researchers to obtain information from a large number of persons within a relatively short time and are said to be the most commonly used method of obtaining survey data (Leedy 1985: 135; Treece & Treece 1986:277; Mateo & Kirchhoff 1991:138,158). The questionnaire was hence selected as the most appropriate tool for collecting data for this study.

3.5.2. Development of questionnaire

One questionnaire was developed by the researcher to assist in gathering data related to ethical decision making by registered nurses in a bureaucratic context. Questions were formulated from a number of sources, including the literature review, clinical experiences and information from colleagues (Crookes & Davis 1998: 142).

A statistician was consulted after the questionnaire was compiled in order to ensure that the correct information was gathered, to prepare data for computer analysis, to decide on the scales to be used, and for selecting statistical tests to describe subjects in the study; to determine if there was a relationship or no relationship between variables, or to identify changes that might have occurred in the variables under examination (Mateo & Kirchhoff 1991:200).

The questionnaire comprises four sections, that is sections A, B, C and D. Most questions required participants to choose responses from predetermined choices; however, a few open-ended questions were asked at the end of Section B, C, and D, which required participants to explain a statement (Mateo & Kirchhoff 1991:158).

A Likert scale was used for most questions. Registered nurses were required to choose the most appropriate option from always to never; or strongly agree to strongly disagree. Section A was used to obtain demographic information about registered nurses, namely age, gender, religion, ethnic group, qualifications, post level, years of experience and the units/wards in which they worked.

Section B was used to obtain the information related to the bureaucratic factors influencing ethical decision making.

Section C was used to obtain information dealing with the influence of ethical principles on ethical decision making. The aim was to determine the impact of ethical principles such as autonomy, justice, beneficence, nonmaleficence, truth telling and loyalty on ethical decision making.

Section D was used to obtain information dealing with the influence of cultural, religious, and occupational factors on ethical decision making. (See questionnaire in Annexure B).

3.5.3. Pre-testing the instrument

3.5.3.1. Validity and reliability

Validity refers to whether a measurement instrument accurately measures what it is supposed to measure (Seaman 1987: 318; LoBiondo-Wood & Haber 1990: 250; Polit & Hungler 1991:357).

Reliability refers to the degree with which the instrument measures the attribute it is supposed to be measuring; it entails the stability, consistency, accuracy and dependability of a measuring instrument (Seaman 1987:317; Treece & Treece 1986:253; and Polit & Hungler 1991:367).

The questionnaire was developed after a thorough review of literature relating to ethical decision making, ethical principles, ethical issues, bureaucracy, religion, and occupational or work environment in order to ensure content validity.

The questionnaire was further tested for face and content validity by professional nurses with knowledge in the field of ethics and professional practice as well as in the field of health service management. This was done to determine the instrument's adequacy in covering all the concepts pertaining to the phenomena being studied (Mateo & Kirchhoff 1991:164).

The statistical reliability of the questions and statements was also checked and pretested by statisticians and also by the researcher's supervisor and co-supervisor at the University of South Africa. Some changes were made, for example, instructions were to be written in bold letters so that respondents could easily understand what was expected of them. The instrument used in this study was regarded as reliable since relevant and clear instructions were given at the beginning of each section of the questionnaire to ensure that respondents understood exactly what was expected of them.

3.6. ETHICAL ASPECTS

Ethical use of human subjects in research involves protecting the rights of those persons studied. In order to protect such rights, the following aspects were considered:

- A letter requesting permission to conduct research in all eight hospitals of the Northern region/ Region Four was sent to the Superintendent/ Director General of the Department of Health and Welfare in the Northern Province. The research questionnaire, the research proposal, proof that the study was recommended by the senate and the research committee of UNISA, accompanied the letter (See Annexure C). The permission granted (See Annexure E) allowed the researcher to conduct the research in the hospitals only after another application was made to the Regional Director of Health and Welfare Northern Region (See Annexure F). Such an application was made and the Regional Office notified all hospitals.
- Arrangements were made with the managers of the hospitals for possible dates on which data could be collected. The manager notified the registered nurses about the nature of this research and that they were expected to complete the questionnaire on a voluntary basis. Letters to this effect are also given in Annexure A.
- The covering letter of the questionnaire clearly specified that participation in the research was voluntary and that confidentiality of information and anonymity of participants would be ensured, and that they could withdraw from the research at any time.

Authors like Roberts & Burke (1989:191); Burns & Grove (1993:94-108); Polit & Hungler (1993: 359) and Brink (1996:38) assert that nurse researchers involved with human subjects, have the responsibility to conduct research in an ethical manner. The respondents received a covering letter in which they were assured of their right to

- voluntarily participate in the research,
- withdraw from the research,
- anonymity.

The researcher was personally involved in the handing out of questionnaires and therefore, participants received sufficient information to make an informed decision to take part.

3.7. LIMITATIONS OF THE STUDY

The following aspects were considered constraints of participation by registered nurses.

- The questionnaire was quite long, taking 20 to 30 minutes to complete; two registered nurses even wrote at the end of the questionnaire that it was very long. Some registered nurses indicated that they did not know some ethical principles used.
- The research was conducted at a time when the hospitals were in transition, for example, hospital “G” was busy relocating staff according to the new staff establishment. This meant that nurses who were allocated to the clinics, yet their posts were in the hospital were transferred back to the hospital, and those in the hospital whose posts were in the community/clinics were sent to the clinics. This affected the return rate of questionnaires and also the years of experience of registered nurses in the hospital.
- There was also dramatic change occurring in all region four hospitals. All professional nurses who had been overdue for promotion since 1987 were promoted to higher ranks, for example professional nurses to senior professional nurses, senior professional nurses to chief professional nurses and others. This also affected the years of experience in the present post and changes in responsibilities. All the above mentioned limitations could have affected the response or participation rate of respondents, and
- Some hospitals did not receive the approval letter from the regional office in time. New arrangements with the regional office were made and this delayed the researcher in making appointments with the nursing service managers in time.

3.8. PILOT STUDY

A pilot study was conducted after the questionnaire was compiled. According to De Raeve (1996:27) "pilot work is valuable in identifying any questions that do not earn their keep".

The questionnaires were given to 25 registered nurses who worked in clinics under hospital "G". Five questionnaires were given to those registered nurses who worked in the teaching and clinical department of the same hospital. The respondents were requested to complete the questionnaire in the presence of the researcher. This made the researcher aware of some typing errors, which needed to be corrected, that some questions were repeated, and that some needed rephrasing, as some of the subjects could not understand the statements clearly. Subjects took 50-60 minutes to complete the questionnaire, which was regarded as long, and therefore some items were deleted. These respondents were not part of the final sample. The responses were similar to those of the final questionnaire, except for the information deleted.

3.9. COLLECTING OF DATA

Data were collected during August 1999 from all eight hospitals. A total of 200 questionnaires were distributed. Prior to the distribution process, the researcher made appointments with the nursing service managers of the eight hospitals. The researcher personally went to these hospitals to make appointments and to distribute the questionnaires. The presence of the researcher during distribution of questionnaires enabled the participants to know who the researcher was, and what the purpose of the study was. The respondents were then left to complete the questionnaires in their own time.

The nursing service managers were very co-operative and assisted in distributing the questionnaires. They even took the responsibility of collecting the questionnaires immediately after they were completed. The researcher then collected the questionnaires from the nursing service managers in various hospitals. One hundred and thirty three (133) (66.5%) questionnaires were returned.

3.10. RESPONSE TO QUESTIONNAIRES

The dates originally agreed upon with the nursing service managers for the return of questionnaires were not adhered to, since it was an inspection period for all region four hospitals in the Regional Office Department of Health; at the same time these hospitals were also busy preparing for the South African Nursing Council Inspection, for accreditation or reaccreditation of nursing schools, which was due in October 1999. Since registered nurses were so busy preparing for both inspections, this could have had an impact on the return rate of questionnaires. Despite all these drawbacks, the researcher managed to collect 133 questionnaires back, which is a 66.5 percent response rate. This was considered to be a good response, since a response rate of greater than 60 percent is considered by Polit and Hungler (1991:292) to be probably sufficient. Table 3.1 below indicates the response to questionnaires according to hospitals surveyed.

TABLE 3.1: Number of questionnaires distributed (N=200) and returned by respondents (N=133)

| HOSPITAL | TOTAL POPULATION | QUESTIONNAIRE RETURNED | % |
|--------------|------------------|------------------------|--------------|
| A | 30 | 30 | 100.0 |
| B | 30 | 19 | 63.3 |
| C | 10 | 9 | 90.0 |
| D | 15 | 5 | 33.3 |
| E | 30 | 13 | 43.3 |
| F | 10 | 6 | 60.0 |
| G | 30 | 30 | 100.0 |
| H | 45 | 21 | 46.6 |
| TOTAL | 200 | 133 | 66.5% |

3.11. DATA ANALYSIS

Data was transferred from the questionnaires to a statistical analysis software (SAS) Programme and processed by the departments of computer services at the University of South Africa and University of Venda.

Each item and sub-item was given a code number. The purpose of the analysis of the computer data was to note the percentage and frequency distributions of items. Tables and graphs will be used to display such percentages and frequencies.

3.12. SUMMARY

This chapter explained in detail the way in which the study was conducted, focusing on the methods of research adopted, the population, the instrument and decisions regarding strategies used to collect data. In chapter four the analysis and interpretation of data is described.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1. INTRODUCTION

This chapter deals with the analysis, interpretation and discussion of the responses to the questionnaire. As indicated in chapter 1, the objectives of the study were to determine the bureaucratic factors, ethical principles, socio-cultural, religious, and occupational factors that influence ethical decision making in the bureaucratic context. The purpose of this chapter is to present the information that was obtained from the responses of 133 respondents from 8 different hospitals.

Analysis of data will be presented under four sections, namely demographic data, ethical decision making and bureaucracy, ethical decision making and ethical principles, and cultural, religious and occupational factors which influence ethical decision making. The findings will be discussed according to the sub-divisions of the questionnaire.

In the tables and figures the following abbreviations will be used.

N = The total number of respondents

n = The number of the different categories that responded to an item

f = frequency of responses

In all the discussions on the influence of demographic variables “strongly agree” and “agree” will be grouped together for discussion purposes as well as “strongly disagree” and “disagree”, as this will indicate positive and negative responses towards the statements.

4.2. DISCUSSION OF THE FINDINGS

SECTION A: Demographic data

The rationale behind seeking demographic information about the respondents was to determine the relationship between the selected demographic variables (such as age, marital status, employment status, education) and ethical decision making. The profile of the respondents was necessary to give insight into the demographic structure of the sample.

Item 1: Gender

The first item in section A: Demographic data, examines the gender of respondents. Since nursing is historically a female profession, it was interesting to establish how many respondents were males. Respondents were therefore, requested to indicate whether they were male or female.

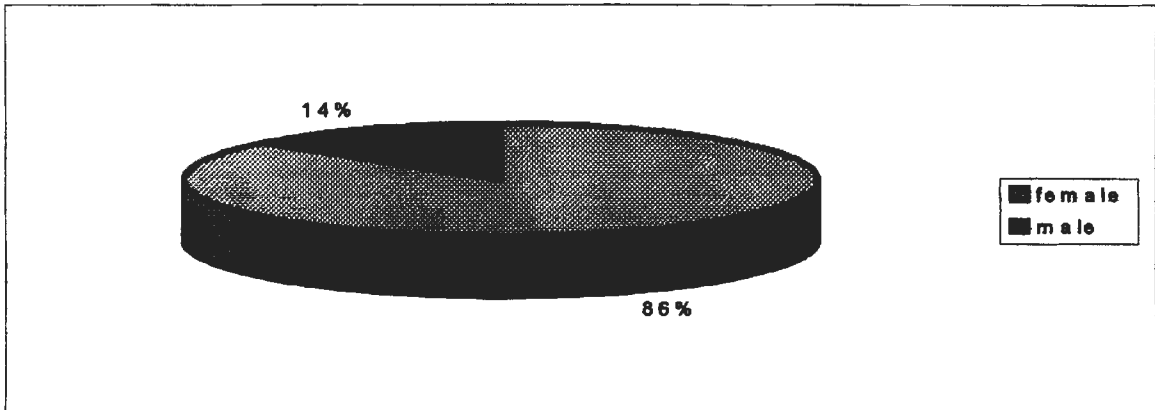


Figure 4.1: Gender of the respondents (N=133)

Figure 4.1 revealed that the largest number 115 (86%) of respondents were females and the remaining 18 (14%) were males. It can therefore be stated that nursing is still a predominantly female profession.

Item 2: Marital status

Respondents were asked to indicate their marital status in order to establish if their multiple roles could have an impact on their ethical decision making.

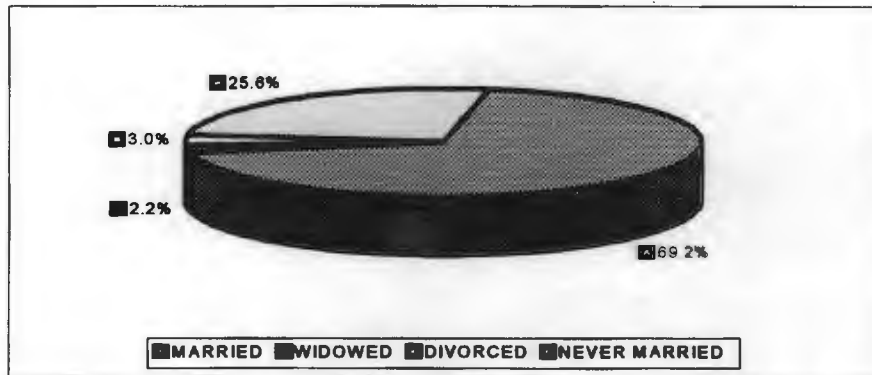


Figure 4.2: Marital status of respondents (N=133)

Figure 4.2 reveals that the largest number 92 (69.2%) of respondents were married, followed by 34 (25.6%) who never married, and 4 (3%) who were divorced and lastly 3 (2.2%) who were widowed. During the early twentieth century most nurses were unmarried and they devoted most of their time to the profession. Respondents who are married today have multiple roles to play, for example, the role of being a parent, a wife or husband, and that of being a professional person. One can deduce that they may experience role conflict. Since the remaining number, 41 (30.8%), were either never married, or were divorced or widowed, they may be single parents who may have similar responsibilities to married persons, and therefore they may experience role conflict. According to Morrison (1993:151) "when the expectations of two or more roles clash, role conflict occurs". The example is given of the mother who has to go to work when her child is ill. When adding cultural, social, educational and language differences this conflict becomes even more complex.

Item 3: Ethnic group

The ethnic groups of respondents are displayed in figure 4.3.

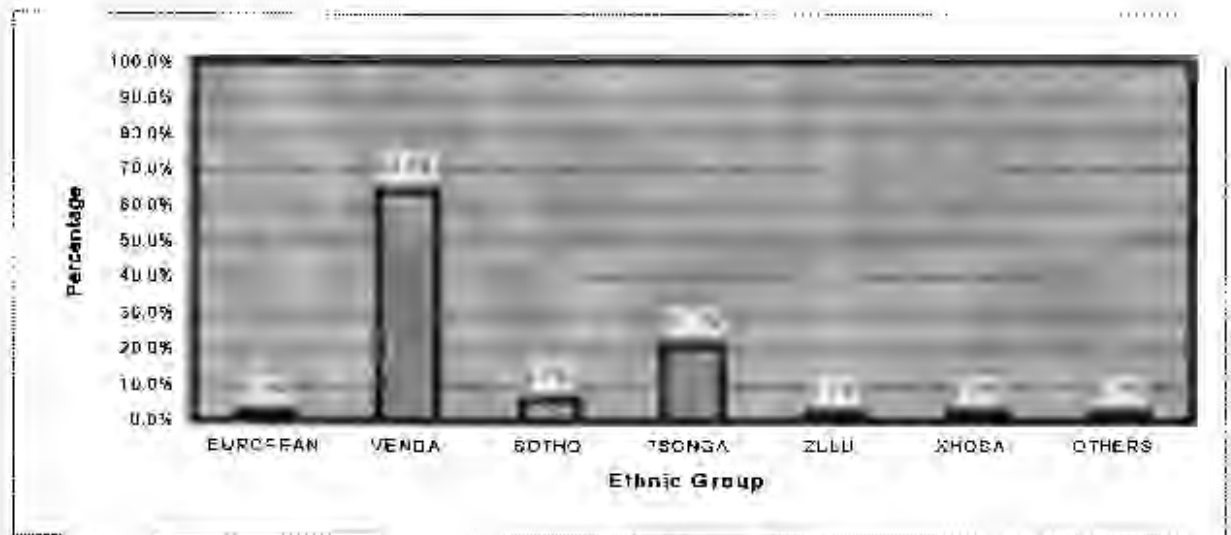


Figure 4.3: Ethnic group of respondents (N=133)

Figure 4.3 reveals that the largest number of respondents 85 (63.9%) were Vendas, followed by 28 (21.1%) Tsongas, eight (6.2%) Sothos, 3 (2.2%) Xhosas, 3 (2.2%) Zulus, 3 (2.2%) European and 3 (2.2%) others. The largest number of respondents are Vendas which can be attributed to the fact that four of the hospitals surveyed are from the former Venda, while two hospitals are in the former Gazankulu and two from the former Transvaal Provincial Administration. This is a positive aspect as the nurses will then be of the same ethnic groups as the patients, which will give them an understanding of the culture of patients when making ethical decisions.

Item 4: Home language

The home language of respondents is shown in figure 4.4.

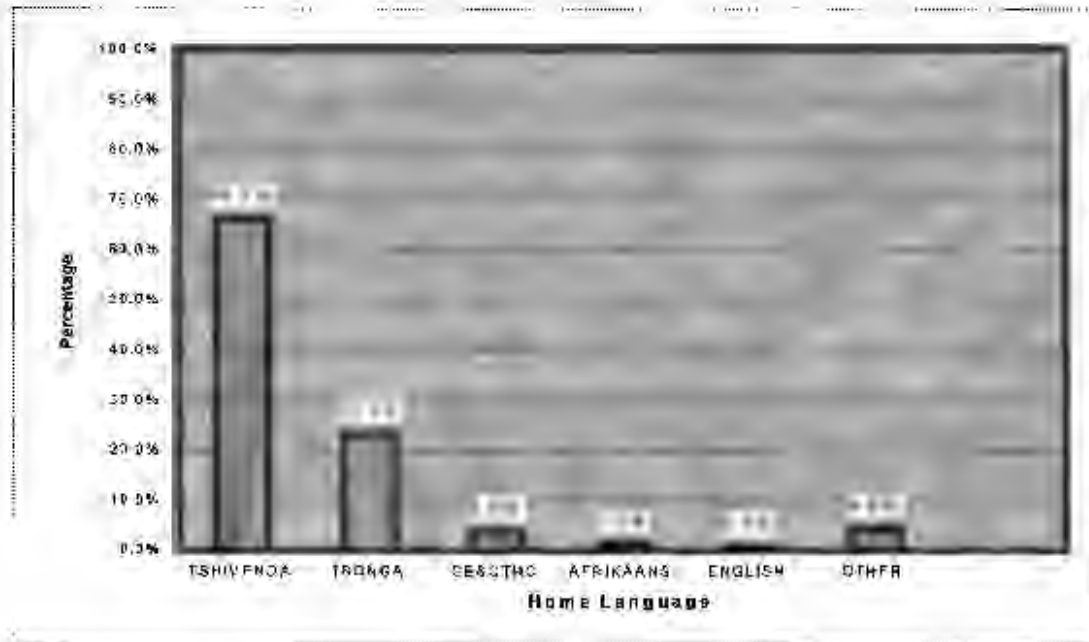


Figure 4.4: Home language of respondents (N=133)

The largest number 88 (66.2%) of respondents use Tshivenda, followed by 31 (23.3%) who use Tsonga; 6 (4.5%) use other languages, 5 (3.8%) use Sesotho, 2 (1.5%) use Afrikaans, and 1 (0.7%) uses English. The language of the respondents corresponds with the dominant ethnic group and the nurses will therefore be able to communicate effectively with their patients.

Item 5: Age distribution of respondents

The ages of respondents were grouped into eight groups of five years intervals. The ninth alternative of above 60 (60+) was included to accommodate those respondents who had long service or who may have been registered as nurses at an advanced age.

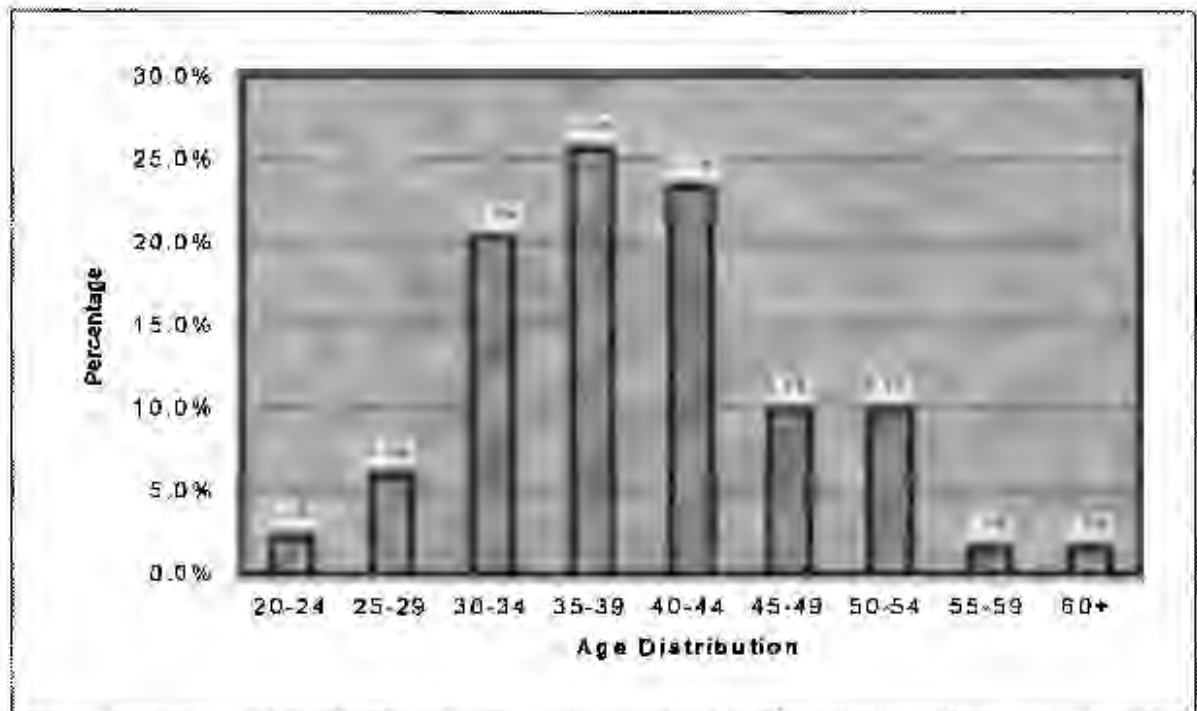


Figure 4.5: Age distribution of respondents (N=133)

Figure 4.5 reveals that the largest number, 31 (25.6%) of respondents, ranged within the age group of 35-39 years, followed by the age group of 40-44 years, 31 (23.3%). Twenty-seven (20.3%) respondents were between the ages 30-34 and 13 (9.8%) each within the ages of 45-49 and 50-54, Eight (6.0%) respondents fell within the age group of 25-29, 3 (2.2%) respondents fell within the age group of 20-24 and lastly 2 (1.5%) respondents fell within the age group of 55-59. Two (1.5%) were above 60 years of age.

The fact that only 11(8.2%) of the respondents are younger than 29 years indicates that most of the respondents are of a mature age and this could also imply that they have longer experience as nurses.

It would be interesting to note whether the older age groups with more experience, find fewer problems in making ethical decisions as experience from the past colours many of the issues you are confronted with in the present (Morrison 1993:30).

The influence of the age of respondents on the input in the care and discharge of patients in the hospitals.

Table 4.1: The influence of age of the respondents on the input regarding the care and discharge of patients (N=133)

| AGE | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|-------|----------------|-----|-------|------|----------|-----|----------|------|-------------------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| 20-24 | | | | | | | | | 3 | 100 | 3 | 100 |
| 25-29 | | | 1 | 12.5 | | | 1 | 12.5 | 6 | 75.0 | 8 | 100 |
| 30-34 | 1 | 3.7 | 1 | 3.7 | | | 13 | 48.1 | 12 | 44.5 | 27 | 100 |
| 35-39 | | | 3 | 8.8 | 3 | 8.8 | 8 | 23.5 | 20 | 58.9 | 34 | 100 |
| 40-44 | 2 | 6.5 | | | | | 14 | 45.1 | 15 | 48.4 | 31 | 100 |
| 45-49 | 1 | 7.7 | 1 | 7.7 | | | 5 | 38.5 | 6 | 46.1 | 13 | 100 |
| 50-54 | 1 | 7.7 | 1 | 7.7 | | | 5 | 38.5 | 6 | 46.1 | 13 | 100 |
| 55-59 | | | 1 | 50.0 | | | 1 | 50.0 | | | 2 | 100 |
| 60+ | | | 1 | 50.0 | | | | | 1 | 50.0 | 2 | 100 |

The findings reveal that all respondents, 3 (100%), whose ages fall between 20-24 strongly disagree that nurses have no input in the care and discharge of patients.

Between ages of 25-29 years 7 (87.5%) respondents gave a negative response while only 1 (12.5%) respondent agreed that nurses have no input regarding the care of and discharge of patients. Between the ages of 30-34 years 25 (92.6%) respondents gave a negative response while only 2 (7.4%) gave a positive response that nurses have no input in the care and discharge of patients.

Between the ages of 35-39 years 28 (82.4%) respondents gave a negative response while 3 (8.8%) respondents gave a positive response, and 3 (8.8%) respondents were not sure if nurses have no input regarding the care and discharge of patients.

Between the ages of 40 – 44 years 29 (93.5%) respondents gave a negative response, while only 2 (6.5%) respondents strongly agreed that nurses have no input regarding the care and discharge of patients.

It is interesting to note that respondents aged 45-49 years and 50-54 years gave similar responses. Eleven (84.6%) respondents each gave a negative response while only 2 (15.4%) respondents gave a positive response that nurses have no input regarding the care and discharge of patients.

Between the ages of 55-59 years 1 (50%) respondent agreed that nurses have no input in the care and discharge of patients, while 1 (50%) respondent disagreed that nurses have no input in the care and discharge of patients.

From sixty years and above (60+) 1 (50%) respondent agreed that nurses have no input in the care and discharge of patients, while 1 (50%) respondent strongly disagreed. Thus there is no significant difference between the age of respondents and whether they have input in the care and discharge of patients. It is encouraging to note that most nurses disagreed with the statement that nurses had no input regarding the care and discharge of patients. Sixty-nine nurses (51.9%) strongly disagreed and 47 (35.3%) disagreed. Nine (6.8%) agreed, 5 (3.8%) strongly agreed and only 3 (2.2%) were not sure.

Item 6: Church affiliations

The respondents were asked to indicate if they were affiliated to any religious group or not. The purpose of this item was to determine if belonging to a certain religious denomination could influence ethical decision making.

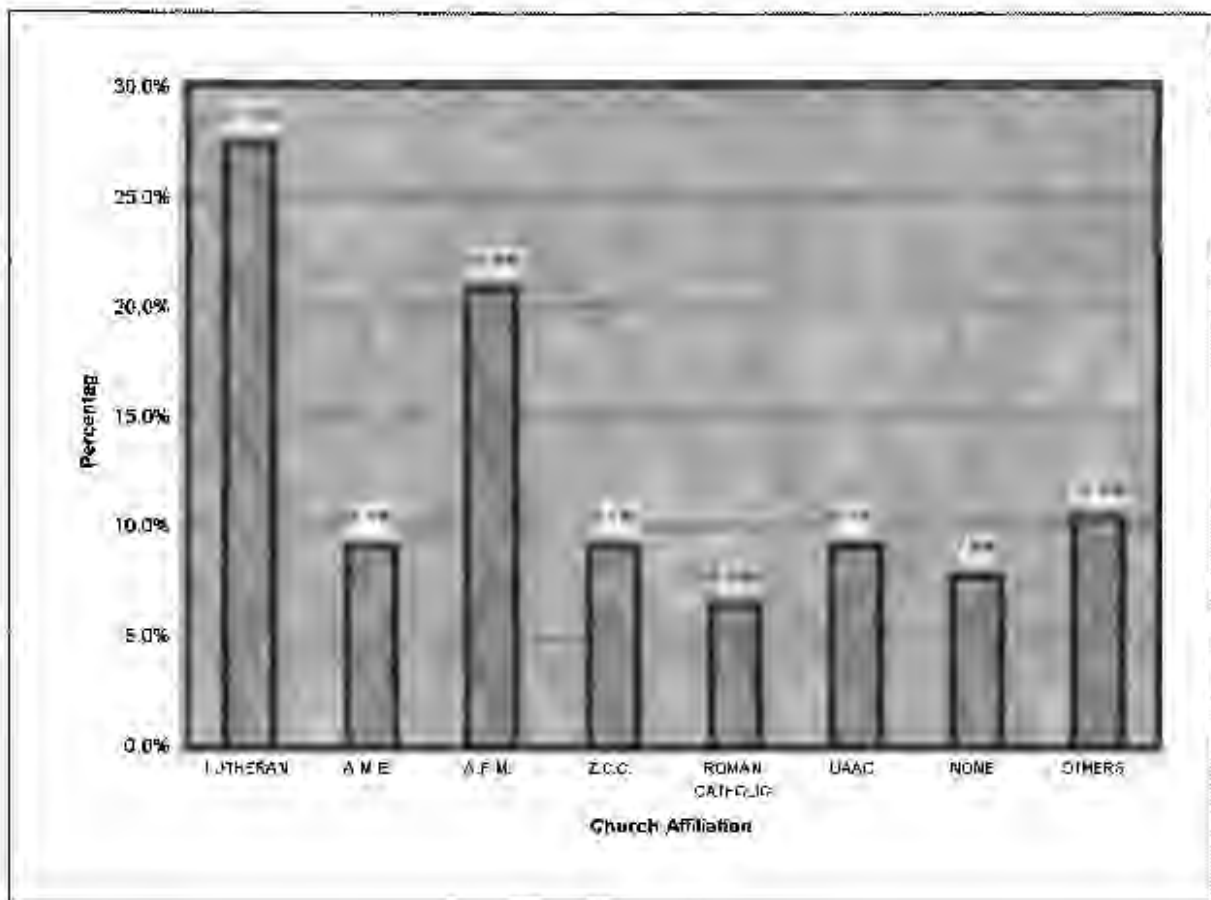


Figure 4.6: Church affiliation of the respondents (N=77)

Twenty one (27.3%) of the respondents attended the Lutheran Church, 16 (20.8%) attended the AFM church, 8 (10.3%) attended other churches not mentioned in the survey. The AME Church, ZCC and UAAC were attended by 7 (9.1%) for each group. Six (7.8%) of the respondents are not churchgoers, and 5 (6.5%) of the respondents attended the Roman Catholic Church. It became evident that most respondents 63 (81.9%) belonged to the Christian Religion, while 8 (10.3%) of the respondents who did not belong to any church could be members of other religious groups such as traditional or ancestral religion (Chidester 1992:3).

Although a person's moral values and beliefs play a role in ethical decision making it must be kept in mind that in ethical dilemmas a nurse has to make "a choice between two equally desirable or undesirable alternatives." An ethical dilemma consists of three characteristics, that

is, it cannot be solved using empirical data, it is difficult to know what data to use and its effects are far-reaching (Marquis & Huston 1994:416)

Item 7: Highest educational qualification in nursing

The purpose of this item was to establish the respondents' highest educational qualification.

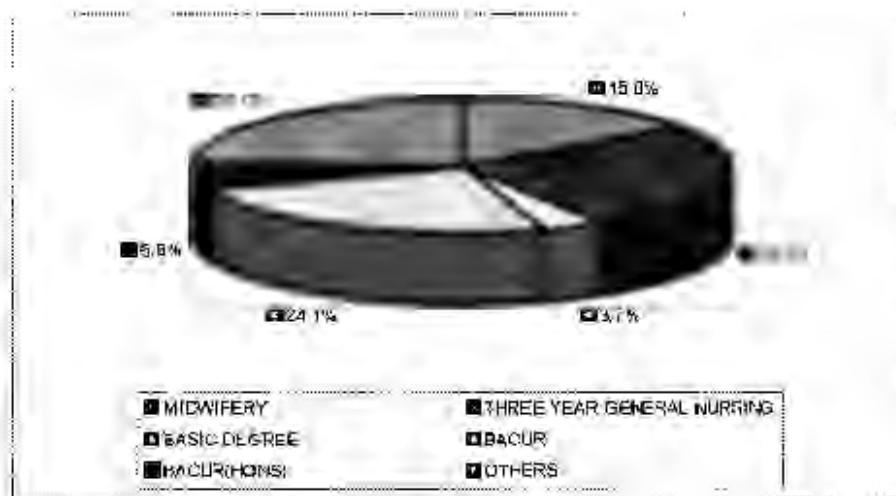


Figure 4.7: Highest educational qualification in nursing (N=133)

Figure 4.7 reveals that the largest number, 35 (26.3%) of respondents, completed a three year general nursing diploma, whereas 32 (24.1%) had BACur Degrees and 32 (24.1%) had other qualifications (only four year integrated course or other qualification); 20 (15.0%) respondents had midwifery, 9 (6.8%) had BACur (Hons) and a small number, 5 (3.7%), have a basic degree. Thirty seven (27.8%) were graduates and 9 (6.8%) had postgraduate degrees.

Item 8: Years of experience

The purpose of this item was to determine the impact of the registered nurse's experience in the working situation as far as ethical decision making is concerned.

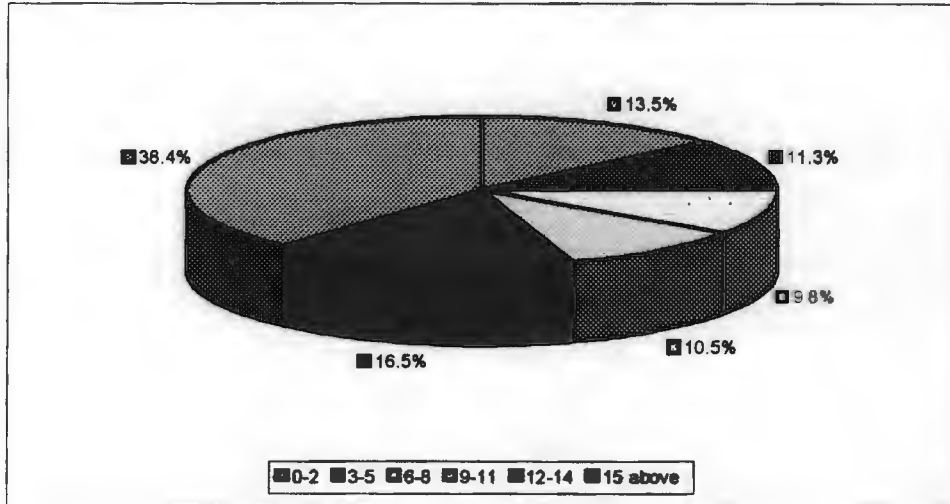


Figure 4.8: Years of experience (N=133)

It can be seen from figure 4.8 that a fair number, 51(38.4%) of the respondents, had more than 15 years experience, 22 (16.5%) had experience ranging from 12-14 years, 18 (13.5%) had experience ranging between 0-2 years, 15 (11.3%) had experience ranging between 3-5 years. Fourteen (10.5%) had experience ranging between 9-11 years, and 13 (9.8%) had experience ranging between 6-8 years. It can be concluded that most, 100 (75.1%) of the respondents, had experience of more than six years. Only a small percentage (13.5%) had less than two years experience.

Aristotle in Bandman and Bandman (1995:52) "believed that experience is tangible and concrete; we learn by doing." If this is true it can be assumed that nurses with more experience will be able to make ethical decision more readily than those with less experience.

Item 9: Post level held by respondents

The purpose of this item was to establish whether the position of the respondents in the bureaucratic hierarchy could influence their ethical decision making, since in a bureaucratic setting authority is vested in those in higher positions.

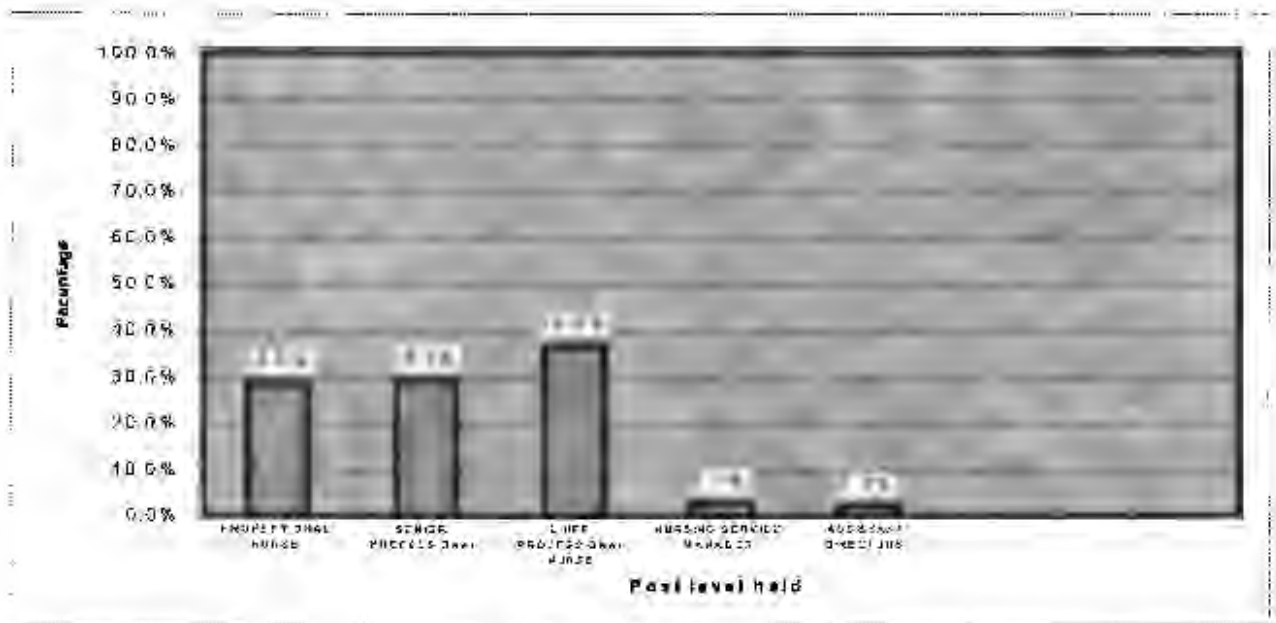


Figure 4.9: Post level held by respondents (N=133)

Figure 4.9 reveals that 49 (36.8%) of the respondents were chief professional nurses, 39 (29.3%) senior professional nurses, 38 (28.6%) professional nurses, 4 (3.0%) nursing service managers, and 3 (2.3%) assistant directors. Of all the respondents, 56 (42.1%) are at managerial level holding managerial posts such as chief professional nurses, nursing service managers and assistant directors. It can be deduced that these professional nurses are at a position or level which enables them to make ethical decisions.

When in a managerial position nurses should have learned to use a systematic approach to ethical decision making. "If a structured approach is used, data gathering is adequate and multiple

alternatives are carefully analyzed, then regardless of the outcome, the manager should feel comfortable that the best possible decision was made" (Marquis & Huston 1994:424)

Item 10: Years of experience in current post

In item 10, respondents were asked to indicate their experience in years, in their current position as shown in figure 4.10.

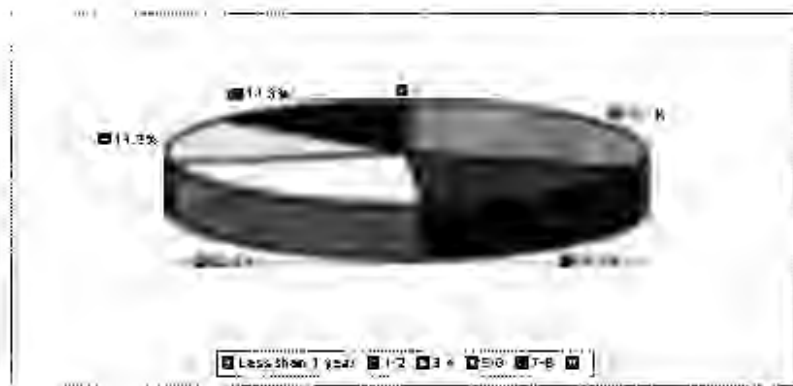


Figure 4.10: Years in current post (N=133)

According to figure 4.10 the highest number 40 (30.1%) of the respondents had less than one year experience, 30 (22.6%) had 3-4 year experience, 25 (18.7%) had 1-2 years experience, 19 (14.3%) had 5-6 years experience, and 19 (14.3%) had 7-8 years experience. The number of years in a specific post can be an indication that confidence to make ethical decisions is enhanced. The longer someone is in a specific post the more expertise can be gained, which results in other health care personnel respecting them. This gives the person expert power which enables them to participate meaningfully in ethical decision making (Booyens 1998:430).

Item 11: Areas where respondents were working

Responses to this item revealed that respondents were operating in a variety of sections or units.

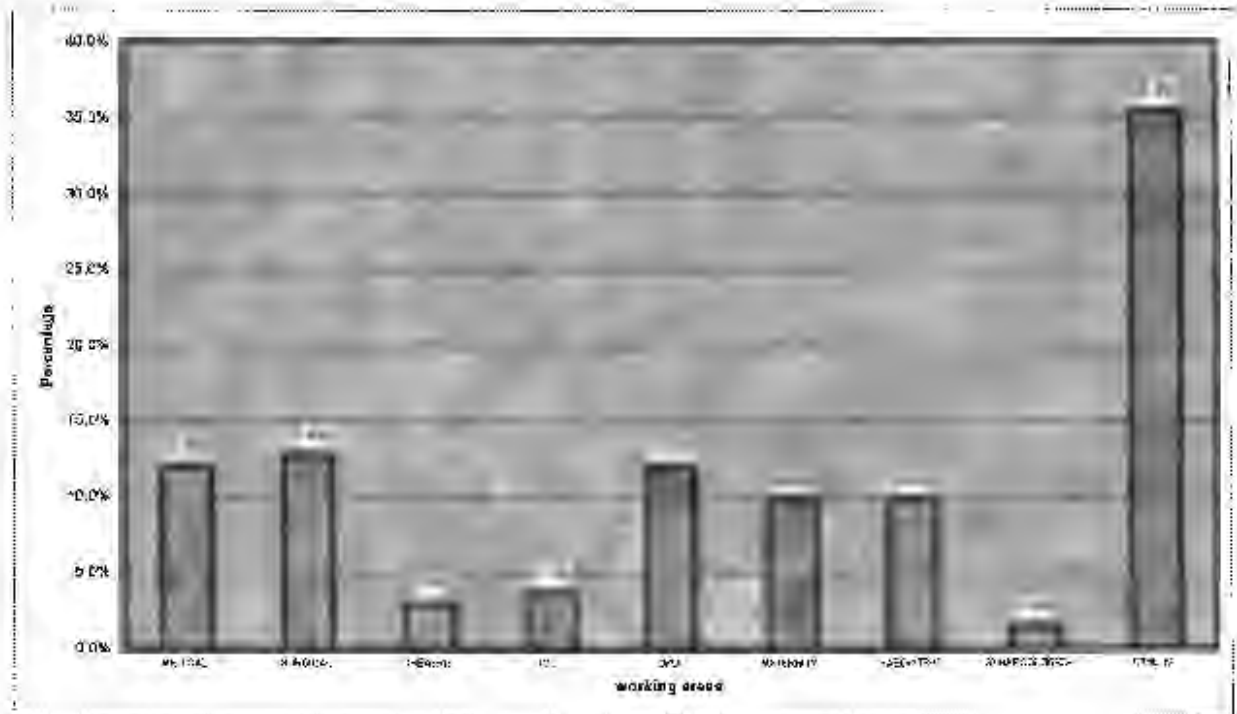


Figure 4.11: Areas where respondents are working (N=133)

According to figure 4.11 the highest number 47 (35.4%) of the respondents work in other wards (chronic wards) or sections (nursing administration) not indicated on the diagram, 17 (12.8%) work in the surgical ward, 16 (12.0%) work in the OPD, Sixteen (12.0%) of respondents work in a medical ward, 13 (9.8%) work in a maternity ward, 5 (3.7%) work in ICU, 4 (3.0%) work in theatre and 2 (1.5%) work in a gynaecological ward.

In a bureaucratic structure “employees are organized and ranked according to their degree of authority within the organization” (Booyens 1998:188). If this high percentage, 47 (35.4%), of the respondents are in senior positions this would give them the authority to make ethical decisions more readily than those lower down in the hierarchical structure.

SECTION B: THE INFLUENCE OF BUREAUCRACY ON ETHICAL DECISION MAKING

One of the objectives of the study was to determine the bureaucratic factors which influence ethical decision making in a bureaucratic context. The purpose of this section was to determine how often respondents participated in the budgeting procedure of the hospital, whether they participated in the care and discharge of patients in the hospital and whether their ethical decision making was influenced by other members of the health team.

Characteristics of a bureaucracy include: 1) rules and regulations, 2) specialization of tasks and division of labour, 3) appointment by seniority and achievement, and 4) an impersonal relationship between management and workers (Marquis & Huston 1994:32).

It is further mentioned by Marquis and Huston (1994:121) that “there is no single, widely acceptable alternative model for organizational structure that eliminates the problems of bureaucratic institutions.”

Section B is divided into four (4) parts, namely: - section B(1), B(2), B(3) and B(4).

Section B (1): The extent of respondents’ participation in the budgeting procedure of the hospital.

In this section respondents were asked how often they participated in the budgeting procedure of the hospital.

Table 4.2: The extent of respondents' participation in the budgeting procedure of the hospital (N=133)

| Item | Activities | Always | | Usually | | Some times | | Rarely | | Never | | Total | |
|------|---|--------|------|---------|------|------------|------|--------|------|-------|------|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 1. | Drawing up the budget for your unit | 40 | 30.1 | 13 | 9.8 | 32 | 24.0 | 11 | 8.3 | 37 | 27.8 | 133 | 100 |
| 2. | Providing input regarding needs of unit | 52 | 39.1 | 48 | 36.1 | 20 | 15.0 | 7 | 5.3 | 6 | 4.5 | 133 | 100 |
| 3. | Maintenance of equipment | 84 | 63.2 | 22 | 16.5 | 16 | 12.0 | 7 | 5.3 | 4 | 3.0 | 133 | 100 |
| 4. | Condemning equipment | 55 | 41.4 | 26 | 19.5 | 29 | 21.8 | 14 | 10.5 | 9 | 6.8 | 133 | 100 |

Item 1: Participation in drawing up the budget

Forty (30.1%) respondents always participated in drawing up of the budget, 13 (9.8%) usually participated, 32 (24.0%) sometimes participated, 11 (8.3%) rarely participated, and 37 (27.8%) never participated. As 100 (75.1%), according to Section A, item 8 had more than six years experience, it is disappointing that 80 (60.0%) never, rarely or only sometimes participated in drawing up of the budget.

The influence of years of experience and whether respondents participated in the drawing up of the budget for the unit.

Table 4.3: The influence of years of experience on drawing up of the budget (N=133)

| Years of Experience | Always | | Usually | | Sometimes | | Rarely | | Never | | Total | |
|---------------------|-----------|------|-----------|------|-----------|------|-----------|------|-----------|------|------------|-------------|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| 0-2 | 2 | 11.1 | 1 | 5.5 | 6 | 33.4 | 1 | 5.5 | 8 | 44.5 | 18 | 100 |
| 3-5 | 3 | 20.0 | | | 6 | 40.0 | 3 | 20.0 | 3 | 20.0 | 15 | 100 |
| 6-8 | 4 | 30.7 | 1 | 7.7 | 1 | 7.7 | 1 | 7.7 | 6 | 46.2 | 13 | 100 |
| 9-11 | 2 | 14.3 | 3 | 21.4 | 5 | 35.8 | 1 | 7.1 | 3 | 21.4 | 14 | 100 |
| 12-14 | 7 | 31.8 | 4 | 18.2 | 4 | 18.2 | 3 | 13.6 | 4 | 18.2 | 22 | 100 |
| 15+ | 22 | 43.1 | 4 | 7.9 | 10 | 19.6 | 2 | 3.9 | 13 | 25.5 | 51 | 100 |
| TOTAL | 40 | | 13 | | 32 | | 11 | | 37 | | 133 | 100% |

From table 4.3 it becomes clear that nurses with more than 9 years experience more often participate in drawing up of the budget than those with less experience. Of those with experience between 12 and 14 years 15 (68.2%) agreed that they participate to some extent in drawing up the budget, compared to 36 (70.5%) of those with more than 15 years experience and 10 (71.4%) of those with between 9 and 11 years of experience. The percentage of participation of the respondents who had less experience varied between 46.1 percent and 60 percent.

It is encouraging to note that on average almost two-thirds, 85 (64%) of the respondents, participate to a certain extent in the budgeting procedure. Cooperation from all levels of staff in the budgeting procedure is essential to ensure effective planning of the budget. Each member should, however, be clear as to what his/her responsibilities are. Ethical decision making regarding the budget refers, inter alia, to allocating resources available, fairly and justly. According to Koch (1998:182) "ever-increasing demands are being made on nursing managers to utilize the funds available to a health service cost-effectively".

Item 2: Providing input regarding needs of unit

It appears that 52 (39.1%) of the respondents always provided input regarding needs of the units, 48 (36.1%) usually provided input, 20 (15.0%) sometimes provided input, 7 (5.3%) rarely provided input, and 6 (4.5%) never gave input regarding needs of the unit. It is encouraging that most of the nurses had the opportunity to give input regarding the needs of the unit.

The combined percentage of 75.2% who always or usually provide input regarding the needs of the unit also agrees with item 1 (post level held by respondents) in section A, where 42.1% of the respondents indicated that they were of a managerial level which would give them the necessary authority to give input in determining the needs of the unit (Marquis & Huston 1994:110).

Item 3: Participation in maintenance of equipment

The findings in Table 4.2 reveal that 24 (63.2%) of the respondents always participated in maintenance of equipment, 22 (16.5%) usually participated, 16 (12.0%) sometimes participated, 7 (5.3%) rarely participated, and 4 (3.0%) never participated in the maintenance of equipment. All staff members should be involved on a continuous basis in the maintenance of equipment (Troskie 1996:268). If 27 (20.3%) of the respondents seldom or never participate in maintenance of equipment there is a need for in-service training providing input regarding needs of the unit.

Item 4: Participation in condemning equipment

Regarding condemning equipment, 55 (41.1%) always condemn, 20 (19.5%) usually condemn, 29 (21.8%) sometimes condemn, 14 (10.5%) rarely condemn, and 9 (6.8%) never participated in condemning equipment. All breakages need to be reported to the person in-charge of a unit; as only 38 (26.8%) of the respondents are in a post below senior professional nurse, it is a cause for concern that 52 (39.1%) are not involved on a regular basis with condemning of equipment. As far as maintenance of equipment and condemning of equipment is concerned, there are functions (delegated) which are the responsibility of all categories of nurses. Everyone working with or operating equipment should have knowledge of how to maintain it and should be able to evaluate when it needs replacement (Troskie 1996:268). It could be that respondents do not always regard their input in this respect as participation, which could account for the percentage of respondents who seldom or never participate.

All managers should have an understanding of fiscal principles and should be accountable to manage their units cost effectively. They must have the assertiveness to professionally articulate

the needs of their units and they must be skilful in monitoring the budget control (Marquis & Huston 1994:110).

Decisions regarding the budget are very important and nurses should have the knowledge and authority to participate in these activities.

Section B (2): The participation of respondents in the care and the discharge of patients in hospital

In this section respondents were requested to give their opinion on whether they participated in the care in, and the discharge of patients from hospital.

Participating or not participating in such activities by nurses is believed to have a significant impact on ethical decision making.

Table 4.4: The participation of respondents in the care and the discharge of patients in the hospital (N=133)

| Statement | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | Total | |
|---|----------------|------|-------|------|----------|------|----------|------|-------------------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| 5 I must consult with the medical doctor when making decisions regarding patients' treatment | 76 | 57.1 | 44 | 33.1 | 2 | 1.5 | 6 | 4.5 | 5 | 3.8 | 133 | 100 |
| 6 I have no input on the doctor's decision to discharge a patient | 8 | 6.0 | 9 | 6.8 | 3 | 2.3 | 42 | 31.6 | 71 | 53.3 | 133 | 100 |
| 7 The doctor's power influences my ethical decision when giving patients treatment | 18 | 13.5 | 26 | 19.6 | 6 | 4.5 | 46 | 34.6 | 37 | 27.8 | 133 | 100 |
| 8 The doctor's power influences my ethical decision making when informing patients of their condition | 16 | 12.0 | 36 | 27.1 | 12 | 9.0 | 32 | 24.1 | 37 | 27.8 | 133 | 100 |
| 9 Doctors are the main decision makers on patient matters in hospitals | 12 | 9.0 | 23 | 17.3 | 2 | 1.5 | 41 | 30.8 | 55 | 41.4 | 133 | 100 |
| 10 Nurses in the hospital setting are expected to carry out doctors' orders | 57 | 42.8 | 61 | 45.8 | 3 | 2.3 | 9 | 6.8 | 3 | 2.3 | 133 | 100 |
| 11 The perception that nurses who ask many questions are disliked by doctors leads to inappropriate decisions being taken by nurses | 20 | 15.0 | 29 | 21.8 | 19 | 14.3 | 37 | 27.8 | 28 | 21.1 | 133 | 100 |
| 12 Nurses do not challenge doctor's decisions on patient care because nurses are not part of the decision making process | 4 | 3.0 | 12 | 9.0 | 3 | 2.3 | 47 | 35.3 | 67 | 50.4 | 133 | 100 |
| 13 Nurses do not challenge doctor's decisions on patient care because they occupy the bottom level of the hospital hierarchy | 9 | 6.8 | 12 | 9.0 | 9 | 6.8 | 45 | 33.8 | 58 | 43.6 | 133 | 100 |
| 14 Because doctors spend less time with patients nurses are best suited to make ethical decisions | 40 | 30.1 | 44 | 33.1 | 13 | 9.8 | 25 | 18.8 | 11 | 8.2 | 133 | 100 |
| 15 More appropriate ethical decisions are made when doctors and nurses discuss a patient's condition | 74 | 55.6 | 39 | 29.3 | 11 | 8.3 | 4 | 3.0 | 5 | 3.8 | 133 | 100 |
| 16 Doctors do not recognise nurses as colleagues or co-workers, but see them as a working force | 36 | 27.0 | 40 | 30.1 | 2 | 1.5 | 28 | 21.1 | 27 | 20.3 | 133 | 100 |

Item 5: I must consult with medical doctors when making decisions regarding patients' treatment

It appears from Table 4.4 that the respondents are aware that they should work hand in hand with doctors when making ethical decisions, since most of the respondents 76 (57.1%) strongly agreed that they must consult with doctors when making ethical decisions, while 44 (33.1%) agreed, and only 6 (4.5%) disagreed, 5 (3.7%) strongly disagreed, and 2 (1.5%) were not sure.

It was determined whether the post level held by respondents had any influence on consulting with the medical doctors when making ethical decisions.

Table 4.5: The influence of post level of respondents on consulting with the medical doctor when making ethical decisions (N=133)

| Post level | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|---------------------|----------------|------|-------|------|----------|-----|----------|-----|-------------------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Professional Nurse | 21 | 55.2 | 13 | 34.2 | 2 | 5.3 | 2 | 5.3 | | | 38 | 100 |
| Senior Professional | 27 | 69.2 | 12 | 30.8 | | | | | | | 39 | 100 |
| Chief Professional | 25 | 51.0 | 16 | 32.6 | | | 4 | 8.2 | 4 | 8.2 | 49 | 100 |
| Nursing Service | 2 | 50.0 | 1 | 25.0 | | | | | 1 | 25.0 | 4 | 100 |
| Other | 1 | 33.3 | 2 | 66.7 | | | | | | | 3 | 100 |

According to table 4.5 it is clear that most of the nurses agreed that they first have to consult with the medical doctor when making ethical decisions. Of the professional nurses 34 (89.4%) agreed, so did 39 (100%) of the senior professional nurses, 3 (100%) of the professional nurses, 3 (75%) nursing service managers and 3 (100%) assistant directors. This is a reflection that teamwork is taking place in the services, which is essential for making effective ethical decisions related to patient care. Morrison (1993:291) mentions that "most, if not all, of clients' care is determined by several specialists, team-building skills are important for fostering an effective, upbeat work environment". It is therefore clear that post levels does not have an influence on consultation with medical doctors when making ethical decisions.

Item 6: I have no input on the doctor's decision to discharge a patient

It appears in table 4.4 that the majority, 113 (84.9%), of the respondents disagree with the statement that they have no input on the doctor's decision to discharge a patient, 17 (12.8%) respondents agreed, while only 3 (12.8%) respondents were not sure.

Item 7: The doctor's power influences my ethical decision when giving patients treatment

The findings in table 4.4 reveals that the majority 83 (62.5%) of respondents did not believe that the doctor's power influenced their ethical decisions when giving patients treatment, 44 (33.0%) agreed, and only six (4.5%) were not sure.

Item 8: The doctors power influences my ethical decision making when informing patients of their condition

More than half (51.9%) of the respondents disagreed that the doctor's power influenced their decision making when informing patients of their condition, while 52 (39.1%) respondents agreed and only 12 (9.0%) were not sure.

Item 9: Doctors are the main decision makers on patient matters in hospital

According to table 4.4 the majority 96 (72.1%) of respondents, disagreed that doctors are the main decision makers on patient matters, in hospital, only 35 (26.4%) agreed and 2 (1.5%) were not sure.

It was analysed whether the post level held by respondents had any influence on the respondent's perception that the doctors are the main decision makers on patient matters in hospital.

Table 4.6: Post level of respondents and their perception on whether doctors are the main decision makers (N=133)

| Post level | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|---------------------|----------------|------|-------|------|----------|------|----------|------|-------------------|-------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Professional Nurse | 4 | 10.5 | 1 | 2.6 | 9 | 23.7 | 12 | 31.6 | 12 | 31.6 | 38 | 100 |
| Senior Professional | 4 | 10.3 | 11 | 28.2 | | | 11 | 28.2 | 13 | 33.3 | 39 | 100 |
| Chief Professional | 3 | 6.1 | 2 | 4.1 | 2 | 4.1 | 18 | 36.7 | 24 | 49.0 | 49 | 100 |
| Nursing Service | | | | | | | | | 4 | 100.0 | 4 | 100 |
| Assistant Director | 1 | 33.3 | | | | | | | 2 | 66.7 | 3 | 100 |

As can be seen from table 4.6 that all categories of nurse respondents mainly disagree with the statement that doctors are the main decision makers. Of the professional nurses 24 (63.2%) disagreed as did 24 (61.5%) of the senior professional nurses, 4 (100%) nursing service managers and 2 (66.7%) assistant directors. It can be deduced that the post level of nurses does not have an influence on how they see doctors as main decision makers. Marquis and Huston (1994:157) are of the opinion that managers “must not only understand the organizational structure they work in, but also be able to function effectively within that structure, including dealing with inherent organizational politics present”. At the same time the nurse and doctor both share the responsibility for the patient and each is accountable for his/her acts and omissions. If nurses therefore, agree that doctors are the main decision makers they should also be willing to accept the responsibility for their ethical decisions. From table 4.5 it did, however, become clear that they do consult with the doctor in matters related to patient care.

Item 10: Nurses in the hospital setting are expected to carry out doctors' orders

The findings in table 4.4 reveal that the largest number 118 (88.7%) agreed that nurses are expected to carry out doctors' orders in a hospital setting, a small number 12 (9.0%) disagreed, and only 3 (2.3%) were not sure. According to Searle and Pera (1995:218) “Modern developments in health care require that nurses fulfil a more extensive instrumental role based on a team relationship with the doctor and other members of the health team”. The authors further

mentioned that the nurse “is the associate and the co-worker in the provision of the care and not the doctor’s handmaiden”.

Item 11: The perception that nurses who ask many questions are disliked by doctors leads to inappropriate decision being taken by nurses

The findings in table 4.4 reveal that 65 (48.9%) disagreed with the statement that the perception, that nurses who ask many questions are disliked by doctors, leads to inappropriate decisions being taken by nurses, 49 (36.8%) agreed, and 19 (14.3%) were not sure. According to Booyens (1998:511) the nurses’ incapacity to decide can arise “because the situation is new or unfamiliar to them, because there are conflicting orders confronting them, or because the necessary authority to decide has not been delegated to them.”

Item 12: Nurses do not challenge doctor’s decisions on patient care because nurses are not part of the decision making process

The findings in table 4.4 reveal that the majority, 114 (85.7%) of respondents, disagreed that nurses do not challenge doctor’s decisions on patient care because they are not part of the decision making process, while only 16 (12.0%) agreed and 3 (2.3%) were not sure. When looking at the primary focus of a bureaucracy which is proper allocation of work to people with a simple direct chain of command pattern where authority and responsibility as well as span of control is clearly defined, these findings are understandable (Morrison 1993:201).

Item 13: Nurses do not challenge doctor’s decisions on patient care because they occupy the bottom level of the hospital hierarchy

It became evident in table 4.4 that the majority, 103 (77.4%) of the respondents, disagreed that nurses do not challenge doctor’s decisions on patient care because they occupy the bottom level of the hospital hierarchy, only 21 (15.8%) agreed and 9 (6.8%) were not sure. It can be decided that nurses have some input into the care and discharge of patients in hospital.

Item 14: Because doctors spend less time with patients nurses are the best suited to make ethical decisions

In table 4.4, it became evident that most 84 (63.2%) respondents agreed that nurses are best suited to make ethical decisions since doctors spend less time with patients, 36 (27.0%) disagreed, and 13 (9.8%) were not sure. Nurses will have to become more assertive in exercising their advocacy role to ensure that decisions made are in the best interests of their patients.

Item 15: More appropriate ethical decisions are made when doctors and nurses discuss a patient's condition

According to table 4.4 the majority 113 (84.9%) of respondents were of the opinion that more appropriate ethical decisions are made when doctors and nurses discuss a patient's condition, while only 9 (6.8%) disagreed, and 11 (8.3%) were not sure. In order to make more appropriate ethical decisions, doctors and nurses should establish a trusting relationship; doctors as leaders of the health team should trust nurses to perform to expected standards (Booyens 1998:440).

Item 16: Doctors do not recognize nurses as colleagues or co-workers, but see them as a working force

The findings in table 4.4 reveal that the majority 76 (57.1%) of the respondents agreed that doctors do not recognize nurses as colleagues or co-workers, but see them as a working force, 55 (41.4%) disagreed and only 2 (1.5%) were not sure. If it is true that more than half of the respondents are of the opinion that doctors do not recognise nurses as colleagues, statements made by Searle and Pera, (1995:221) regarding the role status of the nurse that "In Southern Africa, the registered nurses/midwife practitioner has the role status of autonomous practitioner" will have to be investigated. They further mentioned that the nurse "is fully accountable for her own acts of commission and omissions, that she is fully responsible and accountable for how she practices her profession". If this role status is not acknowledged by doctors, this will affect the nurses' ethical decision making on matters concerning patient care. This bureaucratic tendency needs to be curbed if satisfactory decisions are to be made.

Section B (3): The influence of other staff on respondents' ethical decision making

In this section respondents were requested to give their opinion on whether other staff members influence their ethical decision making.

Table 4.7: The influence of other staff members on respondents' ethical decision making

(N=133)

| Statement | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | Total | |
|---|----------------|------|-------|------|----------|-----|----------|------|-------------------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| 17 The immediate supervisor allows you to function independently | 28 | 21.0 | 64 | 48.1 | 11 | 8.3 | 16 | 12.0 | 14 | 10.6 | 133 | 100 |
| 18 The supervisor can easily be persuaded to implement improvements in the job situation | 33 | 24.8 | 63 | 47.4 | 9 | 6.8 | 23 | 17.3 | 5 | 3.7 | 133 | 100 |
| 19 Ethical decision making is enhanced when nurses collaborate with other health personnel | 54 | 40.6 | 59 | 44.4 | 9 | 6.8 | 5 | 3.7 | 6 | 4.5 | 133 | 100 |
| 20 The superintendent should be informed of decisions made since he/she is not in close contact with patients | 55 | 41.4 | 55 | 41.3 | 8 | 6.0 | 9 | 6.8 | 6 | 4.5 | 133 | 100 |
| 21 The Nursing Service Manager should be informed of decisions made since he/she is not in close contact with the patient | 53 | 39.8 | 57 | 42.9 | 6 | 4.5 | 10 | 7.5 | 7 | 5.3 | 133 | 100 |

The findings in table 4.7 reveal that the majority of the respondents were aware that other staff members could influence their ethical decision making. "Strongly agreed" and "agreed" were grouped together for discussion as were "disagreed" and "strongly disagreed."

Item 17: The immediate supervisor allows you to function independently

With regard to whether the immediate supervisor allowed them to function independently 92 (69.1%) agreed, 30 (22.6%) disagreed, and 11 (8.3%) were not sure. The fact that 92 (69.1%) of the respondents agreed that they were allowed to function independently indicates that

supervisors have confidence in the skills of their sub-ordinates. This collegial structure “is more sensitive to the environment than the bureaucratic structure, yet it retains enough components of the bureaucratic model to provide organizational stability” (Booyens 1993:187-188).

Item 18: The supervisor can easily be persuaded to implement improvements in the situation

Regarding whether the supervisor can easily be persuaded to implement improvements in the job situation 96 (72.2%) agreed, 28 (21.0%) disagreed and 9 (6.8%) were not sure. It is encouraging to note that a higher percentage (72.2%) is of the opinion that improvements can be made with the consent of supervisors. This is an indication that even though a bureaucratic structure is in place, specialized lower-level workers are given the opportunity to make the necessary decisions and give input regarding the needs of their field of speciality (Booyens 1998: 188).

Item 19: Ethical decision making is enhanced when nurses collaborate with other health personnel

Regarding whether decision making can be enhanced when nurses collaborate with other health personnel 113 (84.9%) agreed, 11 (8.3%) disagreed and 9 (6.8%) were not sure. This is supported by Searle and Pera (1995:265, 266) who asserted that “in the interest of the total health of her patient, the nurse has the duty to collaborate with all other members of the health team involved with the patient, as well as with the patient, his relatives, friends and society in general”.

Item 20: The superintendent should be informed of decisions made since he/she is not in close contact with patients

Regarding whether the superintendent should be informed of the decisions made since he/she is not in close contact with the patient 110 (82.8%) agreed, 15 (11.2%) disagreed, and 8 (6.0%) were not sure.

The fact that 110 (82.8%) agreed that the superintendent should be informed regarding decision making indicates a bureaucratic structure aimed at smooth operation within a complex organization (Booyens 1998:187).

Item 21: The nursing service manager should be informed of the decisions made since she/he is not in close contact with the patient

With regard to whether the nursing service manager should be informed of the decisions made since s/he is not in close contact with the patient 110 (82.8%) agreed, 17 (12.7%) disagreed, and 6 (4.5%) were not sure. As with superintendents, nursing service managers are placed at the top of the hierarchical structure. This bureaucratic “red tape” often leads to frustration in making a decision as it could be hampered if responsibility to make a decision sometimes needs the approval of up to six different people (Booyens 1998:190). “People do not derive the necessary satisfaction from or pride in their work because it is too difficult to determine their specific contribution to the end result” (Booyens 1998:190).

Creighton (1986) in Morrison (1993:38) postulates that “managers, supervisors and leaders have special obligations when getting work done through the efforts of others”. In fact, a supervisor “may be liable for the negligence of others to whom she or he has assigned certain duties”. As supervisors have to act with due care towards both clients and employees, the responses to the above five statements are to be expected.

Section B (4): The extent to which respondents view the influence of their present work situation on ethical decision making

In this section the respondents were asked to indicate the extent to which they view the influence of their present work situation on ethical decision making.

In order to get a picture of the influence of the present work situation on ethical decision making, respondents were to indicate if their present work situation always, usually, sometimes, rarely, or never had an impact on ethical decision making.

Table 4.8: The extent to which respondents view the influence of their present work situation on ethical decision making (N=133)

| Statement | Always | | Usually | | Some-times | | Rarely | | Never | | Total | |
|--|--------|------|---------|------|------------|------|--------|------|-------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| 22. I find my post exciting | 47 | 35.3 | 33 | 24.8 | 36 | 27.1 | 7 | 5.3 | 10 | 7.5 | 133 | 100 |
| 23. My work is complicated | 13 | 9.8 | 20 | 15.0 | 51 | 38.3 | 17 | 12.8 | 32 | 24.1 | 133 | 100 |
| 24. My workload is manageable | 28 | 21.1 | 35 | 26.3 | 49 | 36.8 | 10 | 7.5 | 11 | 8.3 | 133 | 100 |
| 25. The supervisor of the unit manages the unit in a democratic way | 34 | 25.6 | 40 | 30.0 | 36 | 27.1 | 12 | 9.0 | 11 | 8.3 | 133 | 100 |
| 26. I am allowed to make my own decisions related to patient care | 36 | 27.1 | 31 | 23.3 | 37 | 27.8 | 11 | 8.3 | 18 | 13.5 | 133 | 100 |
| 27. Nurses do not participate in ethical decision making because they are afraid to make wrong decisions | 16 | 12.1 | 18 | 13.5 | 49 | 36.8 | 21 | 15.8 | 29 | 21.8 | 133 | 100 |
| 28. Ethical decision making in the unit is influenced by the policies of the institution | 40 | 30.1 | 29 | 21.8 | 41 | 30.8 | 15 | 11.3 | 8 | 6.0 | 133 | 100 |
| 29. There are standing orders that come into conflict with my scope of practice | 28 | 21.1 | 14 | 10.5 | 50 | 37.6 | 17 | 12.8 | 24 | 18.0 | 133 | 100 |

Item 22: I find my post exciting

It appears in table 4.8 that a high number 80 (60.1%) of respondents always or usually found their work exciting and 36 (27.1%) sometimes found it exciting. Only a small number 17 (12.8%) rarely or never found their work exciting. Excitement refers to enthusiasm for the job, so if a high percentage (60.1%) usually or always found their job exciting it could imply that they experienced job satisfaction. According to Booyens (1998:203) "Nurses like to work in a climate where they can achieve satisfaction from their jobs when the jobs are perceived as challenging,

when patients and managers recognize their achievements, when they can participate in decision-making on collegial basis with other health professionals.” Therefore, even though these nurses are working in a bureaucratic environment they still experience conditions conducive to ethical decision making.

Item 23: My work is complicated

Most, 51 (38.3%), respondents found their work sometimes complicated, while 32 (24.1%) never found it complicated, 20 (15.0%) usually found it complicated, 17 (12.8%) rarely found it complicated, and 13 (9.8%) always found it complicated. For a job to be exciting it must offer variety of opportunities, the employee should understand it and it must be meaningful (Bezuidenhout 1998 (a): 674)). It would seem as though nurses are granted the opportunity to enrich their jobs as only 33 (24.8%) usually or always found their jobs complicated. The rest were only sometimes, rarely, or never faced with complicated work which reflects that they were allocated to posts where they could function optimally.

It was determined whether the units where the respondents work influenced their perception on whether their work was complicated or not.

Table 4.9. The influence of work units and the respondents’ perception on whether they find their work complicated (N=133)

| Work Unit | Always | | Usually | | Sometimes | | Rarely | | Never | | Total | |
|---------------|--------|------|---------|------|-----------|------|--------|------|-------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Medical | 4 | 25.0 | | | 6 | 37.5 | | | 6 | 37.5 | 16 | 100 |
| Surgical | 1 | 5.9 | | | 4 | 23.5 | 5 | 29.4 | 7 | 41.2 | 17 | 100 |
| Theatre | | | | | 2 | 50.0 | | | 2 | 50.0 | 4 | 100 |
| ICU | 1 | 20.0 | | | 4 | 80.0 | | | | | 5 | 100 |
| OPD | 4 | 25.0 | | | 8 | 50.0 | 1 | 6.4 | 3 | 18.6 | 16 | 100 |
| Maternity | 2 | 15.3 | 1 | 7.7 | 5 | 38.5 | 3 | 23.1 | 2 | 15.4 | 13 | 100 |
| Pediatric | | | | | 7 | 53.9 | 2 | 15.4 | 4 | 30.7 | 13 | 100 |
| Gynecological | | | | | 2 | 100 | | | | | 2 | 100 |
| Other | 1 | 2.1 | 19 | 40.4 | 13 | 27.6 | 6 | 12.8 | 8 | 17.0 | 47 | 100 |

According to table 4.9 most of the nurses only sometimes found their work complicated. The highest percentages who found their work sometimes complicated were those working in the gynaecological unit: 2 (100%), ICU 4 (80%), and paediatric 7 (53.5%). Only 4 (25%) of those in the medical ward, 1 (5.9%) of those in the surgical ward, 1 (20%) in ICU, 4 (25%) in OPD, 2 (15.3%) in maternity, and 1 (2.1%) in other units not mentioned, always found their work complicated.

It would seem that there is not a significant difference between the units where the nurses worked and the way in which they experienced their work as complicated. This could be an indication that nurses are placed correctly according to their interests and skills.

Item 24: My workload is manageable

With regard to whether the workload was manageable 63 (47.4%) respondents always or usually found their workload manageable, 49 (36.8%) sometimes found it manageable, and 21 (15.8%) rarely or never found it manageable.

Item 25: The supervisor of the unit manages the unit in a democratic way

With regard to whether the supervisor of the unit manages the unit in a democratic way 74 (55.6%) respondents indicated that their supervisor always or usually managed their unit in a democratic way, 36 (27.1%) sometimes did, 23 (17.3%) rarely or never did.

Item 26: I am allowed to make my own decisions related to patient care

With regard to whether respondents were allowed to make their own decisions related to patient care 67 (50.4%) respondents indicated that they always or usually make their own decisions related to patient care, 37 (27.8%) sometimes did, 29 (21.8%) rarely or never did make their own decisions related to patient care.

Since respondents work in different units or wards, it was determined whether the units where the respondents work influenced their ethical decision making.

Table 4.10. The influence of work unit on the respondents ethical decision making (N=133)

| Work unit | Always | | Usually | | Sometimes | | Rarely | | Never | | Total | |
|----------------|--------|------|---------|------|-----------|------|--------|------|-------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Medical | 3 | 18.7 | 4 | 25.0 | 5 | 31.3 | 2 | 12.5 | 2 | 12.5 | 16 | 100 |
| Surgical | 7 | 41.2 | 3 | 17.6 | 5 | 29.4 | | | 2 | 11.8 | 17 | 100 |
| Theatre | | | | | 2 | 50.0 | 1 | 25.0 | 1 | 25.0 | 4 | 100 |
| ICU | 1 | 20.0 | 4 | 80.0 | | | | | | | 5 | 100 |
| OPD | 4 | 25.0 | 2 | 12.5 | 6 | 37.5 | 2 | 12.5 | 2 | 12.5 | 16 | 100 |
| Maternity | 5 | 38.4 | 1 | 7.7 | 4 | 30.8 | 1 | 7.7 | 2 | 15.4 | 13 | 100 |
| Pediatric | 3 | 23.1 | 3 | 23.1 | 3 | 23.1 | 1 | 7.6 | 3 | 23.1 | 13 | 100 |
| Gynaecological | | | | | | | 2 | 100 | | | 2 | 100 |
| Other | 13 | 27.7 | 14 | 29.8 | 12 | 25.5 | 2 | 4.2 | 6 | 12.8 | 47 | 100 |

According to table 4.10 nurses in most of the units are able to participate in ethical decision making either sometimes, usually or always. It is clear that nurses in surgical units 7(41.2%) more frequently always participate, followed by those in maternity units 5 (38.4%), others 13 (27.7%), OPD 4 (25%), pediatric 3 (23.1%), ICU 1 (20%) and medical units 3 (18.7%).

Item 27: Nurses do not participate in ethical decision making because they are afraid to make wrong decisions

According to table 4.8 on page 88, 50 (37.6%) respondents indicated that nurses never or rarely participate in ethical decision making because they are afraid to make wrong decisions. It is surprising to note that almost the same number, 49 (36.8%), of respondents accepted the fact that nurses sometimes do not participate in ethical decision making because they are afraid to make wrong decisions. A quarter of the respondents (25.6%) accepted that they always or usually do not participate in ethical decision making because they are afraid to make wrong decisions.

It appears though, that a higher percentage (62.4%) of nurses are those who sometimes, usually or always do not participate in ethical decision making because they are afraid to make wrong decisions. This could imply that there are some nurses who do not have confidence in making ethical decisions, or that they do not have the necessary skills and knowledge as far as the ethical decision making process is concerned.

Item 28: Ethical decision making in the units is influenced by the policies of the institution

According to table 4.8 on page 88, 69 (51.9%) respondents indicated that ethical decision making in the unit is always or usually influenced by the policies of the institution, 41 (30.8%) indicated that ethical decision making is sometimes influenced by policies, and 23 (17.3%) indicated that ethical decision making is rarely or never influenced by policies of the institution.

Item 29: There are standing orders that come into conflict with my scope of practice

According to table 4.8 on page 88, 50 (37.6%) respondents indicated that there are sometimes standing orders that come into conflict with their scope of practice. It is surprising to note that 42 (31.6%) respondents indicated that there are standing orders that always or usually come into conflict with their scope of practice, while almost the same number 41 (30.8) respondents indicated that there are rarely or never standing orders that come into conflict with their scope of practice.

As a follow up to item 29 (there are standing orders that come into conflict with my scope of practice), respondents were asked to give examples of standing orders which in their view, conflict with their scope of practice. The themes extracted from the information obtained in this open-ended question are displayed in Table 4.11.

Table 4.11. Themes from standing orders conflicting with scope of practice (N=21).

| THEMES | FREQUENCIES |
|----------------------|-------------|
| Stopping medications | 4 |
| Intravenous therapy | 9 |
| Blood transfusion | 2 |
| Abortion | 2 |
| Circumcision | 4 |

- **Stopping medications and ventilators**

Four (19%) respondents mentioned that doctors tell them to stop medications for terminally ill patients or to stop/discontinue their life support system or not to resuscitate them.

Examples given include the following:

“Stopping medications to terminally ill patients”

”Discontinue the ventilator of a patient with brain death”

“Do not resuscitate orders”

Searle and Pera (1995:111) believe that the doctor cannot impose on the nurse the duty to withdraw life-support or terminate a life. Even discontinuation of a life-support system after the doctor is satisfied that “brain death” has occurred, or a discontinuation of those life-support systems which prevent nature taking its course is not the function of the nurse. The decision-maker should do the act himself or herself.

Mallik, Hall and Howard (1998:162) assert that “do not resuscitate” orders are at times appropriate but it is important that appropriate discussion takes place between the patient, the patient’s relatives and friends, and healthcare professionals. When resuscitation would have no effect on the process of dying or the patients do not wish their life to be extended then the final decision, not to resuscitate, should be formally documented.

- **Intravenous therapy: injections and solutions**

Nine respondents (42.8%) mentioned that they were to put up drips and give intravenous injections and solutions.

Examples given include:

“giving of soda bic / 50% dextrose intravenously”

“giving of etomine injections intravenously”

“prescribing adalat 10 mg to patients who are having a diastolic blood pressure of above 120 mm hg”.

“giving of valium intravenously to patients who are having seizures”

According to Plumer (1987:204-205), for the nurses to legally administer intravenous therapy, they should verify if the state law delegates this function to them, check if the institution's policy, with the approval of the medical staff, permits the nurse to perform this function, determine if they are limited in the types of fluids and medications they may administer by a list of fluids and drugs delineated by the hospital, ensure that they are qualified by education and experience to administer intravenous therapy. The author also asserts that nurses may properly refuse to perform intravenous therapy if in their professional judgement they are not qualified and competent. It has also been established by law that in a question of negligence, individuals are not protected because they have “carried out the physician's orders.” They are held liable in relation to their knowledge, skill and judgement. Nurses are also legally required to carry out any nursing or medical procedure they are directed to carry out by a duly licensed physician, unless they have reasons to believe harm will result to the patient from doing so.

- **Blood Transfusion**

Two (9.5%) respondents mentioned that nurses are required to put up blood / administer blood. According to Plumer (1987:204) the rapid advancement in transfusion therapy increases the responsibility for administering blood. Only those vested in every phase of therapy should hold this responsibility. The patient's safety depends on adherence to specific rules regarding safe administration, such as:- blood identification, inspection of blood prior to administration to

prevent infusing patients with haemolyzed, clotted or contaminated blood, proper technique and close observation of the patient, and early detection of symptoms of a reaction.

Deloughery (1995: 203) cited an example of a nurse who transfused incompatible blood into a patient and concealed her conduct and falsified the record. The nurse was convicted of manslaughter since the patient died of a transfusion reaction.

- **Abortion**

Two (9.5%) respondents mentioned that they are required to assist doctors while terminating pregnancies on demand.

According to Poggenpoel, Myburgh and Gmeiner (1998:3-6) if a woman for any reason is of the opinion that the pregnancy is an obstacle to her health and quality of life, she may request an abortion at an approved health service (clinic or hospital). The authors also noted that, according to Rooi Rose (1998:33), 39460 legal abortions had been carried out since February 1997 in South Africa. The authors further believed that the nursing profession had been hit hard by the legislation on termination of pregnancy, since large numbers of nurses refuse to be involved in the nursing of women who choose abortions.

- **Circumcision**

Four (19%) respondents mentioned that they are delegated to perform circumcisions. According to Mayatula and Mavundla (1997:18) medical circumcision is the procedure performed by trained male health workers (doctors and nurses) using medical instruments under surgically sterile conditions to excise the prepuce. The authors have identified health problems related to medical circumcision such as operative faults, excessive bleeding and sepsis, especially if the operator is inexperienced.

Item 30: Communication channels mostly followed when making decisions

Respondents were requested to indicate communication channels they follow when making decisions. The purpose of this item was to determine if the respondents first discuss their decisions with unit managers, or doctors, or their employers. Figure 4.12 presents the channels.

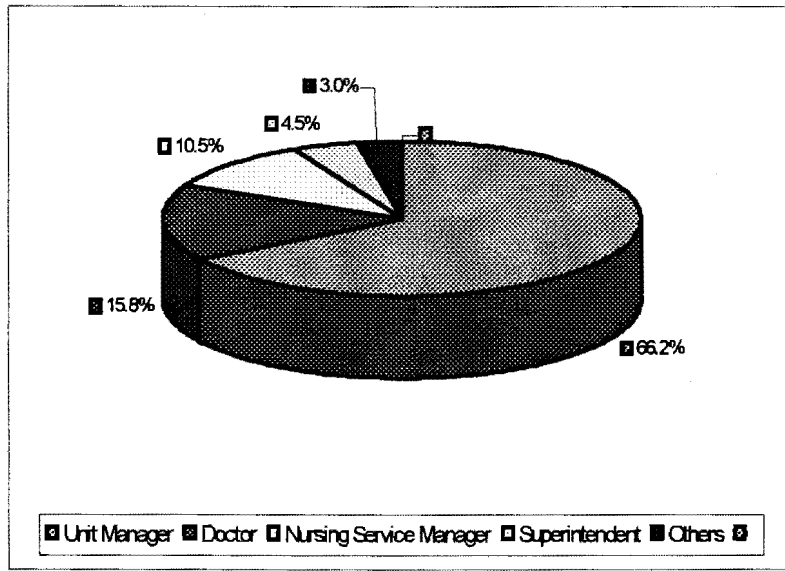


Figure 4.12: Communication channels followed by respondents when making ethical decisions (N=133)

Figure 4.12 reveals that the majority 88 (66.2%) of respondents first discussed their decisions with unit managers, while 21 (15.8%) first discussed them with the doctors. Fourteen (10.5%) first discussed them with their nursing service managers, 6 (4.5%) of the respondents discussed them with other health team members not mentioned. A small number 4 (3%) mentioned that they first discussed their decisions with the superintendent.

Ethical decision making should be a team effort. According to Bandman and Bandman (1995:98) "There is an increase in numbers and diversity of people involved in making ethical decisions". It is further mentioned that patients and their families should also be consulted. This is a limitation in the questionnaire, in that patients were not included as an option.

SECTION C: ETHICAL PRINCIPLES GUIDING ETHICAL DECISION MAKING

In this section respondents were requested to indicate the degree to which they agree or disagree whether certain ethical principles, namely, autonomy, truth telling, beneficence, nonmaleficence and justice influence ethical decision making.

The purpose of this section was to determine whether the respondents had adequate knowledge regarding ethical principles and to ascertain if the above-mentioned principles really guide ethical decision making.

Table 4.12 indicates how autonomy influence ethical decision making.

Table 4.12: The influence of autonomy on ethical decision making (N=133)

| Ethical principles | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | TOTAL | |
|--------------------|--|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 1 | Autonomy is seen as freedom to make choices and decisions about one's care without interference | 45 | 33.9 | 54 | 40.6 | 18 | 13.5 | 12 | 9.0 | 4 | 3.0 | 133 | 100 |
| 2 | Freedom of action allows people the right to make their decisions | 43 | 32.3 | 56 | 42.1 | 20 | 15.0 | 11 | 8.3 | 3 | 2.3 | 133 | 100 |
| 3 | Patients are said to be autonomous if they make their decisions based on necessary and clear information | 51 | 38.3 | 56 | 42.1 | 16 | 12.0 | 5 | 3.8 | 5 | 3.8 | 133 | 100 |
| 4 | Patients have the right to give their consent to medical treatment | 76 | 57.1 | 50 | 37.6 | 1 | 0.8 | 2 | 1.5 | 4 | 3.0 | 133 | 100 |
| 5 | Patients have the right to withhold their consent to treatment | 71 | 53.3 | 54 | 40.6 | 3 | 2.3 | 3 | 2.3 | 2 | 1.5 | 133 | 100 |
| 6 | Patients have the right to be fully advised of the risks and consequences of procedures and expected results if they refuse treatments | 82 | 61.5 | 45 | 33.9 | 1 | 0.8 | 2 | 1.5 | 3 | 2.3 | 133 | 100 |
| 7 | Patients have the right to be informed of alternative procedures | 69 | 51.8 | 54 | 40.6 | 4 | 3.0 | 5 | 3.8 | 1 | 0.8 | 133 | 100 |
| 8 | Health professionals should not force patients to agree to treatment even if it is to their own benefit | 47 | 35.3 | 58 | 43.6 | 13 | 9.8 | 10 | 7.5 | 5 | 3.8 | 133 | 100 |
| 9 | Patients are often forced to agree to treatments by their families | 21 | 15.8 | 50 | 37.6 | 29 | 21.8 | 24 | 18.0 | 9 | 6.8 | 133 | 100 |
| 10 | Patients' autonomy is sometimes not respected by health professionals | 20 | 15.1 | 60 | 45.1 | 22 | 16.5 | 22 | 16.5 | 9 | 6.8 | 133 | 100 |

Items 1 to 10: Autonomy

The findings in table 4.12 revealed that a vast majority of the respondents had adequate knowledge as far as autonomy is concerned. This is evidenced by the fact that 99 (74.5%) respondents agreed that autonomy is freedom to make a choice without interference, and also

agreed that freedom of action allows people the right to make decisions, 107 (80.4%) agreed that patients are autonomous if they make decisions based on the necessary and clear information, 126 (94.7%) agreed that the patient should consent to medical treatments, and also agreed that patients have the right to withhold their consent to treatment, 127 (95.4%) agreed that patients should be fully advised of the results if they refuse treatment. It is agreed by 123 (92.4%) that patients have the right to be informed of alternative procedures, 105 (78.9%) agreed that health professionals should not force patients to agree to treatment, 71 (53.4%) agreed that patients are often forced to agree to treatment by their families, and 80 (60.2%) agreed that health professionals sometimes do not respect patients' autonomy.

If at least between 60.2 percent to 94.7 percent of the respondents agree that patients should be granted autonomy to decide on their treatment and decisions related to their care, it can be assumed that nurses use the principle of autonomy when making ethical decisions about their patients.

Respondents were asked to give an example of a situation where a patient's autonomy was not respected (see item 23 in questionnaire Annexure B). The themes extracted from the information obtained in this open-ended question are displayed in Table 4.13.

Table 4.13: Examples of incidents where patients' autonomy was not respected (N=51)

| THEMES | FREQUENCY |
|---------------------------------|-----------|
| Witchdoctor/ Traditional healer | 3 |
| Confidentiality/ Privacy | 4 |
| Informed consent | 10 |
| Rights | 13 |
| Coercion/ Force | 17 |
| Deception | 3 |
| Negligence | 1 |

- **Witch doctor / traditional healer**

Three respondents (5.8%) mentioned that patients preferred consulting traditional healers to being kept in hospital. They believed that their sickness could be healed by witch doctors or traditional healers but nurses and even relatives did not allow this.

According to Upvall (1990:3) nurses, who provide the majority of cosmopolitan healthcare services in Africa, are particularly affected by indigenous healing systems. In a study of nurses' attitudes towards indigenous healers, nurses were found to be either against active co-operation with indigenous healers or desire a quiet co-existence with the healers.

Examples of statements used are as follows:

- (i) "A patient was refused the opportunity to go and consult a traditional healer."
- (ii) "patient believed that her arthritis cannot be healed in hospital but by traditional healers, relatives forced her to be treated in hospital."

The above statement is supported by O'Connor (1995:28) who asserts that vernacular health belief systems frequently undertake to promote "healing" as differentiated from "curing". Most of these systems recognize medically defined diseases but provide in addition for the treatment of a number of problems not recognized by conventional medicine, such as the effects of witchcraft and soul loss.

Terrell (1990:15) also asserts that "traditional medical systems operate to heal illness on both physical and psychological level, by symbolically activating the belief of sick people in their own ability to be healed." She believes that the scientific medical practitioners lose the traditional healer's special contribution to humanity's fight against sickness and suffering, which enables their patients to assume an active role in recovering their health, by harnessing the non-material power of belief.

- (iii) "A patient who request to be discharged to visit a witch doctor"

The above mentioned statement makes one believe that there are patients who do not feel completely healed if they do not visit a traditional healer / witch doctor, even though they are receiving scientific or modern medical and nursing care.

Let us consider an example given in Graham (1992:229) of a black woman in Baragwanath Hospital who had undergone mastectomy due to cancer. She had all the prescribed radiation treatment and the doctor discharged her since she was fine, but she decided to visit a traditional healer because she felt, "when I die, I will not go to live with my ancestors because I am no longer a whole person." It was said that the "nyanga"/witch doctor helped her by doing a long course of throwing bones and building her up, and telling her that she is a complete being as her spiritual world is complete.

- **Confidentiality / Privacy**

Four respondents (7.8%) revealed that confidential information of patients was exposed to relatives without consent from patients.

Examples given are:

"Diagnosing patients as HIV positive and not keeping this confidential."

"Relatives told by nurses that the patient is HIV positive without the patient's consent".

"Patient's diagnosis divulged to his relatives without the patient's consent, e.g. HIV positive patient."

According to Brown, Kitson and Mcknight (1992:93) maintaining confidentiality is a matter of behaving in such a manner or way as not to bring about a breach of confidentiality. There is always a circle of confidentiality which consists of just those people who are directly involved in the care and treatment of the person concerned. Sometimes information may be confided to one nurse as an individual, so that she alone is in the circle of confidentiality.

According to Milholland (1994:19) " the professional nurse considers the well being, safety, and rights of the client when determining the dissemination of confidential information. Certainly,

relevant data must be shared with other members of the health team if the client is to receive quality, effective care. But the disclosure is limited to those persons directly connected with the client's care. There must be defined protocols, policies and procedures for disclosing information related to the quality, appropriateness, and need for care.”

Cherry and Jacob (1999:272) assert that an invasion of privacy occurs when a person's private affairs (including health history and status) are made public without consent. The nurse has a legal and ethical duty to maintain confidentiality and there may be serious prosecutions when the nurse breaches this duty and violates this fundamental patient right.

Assessment data is treated as confidential because failure to do so robs the patient of his/her autonomy. A client may tell a nurse something in confidence that he/she feels he/she must tell in order to protect the client. If the nurse believes she cannot keep the information confidential, then she is obligated (by the principle of veracity) to tell the client that in the client's best interest, she must share the information with other care givers (Wilkinson 1996:74-77).

- **Informed consent**

Ten respondents (19.6%) mentioned that patients were given treatment or were hospitalized or transferred to other institutions or units without their consent.

According to Kurzen (1997:185) a fundamental right of patients is to make decisions regarding their own health care.

Seedhouse (1998:186) defines consent as an expressed agreement to a procedure, based on a level of information which would be sufficient to satisfy the giver of that information if he were to be on the receiving end.

Thomas and Waluchow (1990:41) asserted that consent is valid when the patient is given sufficient and appropriate information to make an intelligent decision.

Examples given include:

“Doctors perform procedures without informed consent.”

“Patient had an operation but not fully informed of the type of operation, implications and complications.”

Arnold and Boggs (1999:29) asserted that there should be permission for invasive procedures, unless there is a life-threatening emergency; all clients have the right to give informed consent. They further indicate that a valid consent should be voluntary, the client must have full disclosure about risks, benefits, costs, potential side effects or adverse reactions and other alternatives to treatment. The client must have the capacity and competency to understand the information and to make an informed choice.

- **Rights**

Three respondents (5.8%) mentioned that the patients' rights were not respected.

Examples given include:

“Nurses do not respect patients' religious rights eg. Jehovah's Witness”.

“A woman was not allowed to stay with her critically ill patient (husband) for a night in the ward.”

“Patients are refused the right to read what is written on their hospital files.”

“Patients are not given a chance to choose the way they feel best to be treated.”

According to Kurzen (1997:307) hospitals must provide a foundation for understanding and respecting the rights and responsibilities of patients, their families, physicians and other care givers. Hospitals must also ensure a health care ethic that respects the role of patients in decision making about treatment choices and other aspects of their care. Hospitals must also be sensitive to cultural, racial, linguistic, religious, age, gender, and other differences, as well as the needs of patients with disabilities.

Troskie (1998:6) asserts that the right of the patients to decide and act on their own values refers to self-determination, which includes issues involving the quality of life, death with dignity, and

the right of the patient to refuse treatment based on the principle of autonomy. Nurses have an obligation to co-ordinate the care of patients, abiding by the patient's decisions, and also to take the legal constraints into consideration.

Dimond (1994) in Schober and Hinchliff (1995:88) states that "the access to Health Records Acts (1990), gives patients, those with parental responsibility, individuals, e.g. solicitors, nominated by the patient, patient's representatives following their death, the right of access to written records made by health care professionals (excluding social workers).

They have the right to:

- inspect records,
- take a copy of the record,
- an explanation of details contained within them,
- suggest corrections to inaccurate records (Dimond,1994)".

Rhode (1994:609) believes that rights-based concerns, however, have much less relevance in the organizational setting because the privilege belongs to the corporate entity rather than its individual agents.

- **Coercion/Force**

Seventeen respondents (33.3%) mentioned that patients are forced by health personnel (particularly doctors and nurses) and relatives to consent to treatment/operations.

Examples given include:

"a patient refuses to undergo an operation but forced by a health personnel."

"an elderly woman did not want admission, but forced by relatives to be admitted."

"a mother lodger refuses her baby to be tested for HIV but compelled to do so by a doctor."

" patient refusing caesarian section when the baby was in danger, but for the sake of the baby it was done".

Copp in Hamric, Spross and Hanson (1996:282) asserts that an environment in which a coercive and controlling approach is prevalent generates a power imbalance that accentuates vulnerability, and vulnerability damages self-esteem, constrains independence and restricts choices.

However, a coercive approach is sometimes necessary, especially during an emergency. An example is that of a child of Jehovah's Witness parents who had to immediately receive a blood transfusion yet the parent refused to give consent for the treatment, and care givers were compelled to seek legal approval (Hamric, Spross and Hanson 1996:287). This example supports the statement given above which indicates that a patient was forced to have a caesarian section in order to save the baby's life.

A patient did not want to be discharged but was forced to go home because the doctor felt he was fit to go home.

Perry and Potter (1998:4) believe that discharge from an agency can be stressful if the client and family members feel unprepared to resume normal activities, or unable to adapt to normal activities, or unable to adapt the hospital's therapeutic regimens to living at home.

"A patient insisted on discharge but he was forced to stay in the ward".

According to Armitage (1991:73) patients who insist on self-discharge can confound the discharge plan. The author believes that when a patient insists on going home against medical and nursing advice, the caregiver should ensure that continued care is provided in order to avoid unnecessary risk. The patient may within a relatively short time accept that he has not recovered sufficiently to be at home and may then agree to be readmitted, having come to terms with the loss of independence.

- **Deception**

Three respondents (5.8%) mentioned that patients are deceived and not told the truth.

Examples given include:

“A para 6 gravida 7 woman with high blood pressure refuses bilateral tubal ligation, but when she ended in theatre for caesarian section, sterilization was done without her consent.”

“Patients blood taken for HIV without first counseling them.”

Bolander (1994:47) asserts that nurses may deceive patients if they are using the approach of parentalism meaning acting as a parent to do good for a client, despite the client’s ability to make decisions. An example cited was that of a nurse informing a post-operative client who was in pain that a particular postoperative complication would occur if the client did not walk. The nurse was manipulating the client to walk, and she had used deception by giving the false impression that exercise must take precedence over pain relief.

- **Negligence**

One respondent (1.9%) mentioned that some patients are neglected in hospitals.

According to Prosser in Creasia and Parker (1996:251) negligence occurs when a person fails to act in a reasonable manner under a given set of circumstances. Unreasonable conduct by a nurse or other professional is a specific type of negligence known as malpractice. The nurse has the legal duty to provide the patient with a reasonable standard of care.

Cherry and Jacob (1991:252) assert that a claim of negligence is based on the accepted principle that everyone is expected to conduct themselves in a reasonable and prudent fashion.

Items 11 to 15: Truth telling

In table 4.14 the influence of truth telling on ethical decision making is displayed.

Table 4.14: The influence of truth telling on ethical decision making (N=133)

| Ethical principles | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | TOTAL | |
|--------------------|---|----------------|------|-------|------|----------|------|----------|------|-------------------|------|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 11 | Truth telling in nursing is considered to be very difficult since it is not a matter of saying yes or no | 17 | 12.8 | 56 | 42.1 | 16 | 12.0 | 30 | 22.6 | 14 | 10.5 | 133 | 100 |
| 12 | Nurses may be tempted to lie, for smoother handling of an awkward situation | 21 | 15.8 | 53 | 39.8 | 17 | 12.8 | 30 | 22.6 | 12 | 9.0 | 133 | 100 |
| 13 | Patients' families often force nurses, to tell them about their patients diagnoses even if patients do not want them to know | 24 | 18.0 | 55 | 41.4 | 10 | 7.5 | 25 | 18.8 | 19 | 14.3 | 133 | 100 |
| 14 | In the case where a doctor or any health professional makes a careless mistake/error the nurse should inform the patient and relatives of the truth | 31 | 23.3 | 24 | 18.0 | 19 | 14.3 | 40 | 30.1 | 19 | 14.3 | 133 | 100 |
| 15 | What is your attitude to AIDS patients regarding truth telling? | | | | | | | | | | | | |
| A | Patients should be told the truth | 76 | 57.2 | 21 | 15.8 | 4 | 3.0 | 16 | 12.0 | 16 | 12.0 | 133 | 100 |
| B | Patients' relatives should be told without patients' consent | 15 | 11.2 | 17 | 12.8 | 1 | 0.8 | 35 | 26.3 | 65 | 48.9 | 133 | 100 |
| C | Patients should never be told the truth | 9 | 6.8 | 5 | 3.7 | 8 | 6.0 | 42 | 31.6 | 69 | 51.9 | 133 | 100 |
| D | Patients' relatives should never know the truth | 17 | 12.8 | 24 | 18.0 | 15 | 11.3 | 34 | 25.6 | 43 | 32.3 | 133 | 100 |

Item 11: Truth telling in nursing is considered to be very difficult since it is not a matter of saying yes or no

According to table 4.14 the majority 73 (54.9%) of respondents strongly agreed or agreed that truth telling in nursing is considered to be very difficult, 44 (33.1%) disagreed, and 16 (12.0%) were not sure.

Item 12: Nurses may be tempted to lie for smoother handling of an awkward situation

Most 74 (55.6%) respondents agreed that nurses may be tempted to lie for smoother handling of an awkward situation, 42 (31.6%) disagreed, and 17 (12.8%) were not sure.

Item 13: Patient's families often force nurses to tell them about their patients diagnoses, even if the patients do not want them to know

The majority 79 (59.4%) of respondents agreed that patients' families often force them to tell them about their patient's diagnoses even if patients do not want them to know, 44 (33.1%) disagreed, and 10 (7.5%) were not sure.

Item 14: In the case where a doctor or any health professional makes a careless mistake or error the nurse should inform the patient and relatives of the truth

With regard to whether the nurse should inform the patient and relatives of the truth in the case where a doctor or any health professional makes a careless mistake or error, it is interesting to note that 59 (44.4%) respondents disagreed, while almost the same number of respondents 55 (41.3%) agreed.

Item 15: What is your attitude to AIDS patients regarding truth telling?

When respondents were asked to give their own attitude to AIDS patients regarding truth telling, 111 (83.5%) respondents disagreed that patients should never be told the truth. One hundred (75.2%) disagreed that patients' relatives should be told without patients' consent, and it is quite disturbing to realize that 77 (57.9%) respondents would really like relatives to know that their patients have AIDS, while only 41 (30.8%) respondents would like patients' relatives never to know the truth.

Table 4.15 indicates the influence of loyalty on ethical decision making.

Table 4.15: The influence of loyalty on ethical decision making (N=133)

| Ethical principles | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | TOTAL | |
|--------------------|---|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 16 | Loyalty implies keeping promises | 44 | 33.1 | 49 | 36.9 | 12 | 9.0 | 18 | 13.5 | 10 | 7.5 | 133 | 100 |
| 17 | Loyalty to patients may conflict with loyalty to one's personal and professional values | 25 | 18.8 | 52 | 39.1 | 17 | 12.8 | 29 | 21.8 | 10 | 7.5 | 133 | 100 |
| 18 | Loyalty to patients may conflict with loyalty to the employer | 28 | 21.1 | 52 | 39.1 | 17 | 12.8 | 26 | 19.5 | 10 | 7.5 | 133 | 100 |

Items 16 to 18: Loyalty

The majority, 93 (70.0%), of the respondents according to table 4.15 responded positively, since they acknowledged that loyalty meant keeping promises. Seventy seven (57.9%) agreed that loyalty to patients may conflict with loyalty to one's personal and professional values, and 80 (60.2%) agreed that loyalty to patients may conflict with loyalty to the employer.

As a follow-up to these aspects of truth and loyalty, respondents were asked to give examples of situations where they did not know whether to tell the truth or not, and also examples of situations where loyalty to patients had conflicted with loyalty to the family, employer, colleagues or physicians.

Although respondents were given two separate questions (items 24 and 25 in questionnaire Annexure B) relating to truth telling and loyalty, they gave similar responses, and therefore, the two principles were combined. The themes extracted from the information obtained in these open-ended questions are displayed in Table 4.16.

Table 4.16: Themes regarding being truthful or being loyal or not (N= 41)

| THEMES | FREQUENCIES |
|----------------------|-------------|
| Terminal illness | 8 |
| Bad news | 9 |
| Invasion of privacy | 15 |
| Employer's rights | 7 |
| Refusal of Treatment | 1 |
| Contraceptives | 1 |

- **Terminal illness**

Eight respondents (19.5%) mentioned that it was difficult to tell terminally ill patients or their relatives about their prognoses.

Examples given include:

“A patient had a terminal illness and relatives wanted to know if the patient will die or not”

“Nurses were afraid to disclose to the patient about his terminal disease”.

“ The patient was very ill and asked the nurse if he was going to die or not”.

According to Moos (1989:392-393) the terminal crisis is complicated and people do not fully comprehend it because some uncertainty is present in every terminal situation. Unexpected events such as miracles do occur; pain, physical debility, and medical technology may interfere with patient's dying work, and lay and professional caregivers may conspire to block the patient's dying work by confusing and contradicting the realization of imminent death. The author also asserts that a patient may know that he is dying, yet behave at times as though he believes that he will recover.

- **Bad news**

Nine respondents (21.9%) mentioned that they felt very uncomfortable when they were expected to tell bad news to patients or their relatives.

Examples given include:

“It was difficult to tell parents about the death of their child”.

“It was almost impossible to tell a woman that she has intrauterine death”.

“The mother and her daughter were admitted in the same unit and the mother died, her daughter was asking where the mother was, the pain was too much to bear”.

According to Kockrow (1999:43) nurses often feel uncomfortable interacting with a grieving patient, for fear of not knowing what to say or saying wrong things. Because of this uneasiness sometimes nothing is said or the subject is avoided entirely.

The above-mentioned statement is supported by Hogston and Simpson (1999:277) who assert that confronting patients with bad news is viewed as uncomfortable, since the intervention may be received by clients with some degree of shock as they come face to face with issues that they were unaware of or not acknowledging. Because of these anxieties, the nurse may avoid the issue or “beat around the bush” or alternatively take a very direct and heavy-handed approach.

It is therefore, essential that when nurses are to communicate bad news, they should use an appropriate time, an appropriate place; with honesty, empathy, and responsibility, they can soften the blow by minimizing the common feelings, of anger, disappointment, and betrayal (Alfaro-Lefevre 1999:193).

- **Invasion of privacy**

Fifteen respondents (36.5%) mentioned that the caregivers were invading patient’s privacy. Berglund (1998:86) is concerned about the lack of personal control over personal information which is stored in computerised data banks and the demand for this information by others for another purpose as this, will lead to privacy interests being overridden.

According to Rumbold (1999:132), pulling the screens round the patients merely allows them to be hidden from sight, but “to then ask the patient questions of a personal and private nature in a voice clearly audible throughout the ward is totally to negate the purpose of pulling the screens”.

- **Employer’s right**

Seven respondents (17%) mentioned that nurses have less authority about patient care but have to carry out employer’s and doctors orders.

Examples given include:

“ Nurses are not expected to say no to doctor’s orders”.

“The employer requires nurses to carry out doctors’ orders”.

“Patients are discharged prematurely but nurses have no say”.

According to Marks-Maran and Rose (1997:74-75) nurses are no longer the doctor’s hand maidens, but it seems they have now become the employers’ handmaidens. Nursing is, therefore, not free of the subservient role, because the opposition is much stronger and tougher and nurses are more easily pushed into a corner where exploitation and abuse of power are possible.

Armitage (1991:43) has noted that Hockey (1968) discovered more patients considering themselves prematurely discharged than retained in hospital too long, while ward sisters felt that some patients in their care no longer required hospital facilities. The main problem identified by the author is that there is inadequate sharing of information about patients, and yet in practice it is frequently medical staff whose opinion dictates the timing of discharge.

- **Refusal of treatment**

One respondent (2.4%) mentioned that a patient refused treatment after the nurse explained about the effects and side effects of drugs. Mallik, Hall and Howard (1998:121) assert that all clients have a right to be fully informed about the medicines they receive and most have a right to refuse treatment if it is against their wishes.

- **Contraceptives**

One respondent (2.4%) mentioned that offering contraceptives to teenagers may pose a problem to their parents.

The example given was:-

“ A teenage girl wanted family planning contraceptives, the mother did not want her to use contraceptives, but at the same time the hospital offers free contraceptives to all”.

Mallik, Hall and Howard (1998:121) gave the example of a court case in which a general practitioner won his case to prescribe contraceptive medication to a child under the age of 16

years without recourse to her parents for permission. It could be considered sound if any decision for treatment for a child under 16 years of age is made with the joint consent of parents.

In table 4.17 the influence of beneficence and nonmaleficence is displayed.

Table 4.17: The influence of beneficence and nonmaleficence on ethical decision making (N=133)

| Ethical principles | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | TOTAL | |
|--------------------|---|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 19 | The principle of beneficence implies the duty to actively do good for patients | 40 | 30.1 | 60 | 45.1 | 27 | 20.3 | 4 | 3.0 | 2 | 1.5 | 133 | 100 |
| 20 | The principle of nonmaleficence implies the duty to prevent or avoid doing harm | 35 | 26.3 | 47 | 35.3 | 31 | 23.3 | 17 | 12.8 | 3 | 2.3 | 133 | 100 |

Item 19: Beneficence

The majority of respondents according to table 4.17, 100 (75.2%), believed that beneficence implied the duty to actively do good for patients, while 27 (20.3%) of the respondents were not sure, and only 6 (4.5%) disagreed.

Item 20: Nonmaleficence

Although 82 (62.4%) respondents acknowledged that the principle of nonmaleficence implied the duty to prevent or avoid doing harm, it is also noticeable that 31 (23.3%) respondents were not sure if nonmaleficence implied preventing or avoiding harm; only 10 (7.5%) disagreed with the statement.

Table 4.18 indicates the influence of justice on ethical decision making.

Table 4.18: The influence of justice on ethical decision making (N=133)

| Ethical principles | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | TOTAL | |
|--------------------|--|----------------|------|-------|------|----------|------|----------|-----|-------------------|-----|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 21 | The principle of justice in nursing relates to the allocation of resources | 36 | 27.1 | 49 | 36.8 | 29 | 21.8 | 12 | 9.0 | 7 | 5.3 | 133 | 100 |
| 22 | Justice in nursing implies an obligation to be fair to all patients | 49 | 36.8 | 66 | 49.6 | 12 | 9.0 | 5 | 3.8 | 1 | 0.8 | 133 | 100 |

Items 21 to 22: Justice

The respondents in table 4.18 gave positive responses, for example, 85 (63.9%) respondents acknowledged that justice in nursing relates to the allocation of resources, and 115 (86.4%) also believed that justice implied an obligation to be fair to all patients.

Looking at the responses about ethical principles and their influence on ethical decision making, it can be deduced that respondents acknowledged that ethical principles influence ethical decision making.

SECTION D: CULTURAL, RELIGIOUS AND OCCUPATIONAL FACTORS WHICH INFLUENCE ETHICAL DECISION MAKING

In this section respondents were asked to indicate to what degree culture, religion and occupational factors influence ethical decision making. Respondents were requested to classify their responses from “strongly agree” to “strongly disagree.” Table 4.19 presents the findings.

Table 4.19: The influence of culture, religion and occupational factors on ethical decision making (N=133)

| Statement | | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | Total | |
|-----------|--|----------------|------|-------|------|----------|------|----------|------|-------------------|------|-------|-----|
| | | f | % | f | % | f | % | f | % | f | % | n | % |
| 1. | In my culture, women are submissive to men regardless of their rank or position | 42 | 31.6 | 66 | 49.6 | 8 | 6.0 | 11 | 8.3 | 6 | 4.5 | 133 | 100 |
| 2. | In my culture, women are prohibited from making ethical decisions | 29 | 21.8 | 46 | 34.6 | 17 | 12.8 | 29 | 21.8 | 12 | 9.0 | 133 | 100 |
| 3. | Male nurses do not like their female counterparts to assist them in decision making | 18 | 13.5 | 35 | 26.3 | 21 | 15.8 | 41 | 30.9 | 18 | 13.5 | 133 | 100 |
| 4. | In discussions which involve both men and women, women are reluctant to make decisions | 28 | 21.1 | 47 | 35.3 | 13 | 9.8 | 36 | 27.1 | 9 | 6.7 | 133 | 100 |
| 5. | In general, most religions require women to be submissive to men | 43 | 32.3 | 59 | 44.4 | 11 | 8.3 | 13 | 9.8 | 7 | 5.2 | 133 | 100 |
| 6. | If women are not competent in making ethical decisions in their work place, it has got nothing to do with their religion | 40 | 30.0 | 47 | 35.4 | 20 | 15.0 | 21 | 15.8 | 5 | 3.8 | 133 | 100 |
| 7. | Abortion on demand is regarded by most religious groups as sin | 63 | 47.4 | 50 | 37.5 | 13 | 9.8 | 5 | 3.8 | 2 | 1.5 | 133 | 100 |
| 8. | In my culture, practicing euthanasia is seen as sin and murder | 63 | 47.3 | 50 | 37.6 | 10 | 7.6 | 4 | 3.0 | 6 | 4.5 | 133 | 100 |

Item 1: In my culture women are submissive to men regardless of their position

With regard to whether women in their culture are submissive to men regardless of their rank or position, the influence of marital status on submissiveness was determined.

Table 4.20. The influence of marital status on submissiveness (N =133)

| Marital status | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|----------------|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Married | 39 | 42.4 | 32 | 34.8 | 6 | 6.5 | 9 | 9.8 | 6 | 6.5 | 92 | 100 |
| Never Married | | | 34 | 100 | | | | | | | 34 | 100 |
| Widowed | 1 | 33.4 | | | 1 | 33.3 | 1 | 33.3 | | | 3 | 100 |
| Divorced | 2 | 50.0 | | | 1 | 25.0 | 1 | 25.0 | | | 4 | 100 |

Those respondents who were married and never married felt the strongest that women are submissive to men. All the unmarried respondents, 34 (100%) agreed with the statement that women are submissive to men. The married respondents were slightly less adamant. The widowed and divorced were few and may not give a clear indication of the groups' feelings. Only 1 (33.4%) of the widowed and 2 (50%) of the divorced agreed that women are submissive to men. It does not seem as though marital status has an effect on the way the respondents feel about submissiveness.

Item 2: In my culture, women are prohibited from making ethical decisions

A feeling of submissiveness to men could have an effect on ethical decision making in nursing, as nursing is predominantly a female profession. The influence of gender on submissiveness was determined.

Table 4.21: The influence of gender on submissiveness (N=133)

| Statement | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly disagree | | Total | |
|-----------|----------------|------|-------|------|----------|------|----------|-----|-------------------|-----|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Female | 31 | 26.9 | 60 | 52.2 | 6 | 5.2 | 11 | 9.6 | 7 | 6.1 | 115 | 100 |
| Male | 9 | 50.0 | 7 | 38.9 | 2 | 11.1 | | | | | 18 | 100 |

The majority of females, 91 (79.1%), agreed that women are submissive to men, which is similar to the response of the males of whom 16 (88.9%) agreed that women are submissive to men. To determine whether submissiveness to men could affect a female's capacity to make ethical decisions, the influence of gender on whether women are reluctant to make decisions which involve both men and women was determined.

Item 3: Male nurses do not like their female counterparts to assist them in ethical decision making

The majority, 59 (44.4%), disagreed with the statement but as 115 of the respondents were women this could have influenced their response. Only a slightly lower percentage 43 (39.8%) agreed with the statement, which indicates uncertainty as to whether males like or dislike females to assist in decision making.

Item 4: In discussions, which involve both men and women, women are reluctant to make decisions

To the question whether women were reluctant to make ethical decisions when both women and men are involved a greater percentage, 75 (56.4%), agreed with the statement, compared to 45 (33.8%) who disagreed. As the majority of the respondents were female this could be an accurate description of the feelings of women regarding decision making, when both genders are involved.

Table 4.22: The influence of gender on women's reluctance to make ethical decisions (N=133)

| Gender | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|--------|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Female | 22 | 19.1 | 40 | 34.8 | 12 | 10.4 | 33 | 28.7 | 8 | 7.0 | 115 | 100 |
| Male | 5 | 27.8 | 8 | 44.4 | 1 | 5.6 | 3 | 16.7 | 1 | 5.6 | 18 | 100 |

According to table 4.22, 62 (53.9%) of the females agreed that being submissive influenced their decision making, compared to 13 (72.2%) of the males, who believed that submissiveness could influence the decision making ability of females. The difference in the views of men and women could be because of the ethnic background of the respondents.

To determine whether ethnic group had any influence on the decision making of nurses, an analysis on the influence of ethnic group on reluctance to make ethical decisions was done.

Table 4.23: Ethnic group and women reluctant to make decisions (N=133)

| Ethnic group | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|--------------|----------------|------|-------|------|----------|------|----------|------|-------------------|------|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| European | 1 | 33.4 | 1 | 33.3 | 1 | 33.3 | | | | | 3 | 100 |
| Venda | 23 | 27.1 | 32 | 37.6 | 6 | 7.1 | 21 | 24.7 | 3 | 3.5 | 85 | 100 |
| Sotho | 2 | 25.0 | 4 | 50.0 | 1 | 12.5 | 1 | 12.5 | | | 8 | 100 |
| Tsonga | 2 | 7.2 | 6 | 21.4 | 4 | 14.3 | 11 | 39.3 | 5 | 17.8 | 28 | 100 |
| Zulu | | | | | 1 | 33.4 | 1 | 33.3 | 1 | 33.3 | 3 | 100 |
| Xhosa | | | 2 | 66.7 | | | 1 | 33.3 | | | 3 | 100 |
| Others | | | 2 | 66.7 | | | 1 | 33.3 | | | 3 | 100 |

According to table 4.23 above, most of the respondents 85 (63.9%) were Venda and as can be seen from table 4.23 most of them 55(64.7%) agreed that they were reluctant to make ethical decisions on their own. Of the three Europeans that responded 2 (66.7%) were also of the opinion that women are reluctant to make ethical decisions, as were the Sothos of whom 6 (75%) agreed, the Xhosas 2 (66.7%) and others 2 (66.7%). Those who were from the Tsonga and Zulu ethnic groups disagreed more frequently with the statement, respectively 16 (57.1%) and 2

(66.7%). These numbers were, however, small, but could be an indication that ethnicity does play a role in ethical decision making.

Item 5: In general, most religions require women to be submissive to men

As can be seen from table 4.19 on page 115, 102 (76.7%) of the respondents agreed that religion requires women to be submissive to men, only 20 (15%) did not agree, and 11 (8.3%) were not sure.

Item 6: If women are not competent in making ethical decisions in their work place, this has got nothing to do with their religion

According to table 4.19 on page 115, 87 (65.4%) of the respondents agreed that if women are not competent in making ethical decisions in their work place, this has got nothing to do with their religion, 26 (19.6%) disagreed, and 20 (15.0%) were not sure. The response here is contradictory to that of item 5 as 87 (65.4%), a slightly smaller percentage of those who agreed that religion influences women's submissiveness in this item, agree that religion has nothing to do with making ethical decisions. If women are submissive to men and have to consult with them in making decisions then it could have a direct influence when women have to make a decision. It could also be that nurses see themselves as autonomous individuals when in the work situation.

Item 7: Abortion on demand is regarded by most religious groups as sin and murder

According to table 4.19, page 115, the majority 113 (84.9%) of respondents agreed that abortion on demand is regarded by most religious groups as sin and murder. The influence of church affiliation on abortion on demand was done. This is displayed in table 4.20

Table 4.24: The influence of church affiliation on abortion on demand (N=133)

| Church affiliation | Strongly agree | | Agree | | Not sure | | Disagree | | Strongly Disagree | | Total | |
|--------------------|----------------|------|-------|------|----------|------|----------|------|-------------------|-----|-------|-----|
| | f | % | f | % | f | % | f | % | f | % | n | % |
| Lutheran | 10 | 47.7 | 9 | 42.8 | | | 2 | 9.5 | | | 21 | 100 |
| AME | 2 | 28.6 | 4 | 57.1 | | | 1 | 14.3 | | | 7 | 100 |
| AFM | 8 | 50.0 | 6 | 37.4 | 1 | 6.3 | | | 2 | 6.3 | 16 | 100 |
| ZCC | 3 | 42.8 | 2 | 28.6 | 2 | 28.6 | | | | | 7 | 100 |
| Roman Catholic | 3 | 42.8 | 3 | 42.8 | 1 | 14.4 | | | | | 7 | 100 |
| UAAC | 3 | 42.8 | 1 | 14.4 | 3 | 42.8 | | | | | 7 | 100 |
| None | 4 | 66.7 | 2 | 33.3 | | | | | | | 6 | 100 |
| Others | 30 | 48.4 | 23 | 37.1 | 6 | 9.7 | 2 | 3.2 | 2 | 1.6 | 62 | 100 |

All the religious groups agreed that abortion on demand is regarded as sin and murder. The only significant difference was in the UAAC where only 4 (57.2%) agreed with the statement but 3 (42.8%) were not sure.

What is of interest is that all of those who mentioned that they did not belong to any religious group, although only six, 100% indicated that they believed it was a sin and murder to have abortion on demand.

The other groups according to the highest percentage were as follows: Lutheran 19 (90.5%), AFM 14 (87.4%), AME 6 (85.7%), Roman Catholic 6 (85.7%), others 53 (85.5%) and ZCC 5 (71.4%). As Roman Catholics are not allowed to have an abortion it is interesting to note that one (14.4%) was not sure whether it was a sin.

Item 8: In my culture, practicing euthanasia is seen as sin and murder

In table 4.19 page 115, 113 (85%) of the respondents see euthanasia as sin and murder, only 10 (7.5%) disagreed, and again 10 (7.5%) were not sure.

In general most of the responses represent a positive view that culture and religion may influence ethical decision making.

Item 9: Organizations to which respondents belong

Respondents were asked to indicate the organizations to which they belong. The purpose was to determine if these organizations address ethical issues that require ethical decision making.

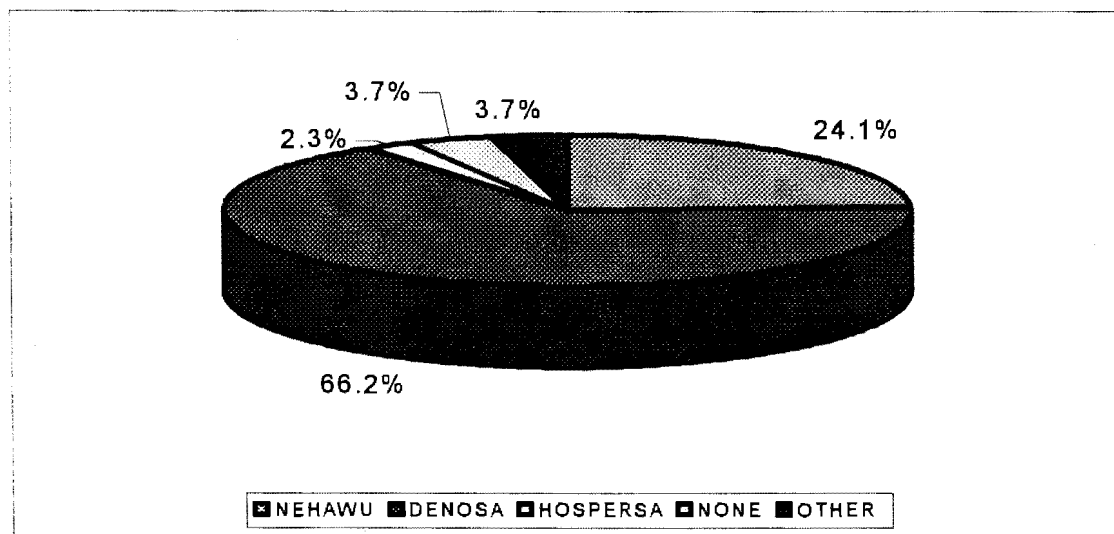


Figure 4.13: Organization to which respondents belong (N=133)

Figure 4.13 indicates the percentage of respondents belonging to different organizations. Most of the respondents, 88 (66.2%), belong to Denosa, followed by 32 (24.1%) Nehawu, 5 (3.7%) belong to Hospersa and 5 (3.7%) to other organizations, while a small percentage of respondents, 3 (2.3%), do not belong to any organization.

The fact that most registered nurses belong to DENOSA may be attributed to the factor that nurses cannot allow a situation to develop where persons other than nurses determine their professional future (Searle & Pera 1992: 321).

Larson (1977) and Moore (1970) in Chaska (1990:11) assert that “ professional associations represent a collective held together by a common ideology, a common style of work, a shared mystique, and usually a technical language.”

According to Muller (1996:53) DENOSA as a professional organization caters for any person who practices nursing or midwifery.

Item 10: Attending meetings inside or outside hospital relating to nursing issues influences ethical decision making

Respondents were asked to indicate whether they attend meetings inside or outside their hospitals related to nursing issues that could influence their ethical decision making.

The purpose of this item was to determine if meetings were held to address ethical issues.



Figure 4.14: A diagram representing attendance of meetings by respondents related to nursing issues that influence their ethical decision making (N=133)

A higher percentage of respondents, 70 (52.6%), according to Figure 4.14, indicated that they do not attend meetings, but quite a noticeable percentage of respondents 63 (47.4%) indicated that they do attend meetings.

Since most 56 (42.1%) of the respondents are at managerial level, figure 4.9 page 71, the reasons for a higher percentage, 52.6%, of respondents not attending meetings could be that according to Booyens (1998:295) "A considerable amount of time spent by managers in meetings is wasted. The manager must first consider the purpose of a meeting – e.g. morale building, the sharing of

information, decision making, problem-solving, etc.” But this does not excuse other respondents from attending meetings because the nurse manager can always send someone to represent her/him, and at the same time this nurse will be acquiring some management knowledge.

Item 11: The organization’s guidance with regard to ethical decision making

Respondents were asked to indicate whether their organizations help or guide them as far as ethical decision making is concerned. The purpose of this item was to determine if the organizations contribute to guiding respondents as far as ethical decision making is concerned.

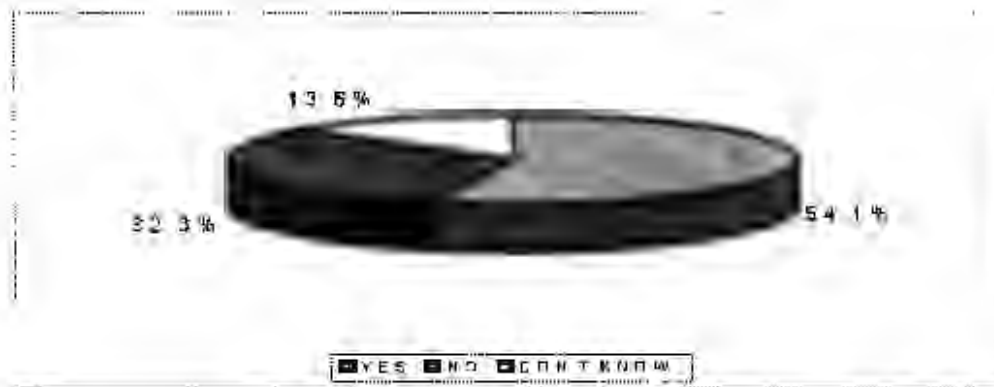


Figure 4.15: Guidance by organization as far as ethical decision making is concerned (N=133)

Figure 4.15 revealed that the highest number, 72 (54.1%), of respondents indicated that their organizations guide them, followed by 43 (32.3%) respondents who indicated that they are not guided, and 18 (13.6%) respondents who did not know whether their organization guides them or not.

Shared decision making in ethical dilemmas is important and it is the duty of the nurse to “coordinate the medical, technical, and nursing activities on behalf of the patient’s well being.” Nurses should therefore receive the necessary guidance on how to fulfil this responsibility (Bandman & Bandman 1995:108).

Respondents who agreed that their organizations give them guidelines were requested to explain how their organizations contributed towards ethical decision making. Table 4.25 presents the themes extracted from the information obtained in this open-ended question.

Table 4.25: Guidelines on ethical decision making (N=30)

| THEMES | FREQUENCY |
|-----------------------|-----------|
| Workshops/ meetings | 6 |
| Journals/ Newsletters | 13 |
| Strike | 4 |
| Policy | 7 |

- **Workshops/ meetings**

Six respondents (20%) mentioned that they do attend meetings and workshops organized by their organizations.

Examples given include the following:-

“We attend meetings and workshops which highlight us on issues regarding ethical decision making”.

“The organization invites us to attend meetings and this enables us to have some insight on how to handle ethical dilemmas”.

According to Creasia and Parker (1996:63) membership of professional associations benefits both the individual and the profession of nursing. If they want to be actively involved in the organization’s activities, nurses should attend meetings and participate in the organization’s activities.

Jooste and Booyens (1998:25) assert that meetings provide the opportunity for an open climate of discussions and joint decision making, where both managers and nurses are involved.

- **Journals/newsletters**

Thirteen respondents (43%) mentioned that their organizations mail them newsletters/Journals/Nursing Updates that can guide them in making certain ethical decisions.

Examples given include:

“I receive nursing journals monthly which covers topics on ethical decision making”.

“In the nursing magazines, handling of abortion issues has been discussed more often”.

According to Mellish and Brink (1996:213) professional journals publish the results of recent research long before those are included in textbooks.

The Democratic Nursing Organization of South Africa (DENOSA) also publishes nursing updates and sends them monthly to its members.

- **Strike**

Four respondents (13.3 %) mentioned that their organizations do not allow them to strike.

Examples given include:

“The organization does not allow us to strike”.

“No strike by nurses”.

Bezuidenhout (1998 (b):11) believes that the presence of trade unions within health services should not be seen as a negative occurrence, but in the current political climate they aim to abolish the ethical code that has guided nurses in the past to care for their patients first and foremost. Unfortunately the freedom of association has resulted in disruption of the services, unprofessional behaviour by nurses and the death of several patients due to strike action by nursing staff.

With regard to arguments supporting the right of nurses to strike, Heunis and Pelsler (1997:45) assert that the power of the individual employer, senior bureaucrat or state policy maker is so

infinitely greater than that of the individual employee, that only through collective action, and threat of strike action, can the power relationship some way be balanced. The authors further argued that nurses in South Africa have little option but to enter into strike action because of the nature of nurses' grievances and discontents and also the impervious attitude and/ or incapacity of authorities to adequately address nurses' problems. The question arises whether a strike action can be effective without harming patients, but the authors believe that well organized strikes by professional and responsible unionists can be entered into in ways that at least largely limit harm to patients. Preventative measures include giving adequate notice of the strike, so that alternative arrangements can be made for patients, and ensuring minimum coverage for emergency services, such as casualty services, labour wards, theatres and intensive care units.

- **Policy**

Seven respondents (23.0%) mentioned that their organization provides them with policies about disciplinary measures in the workplace, how to handle media people in the units, a policy on how to care for HIV/AIDS patients in the units and also some notices regarding the midwives' role regarding Termination of Pregnancy (TOP).

According to Ewles and Simnett (1999:310) professional networks may attempt to influence employers and organizations to reconsider their policies or to develop new policies for the future. Professional networks institute criteria for professional practice and are active in the professional development of their members.

Pope, Nel and Poggenpoel (1998:38) assert that nursing staff should empower each other by facilitating opportunities for continued education, ethical and professional conduct, as well as participating in and management of professional organizations. Nursing should become politically active, acquire power through valuable liaisons and influence policy and legislation to improve the character of nursing.

4.3. SUMMARY

In conclusion, this chapter presented the findings provided by 133 respondents who come from a group of respondents who were mainly senior and chief professional nurses (figure 4.9). A fair number of respondents had more than fifteen years experience (Figure 4.8). It appears that respondents are aware of factors that promote or hinder ethical decision making in a hospital setting. In chapter 5 conclusions and recommendations drawn from these findings will be presented.

CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

In this chapter the research questions are answered by summarizing the most significant findings of the study. Through the use of questionnaires, registered nurses gave their input regarding ethical decision making in a bureaucratic context. Limitations, which were identified during the study, are discussed. Recommendations for further research and acquisition of ethical decision making skill/knowledge are made.

5.2. THE PURPOSE AND METHOD OF STUDY

The purpose of this research project was to describe the ethical decision making in a bureaucratic context by registered nurses. Making moral and ethical decisions requires knowledge of ethics, codes and principles. Registered nurses should clearly understand the standards and principles that guide moral and ethical decision making. It is necessary to have wide knowledge and skills because nursing cannot afford to take the consequences if poor ethical decisions are made by nurses who are charged with added responsibility and accountability for decision making.

In order to achieve this purpose questionnaires were handed to respondents. The questionnaires consisted of four sections. The first section was comprised of questions relating to the demographic data and educational profile of respondents. The second section of the questionnaire consisted of questions which dealt with ethical decision making and bureaucracy. The third section dealt with ethical decision making and ethical principles. The fourth section included questions regarding cultural, religious and occupational factors which influence ethical decision making.

Research questions were formulated to direct the study. The research questions were as follows:-

- To what extent do demographic variables(age, status and education) influence ethical decision making?
- To what extent does bureaucracy influence ethical decision making?
- What is the impact of ethical principles on ethical decision making?
- How do socio-cultural, religious, and occupational factors influence ethical decision making?

The influence of the following variables on ethical decision making was determined:-

- age of respondents and input regarding the care and discharge of patients,
- years of experience and drawing up of budgets,
- post level of nurses and consulting with the medical doctor when making ethical decisions,
- post level of nurses and doctors as main decision makers,
- work units of nurses and whether they find their work complicated,
- marital status and submissiveness,
- gender and submissiveness,
- gender and woman's reluctance to make ethical decisions,
- ethnic groups and woman's reluctance to make ethical decisions, and
- church affiliation and abortion on demand.

5.3. FINDINGS AND CONCLUSIONS OF THE RESEARCH PROJECT

The findings and conclusions of the research are summarized according to the research questions which were formulated in the first chapter.

5.3.1. To what extent do demographic variables (age, status and education) influence ethical decision making?

Purpose: to determine the relationship between the selected demographic variables and ethical decision making.

- **Gender**

The majority (86.4%) of respondents in this research project were females. Figure 4.1 supports the notion that nursing is still a predominantly female profession (Thompson & Thompson 1990: 17). The fact that only a few (13.6%) respondents were males is in accordance with the other findings in literature that nursing is still about 97% a woman's profession (Kelly 1987: 276). The provisional figures of persons on the registers from the South African Nursing Council reveal that there is a total number of 93 357 registered nurses/midwives of which 88 789 are females and 4 568 are males (SANC 1999 provisional figures; 31-12-1999). These figures also support the notion that nursing is still predominantly a female profession.

- **Marital status**

The majority of respondents were married. (Figure 4.2.) Registered nurses who are married today have multiple roles to play. According to Fisher (1991: 33) "another psychosocial factor which can have an impact on decision making is the fact that working women regardless of class have strains of double role; i.e. being a parent or a wife or husband is very demanding. Working women usually want to assume responsibility for their children's physical and mental welfare, shopping, paying bills, etc and these confusing responsibilities are traditionally performed by non-working marriage partners".

Each person has core values related to their individual circumstances. If a married nurse values her family, principles such as happiness, justice and freedom may play a role when ethical decisions must be made, when there is role conflict. Choosing the rights of her family instead of

her responsibility towards her patient could be against her code of ethics, should she decide to stay at home to look after her sick child, rather than going on duty (Doheny et al 1997: 228,229).

- **Ethnic group**

The majority of respondents were Vendas and this can be attributed to the fact that four of the hospitals in the survey are from the former Venda homeland.

“For the nurse to help clients adequately progress toward their own culturally defined health state, it is essential to view clients from the point of view of their own individual cultural beliefs and practices (Doheny et al 1997: 136). Nurses in this study belonged to the same ethnic group as the patients which would assist them in making ethical decisions related to the patient’s care.

- **Home language**

The majority of the respondents use Tshivenda. This is also attributed to the fact that the majority of respondents are Vendas.

When ethical decisions need to be made, the nurse often acts as an advocate for patients. To explain to the patient the implications of the decision, the nurse must be able to convey the message clearly. This can only be done if the nurse can speak the language of the patient. Language is “more than its vocabulary, grammar, sound structures and so forth; it is also a repository of the modes of thought, the motions of causation and the conceptual and cognitive categories of the culture” (Hymes (1968: 248) in Doheny et al 1997: 12).

- **Age distribution of respondents**

The majority of registered nurses fell within the age group of 35-39 years and 40-46 years. This would imply that the registered nurses participating in this study should be able to make ethical decisions in a bureaucratic context because of maturity. The influence of the age of respondents on input regarding the care and discharge of patients in the hospital. (Table 4.1.) It is interesting

to note that the majority of respondents in all age groups disagreed that they have no input in the care and discharge of patients.

It is believed that “as a person matures she moves from a state of dependence... until a state of independence is reached” (Booyens 1998:419). If the nurses in the study are mostly of a mature age it is expected of them to be able to participate more freely in ethical decision making, because of their experience and skills.

- **Church affiliation of respondents**

The majority of respondents belonged to either a Christian religion or other religions not mentioned in the study. (Figure 4.6.) Literature reveals that humans are religious beings (Pera & Van Tonder 1996:207) and their religious beliefs are for many people ultimate values that guide their moral conduct (Bandman & Bandman 1995:295). The influence of church affiliation on abortion on demand was determined. In table 4.24 the results revealed that most religious groups regarded abortion on demand as sin and murder.

- **Highest educational qualification in nursing**

It has been shown that many of the respondents were highly qualified. (Figure 4.7.) Most respondents had either a four-year integrated course, or a BA Cur, or had a basic degree, or had a BA Cur (HONS) degree. Deloughery (1995:230) asserts that knowledge about moral reasoning, about the desired professional conduct, and about the moral obligation of nursing is incorporated into the education nurses receive in both their undergraduate and graduate programmes. If the nurses in the study are highly qualified it is expected of them to be able to participate more freely in ethical decision making, because of their qualifications and expertise.

- **Years of experience**

A fair percentage (38.4%) of the respondents had more than 15 years experience. (Figure 4.8.) It can be concluded that the majority of the respondents were highly experienced since they had

more than six years experience. According to Morrison (1993:30) “Past experiences can have an impact on communication” and “similar situations one has experienced in the past color many present communications”. When the nurse must make an ethical decision the past experience will assist her if she has had a previous experience of a similar situation.

- **Post level held by respondents**

It has been shown that the majority of the respondents were at managerial level. (Figure 4.9.) Most (42.1%) respondents were holding managerial posts such as a chief professional nurses’ post, a nursing service managers’ post and an assistant directors’ post.

It was determined whether the post level held by respondents had any influence on the respondent’s perception that doctors are the main decision makers on patient matters in hospital. (Table 4.5.) It became evident that even though most respondents were managers, they still had to first consult with a medical doctor when making ethical decisions.

If only 13 (9.7%) of the respondents did not agree that they first have to consult with a medical doctor before making an ethical decision regarding patient care, it is clear that nursing staff see ethical decision making as a participatory act. Depending on the type of decision, this could have a positive result, especially when ethical dilemmas occur in the service: for example when deciding on discontinuing a life support system.

- **Years of experience in current post**

The majority of respondents had less than one year of experience in their current post (Figure 4.10). This can be attributed to the fact that the research project was done during a time when respondents that had not received promotions for a long period were granted their promotions (chapter 3).

- **Areas where respondents were working**

It became evident that the respondents were operating in a variety of sections or units but ICUs, theatres and gynaecological wards were not well represented. The areas where they worked did, however, according to table 4.10 on page 91 not make any difference to their ability to make ethical decisions.

In a study done by Bucknall and Thomas (1997: 229-237) on nurses' reflections on problems associated with decision making in critical care settings, where 230 Australian practising critical care nurses were surveyed, the results revealed that between 22 and 56 percent of nurses reported experiencing difficulties in making decisions related to "lack of time to make decisions," "lack of time to implement decisions," and "personal value conflicts with other staff." Nearly one-third (30.3%) of the respondents indicated that they disagreed with other staff who were responsible for making decisions in the units on at least a weekly basis. Major sources of nurse dissatisfaction related to ethical decision making in critical care settings included:-

- treatment decisions for patients with poor prognoses;
- disharmony with medical staff concerning decision autonomy issues, especially with junior doctors;
- time constraints on nursing care;
- the demands of new intensive care technology upon nurses' knowledge bases;
- and
- the need for in-service education to address this problem.

5.3.2. To what extent does bureaucracy influence ethical decision making?

Purpose: To determine the bureaucratic factors that influence ethical decision making in a bureaucratic context.

5.3.2.1. The extent of respondents' participation in the budgeting procedure of the hospital

The majority of respondents always participated in the maintenance of equipment, condemning equipment, provided input regarding the needs of units, and the drawing up of the budget. The influence of years of experience and whether respondents participated in drawing up of the budget was determined. (Table 4.2.) It was concluded that the majority of experienced respondents were involved in the drawing up of the budget in units.

In a bureaucracy the focus is to allocate work to people and machines in such a way that the goals of the institution are met. "The proper division of labour has been called the most important economic concept ever devised" (Morrison 1993: 192). If staff are, therefore, participating in the budgeting procedure it can be deduced that they are seen as having the necessary skills to make the correct decision in matters pertaining to the effective utilization of resources. In turn they will be able to utilize these skills to participate in ethical decisions related to finance.

5.3.2.2. The participation of respondents in the care and discharge of patients in hospital

The majority of respondents accepted that they must first consult with doctors when making ethical decisions. They also acknowledged the fact that more appropriate ethical decisions are made when doctors and nurses discussed a patient's condition. It was concluded that respondents were aware that they should work hand in hand with doctors when making ethical decisions. The problem was that more than fifty percent of respondents agreed that doctors do not recognize them as colleagues or co-workers.

According to Pera and Van Tonder (1996:77), in previous research relating to nurse-doctor relationships, “Alt-White, Charnes and Strayer in Oermann (1991:189-190) found that certain managerial and organizational factors improve co-operation”. It was discovered that “in environments where nurses were under organizational pressure, there was less co-operation between doctors and nurses. Where doctors encourage participation by nurses, there was better co-operation, and where doctors showed no interest in nurses’ opinions, little co-operation was found”.

It was analysed whether the post level held by respondents had any influence on the respondent’s perception that the doctors are the main decision makers on patient matters in hospital (see table 4.6.) It was interesting to note that an equal percentage of respondents holding managerial posts (chief professional nurses, nursing services managers or assistant directors) and those not on managerial posts (professional nurses or senior professional nurses) could not accept that doctors are the main decision makers in the care and discharge of patients. It was concluded that post level or position does not influence the registered nurses’ participation in the care and discharge of patients in the hospital.

5.3.2.3. The influence of other staff members on respondents’ ethical decision making

It was shown in table 4.7 that the respondents were aware that other staff members could have an impact on their ethical decision making.

The majority of respondents accepted that ethical decision making could be enhanced when nurses collaborate with other health personnel. This is supported by Pera & Van Tonder (1996:74-75) who believe that “power sharing and decision making among nurses and doctors are essential,” and that collaborative relationships “distribute control and prevent one health worker from dominating another”.

To deliver high-quality care a spirit of collegiality amongst health professionals is essential. In an environment where complex ethical decisions must be made the nurse must collaborate with other health professionals. To ensure collaborative relationships, the roles of different categories

of staff need to be clarified at the same time sharing control and maintaining contact (Oermann 1997: 155-157).

It is encouraging to note that supervisors allow registered nurses to work independently and are willing to implement improvements in the job situations. This indicates that although a bureaucratic structure prevails, a democratic approach is used.

5.3.2.4. The extent to which respondents view the influence of their present work situation on ethical decision making

It was evident that at least a third of the respondents were aware of factors in their present work situation that could influence their ethical decision making.

Item 22: Respondents find their post exciting

If most (60.1%) nurses (according to table 4.8, page 88) usually or always find their work exciting, it will enhance their ability to make ethical decisions. Husted and Husted (1995:160) postulate that if a nurse has knowledge and understanding of her patients she is able to have empathy with them, which enhances her ethical decision making skills. If the nurse finds her work exciting she will know her patients' needs and values.

Item 23: Work is complicated

Most (75.2%) of the nurses only sometimes, rarely or never experience their work as complicated.

Item 24: Workload is manageable

Most (47.4%) of the nurses always or usually find their work load manageable, 38.6% sometimes find it manageable, and a small percentage (15.8%) rarely or never find it manageable.

The above two items (23 and 24) could indicate that nurses are placed correctly. This is in line with their experiencing excitement (item 22) in their work. When nurses have the necessary skills, knowledge and experience their capacity to make ethical decisions is enhanced (Husted and Husted 1995: 159-160).

The above two findings can also be attributed to the fact that supervisors manage units in a democratic way (item 25) as displayed in table 4.8 page 88, where 82,1 percent of the respondents indicate that the supervisor sometimes, usually or always acts in a democratic way. This is also verified by the 78,2 percent who are allowed to make their own decisions related to patient care (item 26). A democratic leader “provides guidance and direction and counsels the followers when needed” (Jooste 1996: 171). Although nurses will have freedom to make ethical decisions, supervisors will be there to share control and guide them.

Table 4.8 page 88, also indicates that nurses, 83 (62.4%), often do not participate in ethical decisions because they are afraid to make wrong decisions (item 27). If nurses 104 (72.2%) were allowed to make their own decisions, it is cause for concern that 62.4 percent are afraid to make ethical decisions.

The reluctance to make ethical decisions could be addressed by the fact that 82.7 percent, according to table 4.8, indicated that ethical decision making is influenced by the policies of the institution (item 28).

According to Kelly and Joel (1996:289,290) nurses “are still complaining of lack of power on the job – the lack of autonomy and of involvement in the budget setting and in policy making”. The authors also wondered if lack of power on the job is related to a “historical pattern of obedience to authority”, or if it is “their social, cultural, or economic background”, or “they think they don’t have what it takes to be powerful and influential”.

According to Tschudin (1994 (b):43) nursing efforts to achieve parity in health care systems has been limited by the unwillingness of many nurses to assume responsibility for decision making and the lack of support for nurses who try to increase their level of autonomy.

If the reluctance to make ethical decisions is related to lack of power on the job, lack of autonomy and involvement in policy making, the employer need to ensure that staff receive ongoing training, especially when new policies are passed and existing ones are updated. Such policies should be interpreted and communicated to personnel to ensure that they can carry out their duties in accordance with the laid-down policies.

Pike (1991) in Oermann (1997:155) asserts that “nurses need to gain a sense of empowerment that enables them to overcome feelings of timidity, self-doubt, and subservience and allows them to function as full participants in the health care team”.

5.3.2.5.Standing orders that conflict with respondents’ scope of practice

A small percentage of respondents identified standing orders which come into conflict with their scope of practice. (Table 4.11.) The standing orders included stopping of medication and ventilators, intravenous therapy, blood transfusion, abortion and circumcision.

Verschoor, et al (1997:49-50) believe that “if a senior entrusts work to a junior for which he has no experience, the junior must inform the senior that he does not feel up to the task and, if applicable, that it is not included on his duty sheet”. It can be concluded that “when a nurse feels that she lacks the knowledge or skill needed to administer specialist treatment but her seniors insist, she should take the matter to higher authority”.

According to Searle and Pera (1995: 257) a nurse “must understand and observe fully the protocol for the type of nursing care she has to provide”. A standing order is “a written document containing rules, policies, regulations and orders for the conduct of patient care in various stipulated clinical situations” (Searle & Pera 1995: 257).

Moorhed and Gardener Huber (1997: 24) assert that “Using protocols such as clinical pathways can lead to coordination, efficiency, and standardization. The implementation of protocols requires that nurses make judgements about the benefits and risks to specific patients”. If any of the protocols or standing orders are causing conflict when a nurse is having to make an ethical

decision the nurse should incorporate ethical and legal principles to protect herself and the patient.

5.3.2.6. Communication channels mostly followed when making ethical decisions

It can be concluded that the majority of respondents who first discuss their decisions with unit managers could be professional nurses, senior professional nurses and junior managers. Those who first discussed decisions with doctors, nursing services managers or superintendents could be the unit managers themselves, since they should report to the higher authority or their seniors.

According to Douglass (1996: 189) "Nursing has great potential to effect changes in health care, yet because it is primarily a women's profession, attempts to use such potential can lead to power struggles. The traditional nursing role has been one of subservience and service to others. Nurses must develop effective communication skills so that they can articulate their ideas, control their environment, and achieve results. These accomplishments will increase their self-esteem and, consequently, the esteem of the profession".

5.3.3. What is the impact of ethical principles on ethical decision making?

Purpose: to identify ethical principles affecting ethical decision making and to ascertain if such principles really guide ethical decision making.

Ethical principles affecting ethical decision making which were identified include the following:

- Autonomy
- Truthtelling
- Loyalty
- Beneficence
- Nonmaleficence
- Justice

The above mentioned principles, according to Christensen (1988:47), are more tangible for giving direction and guiding actions. Moss (1995:276) believes that principles, values and ethics drive ethical decision making.

5.3.3.1. *Autonomy*

Respondents gave examples of incidents where patients' autonomy was not respected. The following are the conclusions: -

- There is a need for incorporation of traditional healers/witch doctors in the health care system.
- Health personnel should be aware that “it is a serious violation of dignity of a person to intrude on his private life or to expose it to the eyes and ears of the public or even merely individuals who have no right to this information” (Verschoor, et al 1997:57).
- Doctors need to be aware that “it is not the nurses' responsibility to obtain informed consent, only to clearly explain the form to the patient” (Moss 1995:278).
- It is essential for the nurses to note that “no one ever has a right to violate the rights of anyone,” it is therefore crucial to acknowledge that “in a biomedical context, all rights belong to the patient” (Husted & Husted 1995: 247).
- It is unethical to coerce or force a patient (Moss 1995:278).
- Deception is said to violate the right of the person who is being deceived (Husted & Husted 1995:37).

- The health personnel should note that “negligence pertains to a person’s failing to do something that a reasonable and prudent person would do, or doing something that a reasonable and prudent person would not do” (Deloughery 1995:204).
- Nurses are said to be negligent if they fail to observe or report common symptoms such as pain, discoloration of the toes and changes in the patient’s temperature (Verschoor, et al 1997:46).

5.3.3.2. Truth telling and loyalty

Respondents were requested to give examples of situations where they did not know whether to tell the truth or not, or of situations where loyalty to the family, employer, colleagues or physicians comes into conflict. The following are the conclusions:

- Terminal illness is a crisis which is complicated for health professionals and patients and their relatives.
- Confronting patients with bad news is an uncomfortable experience.
- “Nurses as moral agents of clients experience a basic conflict between honoring their obligations to clients and upholding their responsibilities to institutions and their power structures” (Christensen 1988:48).
- Patients have the right to refuse treatment and also have the right to be fully informed of the treatment they receive (Nursing Update 1999/2000:36).
- Offering contraceptives to teenage girls may pose problems but “a doctor may give a girl under the age of 16 years contraceptive advice and treatment without her parent’s knowledge if the doctor is satisfied that:-
 - the girl understands the advice,

- she cannot be persuaded to inform her parents or to allow doctors to inform them,
- it is probable that she will begin or continue with sexual intercourse regardless of whether she is given contraceptives or not,
- unless she gets advice and treatment her physical or mental health or both would probably be prejudiced, and
- it is in the girl's best interest to receive contraceptive advice or treatment without parental consent" (Verschoor, et al 1997:79).

5.3.3.3. Beneficence and nonmaleficence

Respondents acknowledged the fact that the principles of beneficence and nonmaleficence guide nurses to avoid infliction of harm as well as providing benefits to patients, and weighing and balancing the benefits against any harm that can occur to the patient (Christensen 1988:47, and Deloughery 1995:231).

5.3.3.4. Justice

Respondents acknowledged that justice implied their being fair to all patients and that there should be equal distribution of resources. According to the national patients' rights charter everyone should have access to health care and may choose a particular service (Nursing Update 1999/2000:36).

In conclusion, registered nurses were aware that ethical decision making requires the application of ethical stands/principles to health care.

5.4. HOW DO SOCIO-CULTURAL, RELIGIOUS, AND OCCUPATIONAL FACTORS INFLUENCE ETHICAL DECISION MAKING?

Purpose: To identify socio-cultural, religious, and occupational factors which influence ethical decision making, and to determine the degree to which these factors influence ethical decision making.

Literature revealed that cultural, religious, ethnic and environmental factors influence how people as adults work through a moral-reasoning process (Deloughery 1995:236).

The following conclusions were drawn from Table 4.19:-

- **Women are submissive to men**

When the influence of gender on submissiveness was determined, Table 4.21, it became evident that the majority of both females, 91 (79.1%) and males, 16 (88.9%) were positive that women are submissive to men. According to Ellis and Hartley (1992: 345) "Early social beliefs that women's role should be submissive, supportive, and obedient were extremely compatible with pervading concepts of the expectations that our society placed on nurses".

- **Married women are submissive to men**

The influence of marital status on submissiveness was determined, Table 4.20, the majority (77.2%) of married women accepted that they were submissive to men. It is quite interesting to discover that even those respondents who were never married agreed that married women were submissive to men. "In many cultures, the male is the dominant figure. In cultures where this is true, males make decisions for other family members as well as for themselves" (Tayler, Lillis & LeMone 1993:113).

- **Women are reluctant to make decisions in discussions, which involve both men and women**

The analysis of the influence of gender on women's reluctance to make ethical decisions (Table 4.22.) revealed that the majority of both females 62 (53.9%) and males 13 (72.2%) were positive that women are reluctant to make ethical decisions.

“The historically authoritarian and paternalistic attitudes of physicians and hospitals often have relegated nurses, most of whom are women, to dependent and subservient roles. These role differentiations have in the past inhibited nurses from taking independent stands on issues, and they continue to affect relationships in the health care field. Some physicians have been heard to comment that all ethical decisions rest on the physician's shoulders, and that once the physician has made a decision, all other members of the health care team are obligated to acquiesce. This attitude results in people absolving themselves of moral responsibility by simply following orders” (Ellis & Hartley 1992:218).

The above-mentioned statement is further supported by Tschudin (1994 (b):43) who asserts that nurses have been reluctant to take responsibility for decisions because 90 percent of nurses are women who have learned to be passive and obedient to the male medical hierarchy.

Another analysis done on the influence of ethnic group on women's reluctance to make decisions, Table 4.23, revealed that the majority (64.7%) of Vendas, 66.7% of Europeans, 75% of Sothos, of 66.7%Xhosas, and 66.7% of the others were positive that women were reluctant to make ethical decisions. The majority (57.1%) of Tsongas disagreed with the statement that women are reluctant to make ethical decisions.

The fact that women are submissive to men, and that in many cultures the male is the dominant figure, may be the reason that in this study, because of submissiveness, women were reluctant to make ethical decisions.

- **Most religions require women to be submissive to men**

This is evidenced by the fact that the majority (76.7%) of respondents were positive that religions require women to be submissive.

- The majority (65.4%) of respondents agreed that if women are not competent in making ethical decisions in their work place, this has got nothing to do with their religion.
- The above two responses relating to religion were contradictory, because a slightly smaller percentage of those who agreed that religion influences women's submissiveness also agreed that religion has nothing to do with making ethical decisions.

- **Abortion on demand is regarded by most religious groups as sin and murder**

This is evidenced by the fact that the influence of church affiliation on abortion on demand was determined (Table 4.24). The majority of Christian and other religious groups were positive that abortion on demand is a sin and murder.

According to Deloughery (1998:143-144) "The Pro-life movements claim that conception marks the beginning of new life and that any action to terminate that life is analogous to murder. Pro-choice activists claim that each woman has the right to determine what happens to her body, and if she chooses to have an abortion, it is her legal right to do so". As far as the pro-life is concerned, it "cites various religious beliefs that do not allow interference with the procreative process and views abortion as tantamount to infanticide".

According to the Choice on Termination of Pregnancy Act No. 92 of 1996 (Statutes of the Republic of South Africa) the law penalizes "any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for termination of a pregnancy", and this person "shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period

not exceeding 10 years". This Act poses a problem to those nurses who are pro-life, whose religious beliefs "do not allow interference with the procreative process and view abortion as tantamount to infanticide". For nurses who are pro-life, to actively participate in ethical decision making as far as abortion issues are concerned would be practically impossible. To become fully involved in the care and support of women who choose to terminate their pregnancies would be another serious problem, yet the choice on Termination of Pregnancy Act No. 92 of 1996 "promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to individual beliefs."

- **Practising euthanasia is seen as sin and murder**

The majority of respondents were positive that their culture viewed practising euthanasia as sin and murder. According to Kelly and Joel (1996: 335) "many people feel that, under certain circumstances, assisted suicide is morally acceptable". A position statement released by ANA in 1995, "states that there is a continuum of choices that encompass a broad spectrum of interventions for end-of-life care, and nurses can respond with compassion, faithfulness and support, but not assistance in ending life" (Kelly & Joel 1996: 335).

- **Organizations to which respondents belong**

The majority of respondents belong to DENOSA since it caters for persons who practice nursing or midwifery and for the fact that nurses want only nurses to determine their professional future.

According to Mason & Leavitt (1998: 541) "professional associations are logical places to which nurses can take concerns regarding critical issues. Expressing one's concerns and questions will both inform other nurses of the situation and garner suggestions and support for a prompt solution".

A smaller percentage of respondents belong to NEHAWU (which is a union for all hospital workers).

Foley in Mason & Leavitt (1998: 307) asserts that hospitals do not want nurses to organize, they see collective bargaining as a power struggle between union and management, and unions, as opposing parties, are seen as rivals.

This could be the reason why the majority of nurses are members of DENOSA rather than NEHAWU. “Another factor that has hampered the strong development of unionization in nursing is the fact that nursing is primarily a woman’s profession” (Ellis & Hartley 1992: 345).

Since nurses face different issues than do other workers, they contend that only registered nurses should bargain for registered nurses. Many nurses believe that only nurses can effectively negotiate questions pertaining to staffing, patient care concerns, and participation on joint hospital committees” (Ellis & Hartley 1992: 347). If nurses become part of the joint hospital committees they can also negotiate questions pertaining to ethical issues and participate in ethical decision making.

- **Attending meetings inside or outside hospital relating to nursing issues influences ethical decision making**

The majority of respondents do not attend meetings, although noticeable proportions, forty seven percent, do attend meetings.

- **Organization’s guidance with regard to ethical decision making**

Organizations gave nurses guidance or guidelines as far as ethical decision making is concerned. Organizations gave guidance through the following, as cited or depicted by respondents:

- Organizing meetings and workshops to enable registered nurses to acquire knowledge on ethical decision making.
- Mailing nursing journals or magazines monthly, which cover topics about ethical issues and ethical dilemmas.

- Highlighting strike action for members – regarding arguments supporting or preventing the right of nurses to strike.
- Ellis and Hartley (1992: 348,350) assert that “nurses do not like to strike because of fear of placing the level of care to the community in jeopardy or damaging the public image of nursing”. The authors further mentioned that there are other nurses who believe that striking can benefit them to achieve “desired ends” and also “to increase the public awareness of matters related to working conditions, salaries and benefits of nurses”.
- Helping members by formulating policies relating to disciplinary measures, policies on how to care for HIV/AIDS patients, notices relating to the role of midwives regarding Termination of Pregnancy (TOP).

It can be concluded that organizations have a crucial role to play in helping members address ethical issues and dilemmas in the work place.

5.5. LIMITATIONS IDENTIFIED DURING THE STUDY

During the course of the study certain limitations were identified.

- The reallocation of professional nurses from hospital to clinics or clinics to the hospital, according to the new staff establishment, took place during the time of research. This factor could have affected registered nurses’ skill and experience in dealing with ethical dilemmas in a hospital situation, particularly for registered nurses who worked in the clinics for a long time.
- Professional nurses were being granted their long overdue promotions. Professional nurses were promoted to senior professional nurses’ posts, senior professional nurses to chief professional nurses’ posts, chief professional nurses

to assistant directors' posts. The registered nurses' years of experience in their current post could have been affected.

- Many demographic variables were identified but some of them could not be correlated to determine if they influenced ethical decision making in a bureaucratic context. It could be beneficial to determine if educational status influenced ethical decision making.

5.6. RECOMMENDATIONS ARISING FROM THE RESEARCH PROJECT/IMPLICATIONS

These results have implications for nursing administration, organizational environment, nursing education and nurses.

- The nurse administrators must create an ethical organizational environment, which fosters an atmosphere in which ethical decision making is possible.
- There are implications for staff development programmes for all levels of nurses. Programmes that teach the process of ethical decision making for all levels of nurses would enhance the ethical climate. Providing education for nurse administrators about ways to enhance and facilitate support for those encountering ethical dilemmas would also assist in developing an ethical climate. Since the findings in Table 4.8 (on page 88) showed that 62,4 percent of nurses do not participate in ethical decision making because they are afraid to make wrong decisions, these nurses need support from nurse administrators and programmes that teach the process of ethical decision making, so that they can have confidence in making ethical decisions.
- Nurse administrators must know and demonstrate their position and their hospital's position on ethical issues, to provide leadership. They need to look at the ethical implications of nursing practice and institutional policies and

procedures. Findings in Table 4.8 indicated that the majority (51.9%) of respondents agreed that policies influence ethical decision making.

- There is a need to focus attention on ethics in the everyday life of the organization.
- Findings from this research project have implications for nursing education. Educational programmes with clearly defined instruction in general ethics, ethical decision making skills, and bio ethics need to be developed to prepare nurses for positions at all levels. It was stated clearly by the respondents that their organizations should strive to educate members on ethical decision making.
- Considering the findings confirming that doctors spend less time with patients, there is a need for collaboration between nurses and doctors so that participative decisions can be made for the benefit of the patients. Burnard and Chapman (1995: 72) assert that “no discussion on teamwork in health care can ignore the contribution of relatives, voluntary workers and indeed the patients or client as part of the team”.

5.7. RECOMMENDATIONS FOR FURTHER RESEARCH

The following aspects require further investigation.

- The identification of strategies that will empower registered nurses to function as moral agents in the bureaucratic context. (Emphasis needs to be placed on enhancing the knowledge and skills of registered nurses regarding ways in which ethical decision making in a bureaucratic context can be made.)
- Ways in which universities, colleges and nursing schools can empower nursing students and registered nurses to become knowledgeable and competent decision makers as far as ethical issues and dilemmas are concerned. (By exploring

compulsory programmes/courses that can be incorporated in their nursing curricula.)

- In further work it would be worthwhile to explore how physicians, other health care administrators and senior nursing students would respond if given the same questionnaires that were given to registered nurses.
- This research only focused on nurses who worked in hospitals. This does not mean to imply that nurses working in other settings (out-of-hospital settings) do not encounter bureaucratic constraints. Further research could be done in other settings and the responses of nurses from in-hospital and out-of-hospital settings could be compared to the data already collected.

5.8. RECOMMENDATIONS FOR QUALITY IMPROVEMENT IN NURSING SERVICES AND NURSING EDUCATION (CHALLENGES)

Research on ethical decision making in a bureaucratic context may contribute to quality improvement in both nursing service and nursing education.

The nursing profession cannot afford to take the consequences if registered nurses make poor decisions. For the nursing profession to be assured that nurses will systematically analyze situations, predict outcomes, make effective decisions, take actions which they can defend, and evaluate results (Bailey & Claus 1975:6) the following recommendations are made:-

- Bio-ethics committees should be established in bureaucracies that encourage the education of nurses in bioethical issues unique to nursing, the involvement of nursing in institutional ethical concerns, policy making and committee work, and to engage in conflict resolution. (Deloughery 1995:242, Douglass 1996:329 & Kurzen 1997:171).

- Nurse ethics consultants should emerge in greater numbers to work with care givers in addressing ethical dilemmas (Norwood 1998: 301), and to gather and review data and offer an ethical analysis (Ignatavicius, Workman & Mishler 1999: 8).
- The study of health care ethics needs to be incorporated into the everyday nursing curriculum, as well as continuing in service presentations. Nurses must be trained in the process of ethical inquiry and decision making.
- Since nurse administrators have a moral obligation to create an environment for ethical reasoning, they can informally make thoughtful statements to staff that reinforce thinking about, rather than reacting to, ethical problems. They can also in a more formal way educate staff regarding bioethics and ethical practice, and ensure intradisciplinary and interdisciplinary discussion of ethical concerns through ethics rounds and institutional ethic committees (Davis & Aroskar 1983:10, & Christensen 1988:53).
- Seminars or workshops should be conducted for nurses on ethical decision making. These may also contribute to the improvement of ethical decision knowledge and skill.
- The actions and attitudes of an ethically effective nurse are structured by bioethical standards. For nurses to make consistent effective ethical decisions, they should make use of some resources, such as bioethical standards, e.g. autonomy, freedom, veracity, privacy, beneficence, fidelity (Husted & Husted 1995:116).
- There should be collaboration between nurses and other health team members (particularly doctors) so that participative decision making can be done.

According to Davis, Aroskar, Liaschenko, and Drought (1997: 74) “The trust and efficiency that nurses demonstrate are qualities that, in their place, can be of inestimable value to physicians and patients. Obviously, the nursing and medical professions need to find ways in which these and other values can be reconciled with nurses’ fuller exercise of their intellectual and ethical potentialities”.

5.9. PROPOSED WORKSHOP ON ETHICAL DECISION MAKING

A workshop is planned by the researcher so that both student nurses and registered nurses can be made aware of the fact that “ethical decision making is a difficult and demanding task, requiring intense self-awareness, understanding of ethical issues in the emerging social structure, and application of ethical standards to health care, regardless of upheavals in the work environment” (Moss 1995: 276).

The workshop should aim at helping both students and registered nurses gain adequate knowledge regarding moral development theory and ethical decision models. According to Grohar-Murray and Di Groce (1997:106-107) nurses can attend courses in ethics in order to acquire the necessary tools for ethical analyses.

The workshop will be planned in such a manner that positive and negative factors which influence ethical decision making in a bureaucratic context will be discussed in an open discussion. Participants will be divided into small groups to facilitate participation. Hypothetical case studies will be given to different groups so that at the end of the session, group leaders can present how they came to the conclusion or decisions taken (See Annexure I).

5.10. CONCLUSION

The purpose of the study was to describe the influence of bureaucracy, ethical principles, socio-cultural, religious and occupational factors, and selected demographic variables (such as age, gender, status, and education) on ethical decision making.

Findings of the study indicate that registered nurses are aware that bureaucracy and occupational factors affect their ethical decision making since they indicated that there should be cooperation and collaboration between members of the health team.

In conclusion, “of paramount importance is the need for nurses to be involved in all aspects of the ethics domain of their workplace. No matter whether nurses work for a small home-health agency, a large university medical Centre, or a health maintenance organization, they must be part of and represent nursing interests in ethical practice of their employing organizations. This means that they must continue to educate themselves, become part of the committee process in institution, and speak out on issues of importance to society” (Deloughery 1995:242-243).

Deloughery (1998: 239) further asserted that “in some instances nurses within a hospital or agency have developed their own nursing bioethics committee that encourages: -

- (1) the education of nurses in bioethical decision making,
- (2) discussion of ethical issues unique to nursing, and
- (3) the involvement of nursing in institutional ethical concerns, policy making, and committee work.”

This could also be put into practice in the health care institutions in South Africa so that nurses become part of and represent nursing interest in ethical practice.

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ANNEXURE A

Cover Letter

ANNEXURE A

Tel No: 015-966 4326 (H)
015-973 0004 (W)

P.O. Box 156
Dzanani
0955
1999

Cover letter

Nurses, as professionals, need to establish themselves in order to develop a greater skill at ethical decision making, particularly in a bureaucratic context. In view of this, a post graduate student of the Department of Advanced Nursing Sciences of Unisa is undertaking a research study to: -

- determine the relationship between the selected demographic variables and ethical decision,
- determine the bureaucratic factors which influence ethical decision making,
- identify ethical principles affecting ethical decision,
- identify socio-cultural, religious, and occupational factors which influence ethical decision making,

I intend getting opinions/views of registered nurses in the Northern Region hospitals. Your help is earnestly required as it is hoped that the project will serve as a basis for enhancing the skills/knowledge of registered nurses as far as ethical decision making in a bureaucratic context is concerned.

Anonymity and confidentiality is guaranteed through out the research study. You are at liberty to give any comments you may have about any question on the questionnaire.

Thanking you in anticipation.

Mrs. Tshilidzi Rachel Nevhutanda
Senior Professional Nurse

ANNEXURE B

**Structured Questionnaire For
Registered Nurses**

QUESTIONNAIRE

INSTRUCTION: PLEASE MARK THE APPROPRIATE BOX

| |
|--|
| |
|--|

QUESTIONNAIRE NUMBER

| | | |
|--|--|--|
| | | |
|--|--|--|

FOR
OFFICE
USE

SECTION A:

DEMOGRAPHIC DATA

1. **Gender**
- | | |
|--------|---|
| Female | 1 |
| Male | 2 |

2. **Marital status**
- | | |
|--------------------|---|
| Never married | 1 |
| Married | 2 |
| Widowed | 3 |
| Divorced/separated | 4 |

3. **Ethnic group**
- | | |
|------------------|---|
| European | 1 |
| Venda | 2 |
| Sotho | 3 |
| Tsonga | 4 |
| Zulu | 5 |
| Xhosa | 6 |
| Other, (specify) | 7 |

4. **Home language**
- | | |
|------------------|---|
| Tshivenda | 1 |
| Xitsonga | 2 |
| Sesotho | 3 |
| Afrikaans | 4 |
| English | 5 |
| Other, (specify) | 6 |

1-3

4

5

6

7

FOR
OFFICE
USE5. **Age in years**

| | |
|------------------|---|
| 20-24 | 1 |
| 25-29 | 2 |
| 30-34 | 3 |
| 35-39 | 4 |
| 40-44 | 5 |
| 45-49 | 6 |
| 50-54 | 7 |
| 55-59 | 8 |
| Other, (specify) | 9 |

8

6. **Church affiliation**

| | |
|------------------|---|
| Lutheran | 1 |
| AME | 2 |
| AFM | 3 |
| ZCC | 4 |
| Roman Catholic | 5 |
| UAAC | 6 |
| None | 7 |
| Other, (Specify) | 8 |

9

7. **What is your highest educational qualification in nursing?**

| | |
|------------------------------------|---|
| Midwifery diploma | 1 |
| Three year General Nursing Diploma | 2 |
| Basic degree | 3 |
| BA Cur | 4 |
| BA Cur (Hons) | 5 |
| Other, (Specify) | 6 |

10

8. **For how long have you been registered as a nurse?**

| | |
|--------------|---|
| 0-2 years | 1 |
| 3-5 years | 2 |
| 6-8 years | 3 |
| 9-11 years | 4 |
| 12-14 years | 5 |
| 15 and above | 6 |

11

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OFFICE
USE**

9. What post level do you hold?

| | |
|---------------------------|---|
| Professional Nurse | 1 |
| Senior Professional Nurse | 2 |
| Chief Professional Nurse | 3 |
| Nursing Service Manager | 4 |
| Assistant director | 5 |
| Other, (specify) | 6 |

12

10. For how long have you been in your present post?

| | |
|------------------|---|
| Less than a year | 1 |
| 1-2 years | 2 |
| 3-4 years | 3 |
| 5-6 years | 4 |
| 7-8 years | 5 |

13

11. In which unit/ward/section are you currently working?

| | |
|------------------|---|
| Medical | 1 |
| Surgical | 2 |
| Theatre | 3 |
| ICU | 4 |
| OPD | 5 |
| Maternity | 6 |
| Pediatric | 7 |
| Gynaecological | 8 |
| Other, (Specify) | 9 |

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SECTION B:

ETHICAL DECISION MAKING AND BUREAUCRACY

Section: B (1) Participation of registered nurses in the budgeting procedure of the hospital

Please rate your participation in the budgeting procedure of the hospital by marking the appropriate block.

| Activities | | Always | Usually | Some Times | Rarely | Never |
|------------|---|--------|---------|------------|--------|-------|
| 1. | Drawing up the budget for your unit | 1 | 2 | 3 | 4 | 5 |
| 2. | Providing input regarding needs of unit | 1 | 2 | 3 | 4 | 5 |
| 3. | Maintenance of equipment | 1 | 2 | 3 | 4 | 5 |
| 4. | Condemning equipment | 1 | 2 | 3 | 4 | 5 |

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Section B (2). Participate of registered nurses in the care and discharge of patients in hospitals

Please rate your participation in care and discharge of patients in the hospital by marking the Appropriate box.

| Statement | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|-----------|--|----------------|-------|----------|----------|-------------------|
| 5. | I must consult with the medical doctor when making decisions regarding patients' treatment | 1 | 2 | 3 | 4 | 5 |
| 6. | I have no input on the doctor's decision to discharge a patient | 1 | 2 | 3 | 4 | 5 |
| 7. | The doctor's power influences my ethical decision when giving patients treatment | 1 | 2 | 3 | 4 | 5 |

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|-----|--|---|---|---|---|---|
| 8. | The doctor's power influences my ethical decision making when informing patients of their condition | 1 | 2 | 3 | 4 | 5 |
| 9. | Doctors are the main decision makers on patient matters in hospitals | 1 | 2 | 3 | 4 | 5 |
| 10. | Nurses in the hospital setting are expected to carry out doctors' orders | 1 | 2 | 3 | 4 | 5 |
| 11. | The perception that nurses who ask many questions are disliked by doctors leads to inappropriate decisions being taken by nurses | 1 | 2 | 3 | 4 | 5 |
| 12. | Nurses do not challenge doctor's decisions on patient care because nurses are not part of the decision making process | 1 | 2 | 3 | 4 | 5 |
| 13. | Nurses do not challenge doctor's decisions on patient care because they occupy the bottom level of the hospital hierarchy | 1 | 2 | 3 | 4 | 5 |
| 14. | Because doctors spend less time with patients nurses are best suited to make ethical decisions | 1 | 2 | 3 | 4 | 5 |
| 15. | More appropriate ethical decisions are made when doctors and nurses discuss a patient's condition | 1 | 2 | 3 | 4 | 5 |
| 16. | Doctors do not recognise nurses as colleagues or co-workers, but see them as a working force | 1 | 2 | 3 | 4 | 5 |

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Section B (3) The influence of other staff on registered nurses' ethical decision making.

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The following questions have to do with the influence of other staff on your ethical decision making. Please indicate to what extent you agree with the following statements marking the appropriate block.

| Statement | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|-----------|--|----------------|-------|----------|----------|-------------------|
| 17. | The immediate supervisor allows you to function independently | 1 | 2 | 3 | 4 | 5 |
| 18. | The supervisor can easily be persuaded to implement improvements in the job situation | 1 | 2 | 3 | 4 | 5 |
| 19. | Ethical decision making is enhanced when nurses collaborate with other health personnel | 1 | 2 | 3 | 4 | 5 |
| 20. | The superintendent should be informed of decisions made since he/she is not in close contact with patients | 1 | 2 | 3 | 4 | 5 |
| 21. | The Nursing Service Manager should be informed of decisions made since he/she is not in close contact with the patient | 1 | 2 | 3 | 4 | 5 |

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Section B (4): The influence of your present work situation on your ethical decision making

The following questions have to do with the influence of your present work situation on your ethical decision making. Please indicate to what degree you agree with the following statements by marking the appropriate block.

| | Statement | Always | usually | Some times | Rarely | Never |
|-----|--|--------|---------|------------|--------|-------|
| 22. | I find my post exciting | 1 | 2 | 3 | 4 | 5 |
| 23. | My work is complicated | 1 | 2 | 3 | 4 | 5 |
| 24. | My workload is manageable | 1 | 2 | 3 | 4 | 5 |
| 25. | The supervisor of the unit manages the unit in a democratic way | 1 | 2 | 3 | 4 | 5 |
| 26. | I am allowed to make my own decisions related to patient care | 1 | 2 | 3 | 4 | 5 |
| 27. | Nurses do not participate in ethical decision making because they are afraid to make wrong decisions | 1 | 2 | 3 | 4 | 5 |
| 28. | Ethical decision making in the unit is influenced by the policies of the institution | 1 | 2 | 3 | 4 | 5 |
| 29. | There are standing orders that come into conflict with my scope of practice | 1 | 2 | 3 | 4 | 5 |

30. Which communication channel do you follow mostly when making ethical decisions? Do you first discuss it with the

Unit manager

Doctor

Nursing service manager

Superintendent

Other, (specify)

| |
|---|
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |

31. Give an example of a standing order which conflicts with your scope of practice

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SECTION C:**ETHICAL DECISION MAKING AND ETHICAL PRINCIPLES.**

Indicate to what degree you agree that the following ethical principles guide decision making, by marking the appropriate block.

| Ethical principles | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|--------------------|--|----------------|-------|----------|----------|-------------------|
| Autonomy | | | | | | |
| 1. | Autonomy is seen as freedom to make choices and decisions about one's care without interference | 1 | 2 | 3 | 4 | 5 |
| 2. | Freedom of action allows people the right to make their decisions | 1 | 2 | 3 | 4 | 5 |
| 3. | Patients are said to be autonomous if they make their decisions based on the necessary and clear information | 1 | 2 | 3 | 4 | 5 |
| 4. | Patients have the right to give their consent to medical treatment | 1 | 2 | 3 | 4 | 5 |
| 5. | Patients have the right to withhold their consent to treatment | 1 | 2 | 3 | 4 | 5 |
| 6. | Patients have the right to be fully advised of the risks and consequences of procedures and expected results if they refuse treatments | 1 | 2 | 3 | 4 | 5 |
| 7. | Patients have the right to be informed of alternative procedures | 1 | 2 | 3 | 4 | 5 |
| 8. | Health professionals should not force patients to agree to treatment even if it is to their own benefit | 1 | 2 | 3 | 4 | 5 |
| 9. | Patients are often forced to agree to treatments by their families | 1 | 2 | 3 | 4 | 5 |
| 10. | Patients' autonomy is sometimes not respected by health professionals | 1 | 2 | 3 | 4 | 5 |

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| Ethical principles | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|-----------------------|---|----------------|-------|----------|----------|-------------------|
| Truth telling | | | | | | |
| 11. | Truth telling in nursing is considered to be very difficult since it is not a matter of saying yes or no | 1 | 2 | 3 | 4 | 5 |
| 12. | Nurses may be tempted to lie, for smoother handling of an awkward situation | 1 | 2 | 3 | 4 | 5 |
| 13. | Patients' families often force nurses to tell them about their patients' diagnoses even if patients do not want them to know | 1 | 2 | 3 | 4 | 5 |
| 14. | In the case where a doctor or any health professional makes a careless mistake/error the nurse should inform the patient and relatives of the truth | 1 | 2 | 3 | 4 | 5 |
| 15. | What is your attitude to AIDS patients regarding truth telling? | | | | | |
| | Patients should be told the truth | 1 | 2 | 3 | 4 | 5 |
| | Patients' relatives should be told without patients' consent | 1 | 2 | 3 | 4 | 5 |
| | Patients should never be told the truth | 1 | 2 | 3 | 4 | 5 |
| | Patients' relatives should never know the truth | 1 | 2 | 3 | 4 | 5 |
| Loyalty | | | | | | |
| 16. | Loyalty implies keeping promises | 1 | 2 | 3 | 4 | 5 |
| 17. | Loyalty to patients may conflict with loyalty to one's personal and professional values | 1 | 2 | 3 | 4 | 5 |
| 18. | Loyalty to patients may conflict with loyalty to the employer | 1 | 2 | 3 | 4 | 5 |
| Ethical principles | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
| Beneficence | | | | | | |
| 19. | The principle of beneficence implies the duty to actively do good for patients | 1 | 2 | 3 | 4 | 5 |
| Nonmaleficence | | | | | | |
| 20. | The principle of non maleficence implies the duty to prevent or avoid doing harm | 1 | 2 | 3 | 4 | 5 |
| Justice | | | | | | |
| 21. | The principle of justice in nursing relates to the allocation of resources | 1 | 2 | 3 | 4 | 5 |
| 22. | Justice in nursing implies an obligation to be fair to all patients | 1 | 2 | 3 | 4 | 5 |

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Give an example of a situation where a patient's autonomy was not respected

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Have you in your unit, found yourself in a situation where you did not know whether to tell or not to tell the truth?

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Yes

| |
|---|
| 1 |
|---|

No

| |
|---|
| 2 |
|---|

If yes, briefly explain the incident.

73

Have you ever come across a situation in your workplace where loyalty to patients has conflicted with loyalty to the family, employer, other colleagues, or physician?

74

Yes

| |
|---|
| 1 |
|---|

No

| |
|---|
| 2 |
|---|

If yes, briefly explain the incident.

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SECTION D

CULTURAL, RELIGIOUS AND OCCUPATIONAL FACTORS WHICH INFLUENCE ETHICAL DECISION MAKING

The following questions have to do with the influence of culture, religion, and occupational factors on your ethical decision making. Please indicate to what degree you agree with the following statement by marking the appropriate block.

| Statement | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|-----------|--|----------------|-------|----------|----------|-------------------|
| 1. | In my culture, women are submissive to men regardless of their rank or position | 1 | 2 | 3 | 4 | 5 |
| 2. | In my culture, women are prohibited from making ethical decisions | 1 | 2 | 3 | 4 | 5 |
| 3. | Male nurses do not like their female counterparts to assist them in decision making | 1 | 2 | 3 | 4 | 5 |
| 4. | In discussions which involve both men and women, women are reluctant to make decisions | 1 | 2 | 3 | 4 | 5 |
| 5. | In general, most religions require women to be submissive to men | 1 | 2 | 3 | 4 | 5 |

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| Statement | | Strongly agree | Agree | Not sure | Disagree | Strongly disagree |
|-----------|--|----------------|-------|----------|----------|-------------------|
| 6. | If women are not competent in making ethical decisions in their work place, it has got nothing to do with their religion | 1 | 2 | 3 | 4 | 5 |
| 7. | Abortion on demand is regarded by most religious groups as sin | 1 | 2 | 3 | 4 | 5 |
| 8. | In my culture, practicing euthanasia is seen as sin and murder | 1 | 2 | 3 | 4 | 5 |

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9. Which organization do you belong to?

- NEHAWU
- DENOSA
- HOSPERSA
- NONE
- Other, (specify)

| |
|---|
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |

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10. Do you attend meetings inside or outside your hospital related to nursing issues that could influence your ethical decision making?

| | |
|-----|---|
| Yes | 1 |
| No | 2 |

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If yes, please explain how they influence your ethical decision making.

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11. Does your organization help you or guide you as far as ethical decision making is concerned?

| | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't know | 3 |

87

12. Does your organization give you guidelines with regard to ethical decision making in your work place?

| | |
|------------|---|
| Yes | 1 |
| No | 2 |
| Don't know | 3 |

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If yes, please explain briefly how your organization has contributed towards ethical decision making in your work place.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

ANNEXURE C

Letter of Application for Permission to Undertake A Study

(Northern Province Health Department)

ANNEXURE C

P.O. Box 156
DZANANI
0955

THE SUPERINTENDENT GENERAL
DEPARTMENT OF HEALTH
PIETERSBURG
0700

**RE: REQUEST FOR CONDUCTING RESEARCH IN THE NORTHERN PROVINCE
HEALTH INSTITUTIONS**

The above matter refers:-

I am a senior professional nurse stationed at Siloam hospital and currently a master's degree student at the University of South Africa. I intend to obtain relevant information with regard to ethical decision making by registered nurses in a bureaucratic context.

The respondents will include registered nurses and they will be conveniently sampled in the hospitals of Region four (4)

The study may empower registered nurses to make ethical decisions in an autonomous manner.

In this regard I am requesting a written permission for use when visiting the respondents.

This fieldwork may commence as soon as possible.

I have enclosed the research proposal, questionnaire, and the letter from the ethics committee for reference.

Thanking you in advance.

Yours sincerely

T.R. Nevhutanda (Mrs)
Researcher

ANNEXURE D

**Reply from Northern Province Department of Health to Come and Make A
Presentation on the Proposal**



Northern Province

DEPARTMENT OF HEALTH & WELFARE

TEL: (0152) 291 2637
(0152) 295 2851/2
(0152) 295 2987/8
FAX: (0152) 291 5961
(0152) 291 5146

PRIVATE BAG X9302
PIETERSBURG
0700

Enquiries : Sinah Mahlangu

Reference : Research and
Quality Improvement

26 January 1999

PO Box 156
DZANANI
0955

Dear Mrs Nevhutanda:

ETHICAL DECISION MAKING BY REGISTERED NURSES IN A BUREAUCRATIC CONTEXT

Your undated letter refers:

request permission for conducting research

Your proposal was received in December from Human Resource Directorate. The Provincial Research Committee did not meet in December 1998 and January, 1999 because members had taken leave. It will meet on 4th February 1999 at 10h00 in the Bacbarb boardroom

You are requested to come and make a presentation on your proposal on the date mentioned above.

Sincerely,

SUPERINTENDENT-GENERAL
DEPARTMENT OF HEALTH AND WELFARE
NORTHERN PROVINCE

ANNEXURE E

**Reply Granting Permission from the Northern Province Department of
Health**



Northern Province
DEPARTMENT OF HEALTH & WELFARE

TEL: (0152) 291 2637
(0152) 295 2851/2
(0152) 295 2987/8
FAX: (0152) 291 5961
(0152) 291 5146

PRIVATE BAG X9302
PIETERSBURG
0700

Enquiries : Sinah Mahlangu.

Reference : Research and
Quality Improvement

19 February 1999

P O BOX 156

DZANANI

0955

Dear: Ms Nevhutanda

**ETHICAL DECISION MAKING BY REGISTERED NURSES IN A
BUREAUCRATIC CONTEXT**

1. Permission is hereby granted to conduct a study on the above topic in the Northern Province hospitals,
2. The Department of Health & Welfare needs a copy of the research findings for its own resource centre.
3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible.
4. Implications: Permission should be requested from regional and institutional management to do research .

Sincerely,

SUPERINTENDENT - GENERAL
DEPARTMENT OF HEALTH & WELFARE
NORTHERN PROVINCE

ANNEXURE F

**Letter of Application for Permission to Undertake A Study in the Northern
Region Hospitals (Northern Region)**

ANNEXURE F

P.O. BOX 156
DZANANI
0955

The Regional Director
Private Bag X5009
Thohoyandou
0950

Dear Sir

**RE: REQUEST FOR CONDUCTING RESEARCH IN THE NORTHERN REGION
HOSPITALS**

The above refers:-

I am a senior professional nurse stationed at Siloam hospital and current a Master's degree student at the University of South Africa. I intend to obtain relevant information with regard to ethical decision making by registered nurses in a bureaucratic context.

The Northern Province Department of Health have already granted me the permission but advised me to request permission from the regional and institutional management to do research.

Thanking you in anticipation.

Yours Faithfully

T.R. Nevhutanda (Mrs.)

Senior Professional Nurse

ANNEXURE G

**Reply Granting Permission from the Regional Director Region 4/ Northern
Region.**



Northern Province

ANNEXURE G

DEPARTMENT OF HEALTH AND WELFARE
NORTHERN REGION

NORTHERN PROVINCE
REGIONAL DIRECTOR
REGION 4
1999-03-04
PRIVATE BAG X5009
THOHOYANDOU 0950
DEPARTMENT OF HEALTH & WELFARE

REF NO: RESEARCH AND QUALITY
IMPROVEMENT.

ENQ : TRAINING AND DEVELOPMENT


DATE : 26-02-1999.

THE SUPERINTENDENT

ALL HOSPITALS

RE: ETHICAL DECISION MAKING BY
REGISTERED NURSES IN A BUREAUCRATIC
CONTEXT: MS NEVHUTANDA

1. Permission is hereby granted to conduct a study on the above topic in the Northern Province Hospital ~~and College Campuses.~~
2. The Department of Health and Welfare needs a copy of research findings for its own resource centre
3. The researcher should be prepared to assist in interpretation and implementation of the recommendations where possible .
4. Please support the researchers to reach study objective so that we can have new models.
5. Thank you with anticipation.


REGIONAL DIRECTOR : NOTHERN REGION.

ANNEXURE H

Northern Region Hospitals

ANNEXURE H**NORTHERN REGION HOSPITALS**

| SYMBOL | NAME OF HOSPITAL |
|---------------|-------------------------|
| A | DONALD FRASER |
| B | ELIM |
| C | HAYANI |
| D | LOUIS TRICHARDT |
| E | MALAMULELE |
| F | MESSINA |
| G | SILAM |
| H | TSHILIDZINI |
| TOTAL | 8 |

ANNEXURE I

Work shop Programme

ANNEXURE I

TWO DAY WORKSHOP ON ETHICAL DECISION MAKING

| Date/Time | Subject | Tools/Objectives |
|----------------------|--|--|
| Day 1 | | |
| 08:00 – 09:00 | Introduction and ice breaker determining needs of the group | To set the objectives for the workshop and to get to know one another |
| 09:00 – 10:30 | What is ethics? Ethics in nursing | Lecture and brainstorming, to provide background information on what nursing ethics involve |
| 10:30 – 11:30 | Tea | |
| 11:00 – 12:30 | Ethical theories: Difference between deontology and utilitarianism | Case studies and how to approach it from the two perspectives to enable the learners to realise that ethical decisions can be approached in different ways |
| 12:30 – 13:30 | Lunch | |
| 13:30 – 15:00 | Values and ethical decision making.. | Brainstorming, small group discussions to discuss case studies to enable the learners to understand the value systems of those involved in the caring process. |
| 15:00 – 15:30 | Conclusion to the day and lay out of day 2 | Feedback from the small groups on the day's work to identify any problems |

| | | |
|---------------------------------------|--|---|
| <p>Day 2 08:00 - 09:00</p> | <p>Summary of day one and discussion of any questions that learners have concerning the work</p> | <p>Lecture and small group work to enhance understanding of the nurses role in ethical decision making</p> |
| <p>10:30 – 11:00</p> | <p>Tea</p> | |
| <p>11:00 - 12:30</p> | <p>Bio-ethical standards/principles</p> | <p>Lecture and case studies to solve in small groups to indicate the different principles that guide ethical decision making</p> |
| <p>12:00 – 13:30</p> | <p>Lunch</p> | |
| <p>13:30 – 15:00</p> | <p>Ethical dilemmas and ethical reasoning. Introduction to ethical decision models</p> | <p>Case studies and small group work to apply the different ethical principles and decision making models in ethical dilemmas</p> |
| <p>15:00 – 15:15</p> | <p>Short tea break</p> | |
| <p>15:15 – 16:00</p> | <p>Summary of the two day workshop</p> | <p>Panel discussion and question time to ensure that the learners have gained insight into ethical decision making.</p> |