CHALLENGES REGARDING ETHICAL DECISION MAKING DURING CLINICAL PRACTICE AMONG NURSES AT A PUBLIC TERTIARY CARE HOSPITAL IN KARACHI, PAKISTAN

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ABSTRACT

Objective:

To determine the challenges encountered by nurses regarding ethical decision-making during their clinical practice.

Methodology:

A study was carried out using a qualitative thematic content analysis. Total of 07 qualitative interviews from bed side nurses including in-depth interviews and focus group discussions were performed in a public sector tertiary care hospital. Purposive sampling was utilized and written consent was taken from each participant. Nurses were recruited from various departments: gynecology and labor room, medical and surgical intensive care units and wards. Data from April to May 2021 were iteratively collected and analyzed.

Results:

The findings revealed three main themes and five sub categories. The themes were as follows: (1) Barriers to provide optimal care (coercion and influences, resource short fall); (2) Unwillingness to take on professional accountability (deception of information, under reporting of unethical practices) (3) Lack of building therapeutic relationships (poor image of nurses, violence and aggression from patients and family).

Conclusion:

The study highlighted different ethical challenges faced by nurses during their clinical practice at a public sector tertiary care hospital in Karachi, Pakistan. Though the participating nurses were aware of ethical principles, they were practically powerless in applying them in clinical practice. The interviewees suggested the hospital administration should play their role to support bedside nurses with sound training to empower their ethical decision making and ensuring provisions for safety and security to ensure the compassionate patient care which ultimately will improve the quality of nursing care in the public sector.

Keywords:

Challenges, nurses, ethical decision making, clinical practice, public sector, Karachi, Pakistan
I. INTRODUCTION

Nurses, who comprise the largest workforce in the healthcare industry, have been confronted with ethical challenges in their daily practice. This combined with high level of technological integration into the nursing practice has caused the delivery of healthcare to become more complex (1). There are four basic principles of clinical ethics i.e., beneficence, non-maleficence, autonomy and justice (2). Generally, ethics relate to our concern for moral principles which govern our behavior. As nurses, it is our obligations (i) to provide benefit to the patients, (ii) to avoid or minimize their harm, and (iii) to respect the moral values, beliefs and preferences of the patients (2). Ethical behavior is not merely the display of one’s moral integrity in times of any clinical tragedy or mishap with patients. It is the day-to-day expression of one’s assurance to other persons and the ways in which human beings relate to one another in their daily communications (3). Research studies have highlighted ethical challenges faced by nurses during the course of their clinical practice (4-7). Ethical issues are impacted by several factors, such as culture, religion, upbringing, individual values and beliefs. These factors shape our ethical views and impact moral choices that have an effect on nurses and their patients (8). In such situations nurses cannot do what they believe to be “the right thing,” which leads them to experience moral distress. While some have the audacity to take action, others hesitate to deal with the situation. This can later compromise their ability to protect their moral veracity to seek out innovative and adaptable solutions to complex ethical issues across multiple care settings. As part of a study conducted in 2001, a tool was established (Ethical Issues Scale) to assess ethical issues experienced by nurses in their current practice as well as the frequency of incidences. The author included 934 nurses in this study, which revealed that 43% encounter ethical issues in their daily practice; 36% on a weekly basis. As is frequently reported by nurses, four issues involving a breach of patient confidentiality, unethical or illegal practices and endangerment of patient welfare and end of life care were found (1). The Pakistan Nursing Council (PNC) code of ethics provides a framework helping nurses to deal with issues that might arise and makes apparent the obligation to demonstrate compassion and respect for human dignity and rights and to view the responsibility to the patient as supreme (1).

Limited research has been conducted in Karachi, Pakistan to address ethical challenges nurses encounter during their practice. This is unfortunate as this issue can lead to a hindrance in the delivery of quality care and retention of competent staff. The results of this research study is aimed at supporting stakeholders in gaining awareness about various ethical challenges and in turn encouraging the development of strategies in dealing with them effectively.

Objective of the study:
To determine the challenges encountered by nurses with relation to ethical decision-making during the course of their clinical practice at a public sector tertiary care hospital in Metropolitan city of Pakistan.

Research Question:
What are the ethical challenges nurses face in their clinical practice at a public sector tertiary care hospital in Metropolitan city of Pakistan.

II. METHODOLOGY:

The approval for the study was taken from the institutional review board of Jinnah Sindh Medical University. A qualitative study using the thematic content analysis was used. Data were collected with a focus on multifaceted interviews and narratives to produce a description of the nurses’ experiences. A total of 07 qualitative interviews were conducted in one of the major public sector tertiary care hospital located in the center of the city. Data were collected via the purposive sampling technique. Registered Nurses who works on bed side were invited to participate. Technicians and nursing assistants were excluded. Nurses who had less than one year of experience and the nurses who were at managerial positions were also excluded. A total of 03 focused group discussions and 04 in-depth interviews were conducted. Each interview lasted for 35 to 40 minutes. Nurses who were willing to give consent were invited to participate in the study. Nurses were recruited from various departments; the gynecology ward, labor room, surgical and medical ICU and Medical ward to ensure the transferability. The data collection was carried till the saturation was achieved. Field notes were taken and the interviews were audio and video taped, the recordings were later used to transcribe the research interviews verbatim. To enhance the conformability, the data was carefully transcribed. The team of five members individually read the transcripts and familiarized themselves to the data. The data were coded separately and the themes emerged after the consensus of the researchers. Discussion and debate was carried out before the consensus was reached, to ensure
the rigor of the study. The participants were engaged in conversation for a long time to ensure the credibility of the data. A prior thorough literature review was carried out to enhance the dependability of the study.

III. RESULTS

Nearly all participants could identify and had awareness about ethical principles in their practice. The primary theory of producing the greatest good to the patient and minimizing harm was identified as the motive behind every clinical ethical decision.

Theme 1: “Barriers to Provide Optimal Care”

Coercions and influences

“Many a times we receive phone calls to give protocol to the patients who are either belonging to a powerful political party or are influential in some way. We are forced to give them priority and are not able to refuse the request. This leads to a compromise in the care of other equally-deserving patients.”

“This happens everywhere either in the private or public sector the patients with big sources are given more priority. I have worked in a setting in which patients in need of a ventilator were bypassed. It was instead given to those with political influences despite the non-influential patients being higher on the waiting list. We were powerless to assist them in these cases as that is how things worked there.”

“As a female I tend to be more cautious of influential individuals. I have to think that if I refuse one thing to a politically influential patient or attendant, after the shift ends I have to go home as well. I hope you are understanding what I am trying to say.”

Resource shortfall

“Sometimes when female staff are not available, the quality of care to female patients is compromised”

“Many times there are two nurses on around 50 patients and we aim to provide adequate care but we fail to deliver adequate care.”

“Sometimes things and needed equipment are arranged a little late than needed and the available resource constraint puts the patient in an aggressive mood and they shout on us for not providing them the needed medicines or supplies sometimes even when they are short in the market”

Theme 2: “Unwillingness to take on Professional Accountability”

Deception of Information

“As a nurse we try our best to give care to the patient but in many scenarios doctors deliberately hide important information and sometimes a stable patient is admitted but the doctor will say to them that your patient is very critical they just to scare the attendant so much that they will feel their patient is critically ill”

“Even for a stable patient a negative counselling is done to overcome potential violence”

Under reporting unethical practices

“There is also an issue in informing the patient attendant before surgery and most of the times the doctors get the signatures on blank paper while explaining the consent and that is unfair with the patient and their attendant. At such times we feel a need to intervene but we cannot.”

“In this department we work within a friendly environment. Even though sometimes we notice and verbalize to the doctor that prescribed dose is wrong, requesting them to ‘Kindly review it once again,’ I think we should report the incident to the authority for further action, though we do not carry this out.”

Theme 3 “Lack of building of therapeutic relationships”

Poor nurse image

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“The attendants never listen to us and when we tell them a little strictly they get harsh on us. It’s basically I think because they have a poor image of us in their eyes”

“The nurse safety is compromised as attendants and non-nursing staff enter our premises during break time without hesitation as they feel nurses don’t mind. This puts our privacy and security at risk. Many attendants are unwilling to communicate in a respectful manner with nurses, again due to their perceived poor image of us.”

“I am serving since 1991, and similarly my colleagues also have more than 10 years’ experience, many a times we also go beyond our responsibilities to satisfy the patient but we are never rewarded”

_Violence and aggression of patient and family_

When I speak with patients, if my attitude and behavior are aggressive and I am not treating them politely, this is unfair as the patients are already suffering and deserve to be treated with respect. Furthermore, the attendants also suffer as they are already concerned about the patients. Therefore, it is our responsibility to listen and answer their concerns and fulfill their needs.

We are sometimes so burdened that even not intending we become harsh and rude with patients and their attendants, usually which we obviously later regret; but what we can do? We are so burdened and most times attendants do not cooperate or trust nurses on our assessment of their patients.

“If a patient dies I can’t tell you what happens thereafter. Here most times the department equipment is broken, the health care staff is beaten and several legal perusals are made in this regard; although a critical patient dying in an ICU of a hospital is not as alien as they think it is …. But may be its their loss of a loved one and it is always hard to come to terms with it.”

“Many times we have to call the rangers to stop all the violence of the attendants”

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Table A: Thematic Content Analysis: moving from sub themes to themes.

**IV. DISCUSSION:**

The current study highlights the nature of ethical challenges faced by nurses in a public sector tertiary care hospital in Karachi. The findings of the current study were consistent with other national and international studies (1, 5, 9-16).

The current study identified barriers to provide optimal care as coercions and influences, political pressures, exercise of power to demand care. These findings were consistently highlighted by previous studies and proved that patient independence is a principal challenge confronting any utilization of coercion, and some sort of independence infringement is a critical part of the idea of coercion (10). Also, in each circumstance, the pride of the patient is in question when pressure is considered as ethically right, just as when intimidation is not the favored mediation (17). A study conducted in Norway, Germany, and Austria also highlighted that 33% coercion involved during ethical challenges in nursing homes (9). Additionally, Norwegian nursing homes also faced coercion challenges due to lack of understanding on the part of patients regarding different procedures (18), particularly as female nurses are scared to refuse politically-influential patients in Pakistani culture. Contrary to this, senior nurses in Northern Ireland are much better prepared to face the political challenges and provide better nursing care to needy patients (19).

Similarly, findings in term of resource shortfall, such as timely availability of the manpower, medicines and equipment, results in compromise in the quality of patient care. Similar findings have been reported earlier in different national and international literature (20-22).
In this study we also noticed that nurses were unable to maintain the professionalism in their clinical practices. Nurses were unable to report mistakes of their coworkers and themselves and often felt the need to cover up errors. According to the code of ethics nurses are responsible not only for patient care, but are also accountable for their clinical practices(23).

There may be multiple reasons for the deception. One of the reasons shared by participants is the environment of the workplace. Firstly, healthcare professionals are working very closely together, which leads to an inevitable bond. This was manifested in the participants expressing the word ‘friendly environment,’ which infers a setting where one tends to protect others within that environment and expects the same protection in return. There is a culture that if you cover my mistake today, I will cover yours tomorrow. It indicates that nurses often prefer to identify others’ gaps and errors and resolve them internally without reporting it. Here, the healthcare professionals need to rethink the idea that reporting is a means of penalizing and degrading others. On the contrary, this is simply a method of enhancing the optimal care of patients. This action should not have any effect on interpersonal relationships between healthcare professionals.

The study found the lack of therapeutic relationship between nurses and their patients as well as attendants. Participants verbalized a gap in communication which often leads to an overall building of poor image of nurses. These findings were consistent with a qualitative study conducted in Iran which reported similar findings of lack of acceptance and recognition of nurses and nursing overall as a profession (24). The interviews revealed that the poor image of nurses and lack of therapeutic relationships and therapeutic communication often was responsible for violence against the health care providers especially in the death and dying conundrum.

The findings of a study conducted in Germany specified verbal aggression being more frequently reported which was due to the absence of therapeutic communication(25). Another subtheme which emerged from the data was violence and aggression which was frequently reported by the participants because of lack of training of nurses on how to deescalate violence and aggression. These findings were consistent with a nationwide survey and mixed method study conducted in Karachi-Pakistan(26).

The major strength of this study was the rich data using qualitative method which was collected from nurses working in a public tertiary care hospital. Current study cannot be generalizable due to the limited number of focus group discussions and in-depth interviews. There is a need to conduct studies at other public sector hospitals with large sample sizes by using a mixed method designed to assess the extent of the problem of ethical challenges faced by nurses.

V. CONCLUSION

The study highlighted the different ethical challenges faced by nurses during their clinical practice at a public sector tertiary care hospital in Karachi, Pakistan. The study also revealed that the nurses were aware of the ethical principles but most of the time unable to utilize in practical setting due to a number of reasons. The inadequate material resource, coercions and influences, shortage of staff, underreporting of unethical practices, deception of information, poor nurse image and violence and aggression of patient and their relatives are the major ethical challenges encountered by the nurses in their clinical practice. Administration should support bedside nurses by helping to address these ethical challenges and ensuring the safety and security of these professionals so they may provide compassionate patient care which ultimately will improve the quality of nursing care in the public sector. Alongside there is a dire need of training the nurses on de-escalation of aggressive situations from all public sector hospitals to minimize the severity and exposure of violence against them.

Conflict of Interest: No conflict of interest associated with this work.

Authors Contributions:

Ms. Afshan Nazly conceived the idea of the research study, designed the initial study, searched literature review, and communicates roles and responsibilities to each team member.

Ms. Rozina Jalaluddin sought the IRB Approval, collected the data, reviewed literature and designed the draft of the manuscript.

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Ms. Ambreen Aslam collected the data, content analysis worked on the result section and reviewed the manuscript.

Mr. Shahzad Bashir took data collection permission from public sector hospital, worked on discussion and made corrections in the manuscript.

Ms. Shanila Jalaluddin worked in collaboration with all team members, reviewing and writing literature review and reviewing the manuscript at final stage.

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