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The Courage to Stand Up: The Cultural Politics of Nurses' Access to Ethics Consultation

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The Joint Commission on Accreditation of Healthcare Organizations[1] mandates that hospitals have a process for addressing ethical issues in patient care, and most hospitals in the U.S. (82 percent) now offer ethics consultation (EC) services to healthcare providers and patients.[2] EC is a service provided by an individual consultant, team, or committee whose purpose is to improve the process and outcomes of care by helping clinicians to identify, analyze, and resolve ethical problems that arise in specific clinical cases.[3] Ethics consultations are touted by bioethicists as helpful in making medical decisions. Several studies report that ethics consultations for patients in intensive care units were effective in reducing the number of days spent in the hospital and intensive care units, in reducing healthcare costs for nonbeneficial treatment, and in helping 70 percent to 95 percent of the physicians and nurses surveyed to resolve ethical conflicts.[4]

Despite the generally favorable evidence supporting ethics consultation, there is concern about the underuse of such services by physicians, nurses, and other healthcare professionals.[5] Specifically, nurses and resident physicians may face barriers to requesting EC. Studies suggest that such barriers are related to hospital policy regarding who may request an EC and traditional power structures within the medical professional hierarchy.[6] The underuse and/or lack of access to ethics consultants is problematic because both patients and the healthcare professionals who are involved in the care of patients can be adversely affected. Yet little is known about barriers to requesting EC.

This study examined the factors affecting nurses' and residents' awareness, utilization, and perceptions of the EC service in one institution. The residents' perspective was published elsewhere.[7] Following a review of relevant literature, this article presents study results on nurses' perceptions of risk, power dynamics, and regret in requesting EC.

BACKGROUND

Requesting an EC must be understood within its broader political and sociocultural contexts, particularly given the role of hospital policies and the power dynamics that are inherent in hierarchical relations

among healthcare professionals. The following section provides background information on policy and inter-professional factors influencing access to EC, and briefly reviews literature on nurses' efforts to resolve ethical dilemmas and the professional obligations that influence nurses' responses to ethical dilemmas.

POLICY

Barriers to requesting EC may be related to hospital policy. Hospital policies vary as to which type of healthcare professional may request an EC,[8] and the procedures by which they can do so. A 2001 national survey of hospitals ($N = 346$) found that 62 (19.4 percent) of 322 hospitals with ethics committees restricted access to EC to physicians or attending physicians.[9] Even though any healthcare professional may technically request an EC at most institutions, not all request EC equally, in practice.[10]

Inequity in access for all healthcare professionals to EC services raises questions about justice for several authors. Indeed, the need to "help assure that all relevant parties share equal access to and participation in bioethics discussions, and to help assure that bioethics consultations are conducted fairly"[11] is central to bioethics scholars' efforts to promote the utilization and/or regulation of EC services.[12] Ensuring that all professionals involved in the clinical care of patients have equity in attaining the resources available to them may actually have health consequences for providers. Perceptions of unfairness due to having little recourse to resolve conflicts within one's institution was found to have jeopardized the health of hospital employees in one study.[13]

FACTORS THAT INFLUENCE REQUESTS

While little is known about what factors influence the request for a consult, empirical research and anecdotal evidence suggest that professional and political factors related to power and authority may trigger or inhibit requests for EC.[14] Empirical research, albeit more than a decade old, shows that ECs are requested predominantly by physicians (ranging from 57 percent to 88 percent).[15] Anecdotal evidence indicates that some physicians become angry when other members of the healthcare team request an EC because physicians perceive consults as interfering with their medical decision making; consequently, nurses and residents may fear retaliation from attending physicians if they request ethics consultations.[16] Nurses and physicians in training have much at stake when they speak up: they may risk being ridiculed or being seen as disloyal team members and as unprofessional.[17] These risks constitute serious barriers for nurses and residents seeking to resolve ethical dilemmas and ameliorate moral distress.

There is little direct research on healthcare professionals' decisions about requesting EC. A national survey ($N = 344$) of internists' attitudes about EC reveals that most (72 percent) considered consultations to provide information that would be useful in addressing future ethical dilemmas. However, others were hesitant to seek EC, believing that the consultations are too time consuming (29 percent), make situations worse (15 percent), or that consultants are unqualified (11 percent).[18] A 1992 survey study of the effectiveness of five ethics committees in Canada reported that physicians, nurses, and administrators maintained different views about the importance of ethics committees.[19] Physicians perceived ethics committees as irrelevant to their practice for the following reasons:

- Medical decision making was considered to be the physician's responsibility,
- Consultations appeared to interfere in the care of patients,
- Physicians lacked confidence in committee members,
- There was little time to obtain help, and
- Physicians felt confident to make ethical decisions themselves.

In contrast, nurses had little knowledge of the existence of ethics committees, but those who did felt they had no direct access to them due to existing institutional power structures. Physicians and administrators expected that nurses would not take the initiative to manage ethical dilemmas by going to the ethics committee, but would rather go through their nurse supervisors, who confirmed that this was the accepted practice. A qualitative study from 1992 of 12 male senior physicians similarly found that most avoided requesting EC

because they perceived consultation as an intrusion into the doctor-patient relationship, a loss of control over the interaction, and an abdication of a physician's responsibility to a patient.[20] These studies suggest that attending physicians' perceptions of EC can affect nurses' willingness to request consultation.

While a few ethnographic studies have examined the cultural processes involved in ethics consultation services or hospital ethics committees,[21] little research has specifically investigated the cultural dynamics and politics shaping both the process of gaining access to EC and the determinations of whether EC is even considered as a worthwhile resource. Cate McBurney's ethnographic study of one Canadian Catholic hospital's ethics committee, however, indicated that its ability to resolve ethical problems was hindered by multiple factors, including barriers to access based on the committee's authority and membership.[22] Of particular note is her finding that those lower in the medical hierarchy, specifically nurses, had to obtain the endorsement of those who held authority and power to access the ethics committee. In addition, members of the hospital ethics committee dismissed nurses' ethical concerns as communication problems and undermined nurses' credibility by framing their concerns as emotional problems. By these measures, nurses were not viewed as moral agents. Such practices by the ethics committee served to reinforce the status quo of the hierarchy within the healthcare setting.[23] Just as the healthcare system can be considered a culture, EC services and individual patient care units can be viewed as subcultures of the healthcare system. Understanding ECs and hospital units as subcultures helps to make sense of the social dynamics surrounding the use of EC services.

NURSES' APPROACHES TO ETHICAL DILEMMAS

While relatively little is known about how nurses resolve ethical dilemmas,[24] studies report that nurses desire to actively participate in ethical decision making but feel constrained from doing so — often by institutional factors.[25] For example, nurses can feel powerless in their ability to effect a resolution to ethical dilemmas due to physicians' dominance, a lack of knowledge of possible alternatives,[26] or uncertainty about how to carry out what they view as the right action.[27] Numerous factors influence nurses' moral actions including external (physicians, the law, the administration), procedural (the existence of an ethics committee, policy on who may request an EC), and individual factors (demographics, socialization to follow orders, sanctions on past actions, fear of job loss, lack of courage).[28]

Although the nursing literature recognizes and promotes collaborative teamwork as the preferred vehicle for providing care for patients,[29] nurses in many "real world" settings feel unable to collaborate with physicians in practice. The presence or absence of collaborative teamwork may also influence whether nurses take an active role in addressing ethical dilemmas. One study reports that nurses perceived the quality of collaboration and communication with physicians more negatively than did the physicians surveyed.[30] Nurses reported more difficulty in speaking up when they saw a problem with the care given to patients, felt that they had little input into making decisions, and perceived that their input was not well received, compared with the reception of input from physicians.

NURSES AS ADVOCATES FOR PATIENTS

Nurses' approaches to resolving ethical dilemmas are commonly based on their professional role as patient advocates. *Advocacy* refers to "actively support[ing] patients in speaking up for their rights and choices, in helping patients to clarify their decisions, in furthering their legitimate interests, and protecting their basic rights as persons."[31] In addition, being an advocate is seen as a moral obligation for nurses, often predicated on the perception of patients as vulnerable due to illness.[32] Advocacy is identified as a core responsibility in the American Nurses Association's *Code of Ethics.*[33] Literature reviews indicate that this facet of nursing's professional identity has been increasingly noted in the past 20 years.[34] Despite the professional obligation to be a patient advocate, occasions arise that can keep nurses from fulfilling this obligation. In such situations — usually characterized by ethical conflicts or disagreements — nurses may experience what is known as *moral distress.*

MORAL DISTRESS

First defined in the context of nursing practice by Andrew Jameton, moral distress for nurses is a phenomenon that occurs when a nurse knows or believes she or he knows the ethically correct action to take in a particular situation, but is constrained from taking that action because of some obstacle, be it lack of time or supervisory support, institutional or legal constraint, or physicians' power.[35] Jameton distinguished between *initial* moral distress, when a nurse first encounters a difficult situation and recognizes a problem, and *reactive* distress, which Jameton described as the negative emotional response a nurse experiences when she or he is unable to or fails to act on the initial distress.[36] Moral distress is characterized by frustration, anger, anxiety, guilt, compromised integrity, and psychological disequilibrium. Because moral distress involves a perception that personal or professional values or core ethical obligations are being violated, it carries serious consequences: emotional withdrawal from patients and co-workers; painful feelings such as anger, guilt, or depression; physical symptoms; and burnout or leaving a position or the profession altogether.[37] While other providers, including physicians, can and do experience moral distress,[38] the phenomenon has been primarily recognized and discussed in the nursing literature.

RESEARCH METHODS AND DESIGN

STUDY SITE

The study was conducted at a Catholic academic teaching hospital in the Midwest U.S. At this institution, any person involved in a patient's care can request an EC by calling the ethics department. The policy on EC requires that the person requesting the consultation be responsible for personally (or by delegation) notifying the attending physician of the consult because the attending physician is regarded as the leader of the medical team. The policy specifically stipulates that *notifying* the attending does not mean *asking* the attending for permission to pursue the consult. The EC service has been in existence for more than 25 years. It is routinely utilized in the institution; 23 ECs were requested in 2005. Informal feedback has been uniformly positive.

STUDY DESIGN

The study employed a sequential, multi-method approach that included a survey questionnaire followed by an in-depth interview. This approach was used to assess the range of perspectives on EC and to explore them in depth. A self-administered survey was distributed to all in-patient registered nurses ($N = 881$). The surveys were distributed directly to nurses either by the nurse managers or by placement in their individual mailboxes. Surveys were distributed twice with a reminder postcard delivered between surveys, to increase the response rate, as validated by Don A. Dillman.[39] The two-page questionnaire contained 18 open- and closed-ended questions about nurses' knowledge and use of the EC service and demographic information.

The survey included three additional measures. First, one measure asked nurses to rate their perceptions of how receptive four medical team members, the patient, and a family member/surrogate were to their request for an EC on a 5-point Likert scale (1 = very receptive, 5 = very unreceptive). The second measure, the Decisional Regret Scale, consisted of six items originally developed to determine patients' decisional satisfaction with undertaking a medical regimen.[40] This scale was adapted (in wording and by adding one item) to determine nurses' decisional satisfaction with requesting or not requesting an EC (Cronbach's *alpha* = 0.87). The third measure was a 100 millimeter visual analog scale (VAS) on which respondents rated their perception of risk involved in requesting an ethics consultation from "not at all risky" to "very risky." Scores were the number of millimeters at the mark.

Nurses could indicate their interest in participating in an in-depth, semi-structured interview on the survey. During the interviews, the nurses were asked about their perceptions and experiences regarding the hospital's EC service, and to describe their experience with ECs. Interviews lasted on average 30 to 45 minutes. All interviews were tape-recorded and conducted in the principal investigator's office or in a private conference room near the medical unit. Consent for the survey was presumed to have been granted

when respondents completed and returned the self-administered survey. Preliminary consent was obtained upon scheduling the interview, and oral consent was obtained after nurses reviewed an information sheet about the study. Nurses were asked as part of the consent process if their interviews could be tape-recorded, and they were assured that no identifying information would be included in the study if their narrative was used. Additionally, for narratives quoted at length below, we received explicit consent to use these quotations. Approval for the study was granted by the institution's Review Board.

STATISTICAL ANALYSIS

Descriptive statistics were used to analyze the data using statistical software.[41] Short responses were coded and analyzed using descriptive statistics. *T*-tests were used to test differences between means. Differences in proportions were tested using Pearson's *chi*-square test or Fisher's exact test if expected frequencies were less than five. The Friedman and Wilcoxon signed ranks tests were used to examine how nurses ranked individual medical team members' levels of receptivity to the request for an EC.

CONTENT ANALYSIS

The tape-recorded interviews were transcribed verbatim. Nurses' responses to open-ended questions were thematically analyzed. Thematic analysis entails the systematic search for themes and repetitions that emerge from the data;[42] it is an iterative process in which an initial set of participants' responses are coded and a preliminary coding scheme is developed. The codes then are applied to a new group of nurses' responses, the coding scheme is revised to adjust for these new responses, and modified codes are applied to the previous set of responses, continuing in this manner until no new codes emerge.[43] Most of the respondents gave multiple reasons for requesting or not requesting an EC.

We intentionally did not include any identifying information about the nurses, even though specifying the nurses' clinical units might help place a given narrative in its clinical context, and even though we found that nurses' age was a significant variable in their decisions about requesting EC. Some nurses in particular expressed reservations about using their quotation in full, out of fear of retaliation in the workplace. To protect their confidentiality, we worked with the nurses whose quotes had sensitive material to re-state their narratives in a way that accurately reflected their key ideas, while assuring their anonymity. This effort was as important as protecting the confidentiality of respondents, and was a key ethical obligation of the researchers. The efforts to protect nurses' narratives indicate one challenge in doing this type of research: nurses can be so fearful of being "found out" when they disagree with those in power that they become silent and unwilling to speak up or to have their stories described. This may be one reason why there is so little direct empirical evidence on nurses' views of ethical conflict.

RESULTS

RESPONDENTS

Of the 881 nurses who were given the survey, 504 (57 percent) completed the survey. Of these 504 nurses, 93 (19 percent) indicated their interest in being interviewed, and of these 93 nurses, 83 (89 percent) participated in the interview. The mean age of the survey respondents was 38 years; 95 percent were women; and they had an average of 14 years of nursing practice (see table 1). Differences were noted between those nurses who completed only the survey versus those interviewed in age, years in practice, highest degree earned, and role/title (see table 1). The nurses who completed an interview were older, had more years of clinical experience, and were more likely to be an advanced practice nurse or in a managerial role than the nurses who completed a survey, but did not complete an interview.

AWARENESS OF EC SERVICES

The majority of the nurses surveyed (62 percent) were aware of the availability of the EC service, but only 25 percent indicated that they knew how to request an EC. Nurses had learned about the service, on

TABLE 1 Characteristics of Respondents Surveyed ($N = 504$) and Interviewed ($n = 83$)

	Nurses surveyed		Nurses interviewed		
	Years	Range	Years	Range	Significance*
Age in years	38	21 - 61	42	24 - 62	$p = 0.0005$
Years in practice	14	< 1 - 40	17	< 1 - 40	$p = 0.003$
	Nurses surveyed		Nurses interviewed		
	n	%	*n*	%	Significance*
Gender					n.s.
Female	478	95	77	93	
Male	26	5	6	7	
Race/ethnicity**					n/a
White	—	—	73	88	
African-American	—	—	1	1	
Hispanic	—	—	3	4	
Asian	—	—	6	7	
Religion**					n/a
Roman Catholic	—	—	52	63	
Protestant	—	—	26	31	
Jewish	—	—	3	4	
Other	—	—	2	2	
Employment status					n.s.
Full-time	332	66	57	69	
Part-time	150	30	26	31	
Highest RN degree					$p = 0.003$
AD or diploma	117	23	24	29	
BSN	317	63	41	50	
MS, MSN, DNS, or PhD	56	11	17	21	
Role/title					$p = 0.01$
Staff nurse	438	87	68	82	
Advanced practice	23	5	8	10	
Nurse administrator	22	4	7	8	
Clinical specialty					n.s.
ICU	248	49	49	59	
Med-surg	116	23	19	23	
OR/ER/RR	106	21	10	12	
MCN	34	7	5	6	
EC request status					n/a
Requested an EC	40	8	16	19	
Wanted to, didn't	76	15	22	27	
Never wanted to	388	77	45	54	

NOTE: Some figures do not total 100, because some respondents did not respond or data were missing.

* Tests of significance based on comparisons between nurses who were interviewed and nurses not interviewed.

** Some data were not collected at the time of the survey, preventing comparison between those who completed the survey and those who completed the survey and the interview.

average, six years prior to the survey. Half of all of the nurses surveyed (52 percent) reported having learned about the EC service in the following ways:

- Being involved in a case in which an EC was conducted or observing an EC in their unit (25 percent),
- Orientation (21 percent),
- Co-workers (20 percent),
- Word of mouth (8 percent),
- Staff meetings (7 percent),
- Hospital newsletters (5 percent),
- Nursing classes (5 percent), and
- Don't remember/other (7 percent).

It is interesting that 2 percent of the respondents learned about EC through the survey itself, although they had worked at the institution for an average of 11 years.

EXPERIENCE REQUESTING ECs

Of the 504 nurses who completed the survey, 76 (15 percent) reported they had wanted to request an EC in the past but had declined to do so. This figure is almost twice as many as those who had actually personally requested a consult (n = 40; 8 percent); 25 percent (n = 10) of those who requested an EC actually experienced some form of repercussion for doing so, most notably, anger from an attending physician. These nurses reported that physicians yelled at them or gave them the "silent treatment," humiliated them in front of the medical team, told them to stop taking care of certain patients, and even threatened their jobs. One nurse related how she had gone only so far as to give a patient's wife the telephone number for the EC service because the case was a conflict between the patient and the attending physician, and, consequently, the following occurred.

RN: The nursing supervisor is telling me to stay out of it, or you know, there'd be problems. Oh yeah.
EG: And, did you feel that your job was on the line in this particular case?
RN: Yes. Yeah, yeah I did.
EG: Did they say anything about that?
RN: Well, no because I, I, like I said, I did drop it. I just got a phone number for the um —. I gave the ethicist's phone number and the patient advocate phone number to the, the wife. And I, I told her where I stood. I said, "I'm, I'm told I'm to stay out of it, here, call."
EG: And so did the nurse supervisor tell you explicitly that your job was on the line?
RN: Yeah, she — yeah, she did. [Case #0349.]

More than one-third (38 percent) of those who requested an EC reported being hesitant, or, more accurately, afraid to do so. Since their reasons for being hesitant coincided with the reasons given by nurses who wanted to but did not call a consult, they will be examined in the section on barriers to requesting EC.

Were the nurses who requested an EC different from those who did not? The nurses who did request an EC had significantly more experience (19.4 years versus 14.6 years; t = 3.084; p = .003), and were significantly older (42.6 years versus 38.5 years; t = 2.594; p = .011) than those who wanted to, but did not, call an EC.[44]

BARRIERS TO REQUESTING AN EC

Of the 504 nurses who completed the survey question about how risky requesting an EC would be to themselves, 70 percent (n = 264) reported on average 32 mm (range, 0 - 100). Nurses who wanted to, but did not, call for an EC rated the perceived risk of calling for an EC as slightly, but not significantly, higher than nurses who called for an EC (43 versus 34 mm; t = -1.396, p = .166). We construed a rating of 50 mm and higher as a significant perception of risk. The proportion of nurses who rated the level of risk between 50 mm - 100 mm was largest among nurses who wanted to, but did not, request an EC (47 percent), compared to

nurses who did request an EC (38 percent), and the remaining nurses who never considered requesting an EC (22 percent). This finding suggests that experience with having called an EC tempered nurses' perception of risk in asking for one.

We also compared nurses by their level of regret in their decision to request or not request an EC. Nurses who requested an EC reported significantly less regret in their decision than nurses who desired to, but did not, request one (14.07 versus 53.22, $t = -9.066$, $p < .001$, $n = 86$).[45]

The nurses who wanted to, but did not request, an EC reported several reasons for not requesting one. These reasons included, in decreasing order of identification:

1. Lack of awareness or not knowing how to request an EC,
2. Fear of adverse repercussions,
3. Resolution of the case or someone else eventually requested an EC,
4. Emergent situations created time constraints, and
5. Lack of availability of EC on the night shift.

Given their prevalence, the following discussion examines nurses' fear of three repercussions:

1. Incurring physicians' anger,
2. Destabilizing relationships with members of the healthcare team, and
3. Threats to employment.

Attending Physicians' Anger

Nurses reported that calling an EC can make physicians angry. Nurses used the following expressions to describe why they think physicians may be angry when an EC is called: "interference," "their judgment is being questioned," and "overstepping my boundaries." When asked why physicians' anger was a problem, nurses explained that the anger was directed at them: in some cases, nurses noted that physicians expressed their anger about ECs through verbal abuse, retaliation, threats and/or actual repercussions (for example, reporting the nurse to the nurse manager). One nurse described her perceptions about physicians' anger:

RN: Anger and yelling from the attendings who feel their judgment is being questioned. They tend to avoid asking further opinions or consulting the nurses on [patient] related issues after an ethics consult. [Case #0578.]

Strained Working Relationships

Nurses were also concerned that requesting an EC would damage or strain their working relationships with attending physicians and other members of the healthcare team. The nurse quoted above recounted the interaction she had with a physician following her consult request. This example illuminates the gravity, albeit temporary, of the impact of the consult request on their inter-professional relationship.

RN: We have a pretty good relationship with most of the attendings here. . . . A lot of the attendings think they're the only ones who could ever request an ethics consult, and they feel that we're going over their head. So, I think the risk is just with the attending and nurse relationship there — that are they ever going to trust you again, or if you want something in the future or recommend something, will they actually go along with it.

EG: Well, how is your relationship now after having called this consult with that attending?

RN: Actually, it's about the same as it was before. I mean, there hasn't really been a change. For the first few days, he was angry about it.

EG: How can you tell?

RN: Well, he would come around and if a nurse would ask, you know, "Do you think we could try this?" He would say, "No, the physician decides." So, for the first few days, he was like that, and then gradually got over it. So, I think it was just the initial pouting phase that he was showing his authority that he's the doctor. [Case #0578.]

Similarly, another nurse who requested an EC related the following.

RN: I know the attending was very angry with me because I didn't go to him first. He said that I should have gone to him, and then we could have discussed it, and then pursued it together. [Case #0639.]

Nurses also reported fearing the nursing staff would "hold grudges" against them or criticize them because they called for a consult. Moreover, they reported that they feared that their reputations would be damaged if they were to ask for an EC. Several noted that they would be ostracized or alienated; some believed that they would experience a loss of respect or trust by co-workers; and others reported that they would be labeled as a "trouble-maker" and become known for going over the heads of those in authority. One nurse also feared being labeled and stigmatized by other nurses as "nurse Kevorkian" for offering the option of "no treatment" to terminally ill patients. [Case #0781.] One nurse explained how a request for an EC adversely affects the nurse's relationship with the healthcare team:

RN: You don't feel like you're a member of the team. . . . Nurses will be reluctant to make the call, and then by the time they do, they often feel like, "I'm backed in a corner, no one has addressed my concerns about, you know, either from a medical perspective or from the patient's family perspective. So I have nowhere else to turn but to call the ethics consult." And then by that time, you kind of feel like you're being, um, you're outside the system, you know. You're, you're going beyond the scope of the patient's care team instead of including them. [Case #APN-1.]

Threats to Employment

Nurses perceived that they might lose their jobs by calling for an EC, as nurses were directly threatened by a physician, or witnessed other nurses be threatened or lose their jobs over this. [Cases #0564 and #0448.] Nurses also feared they would be reprimanded by their nurse manager or by the attending physician. In addition, nurses believed that their managers might make their work assignments more difficult, that is, assigning night shifts or extra charting. Others related that there would be negative notes in their employee record, and their salaries would be affected. As one nurse noted, "It would be held against me for yearly evaluations and merit increases." [Case #0811.] Nurses specifically perceived that physicians had the power to affect their job status. Although physicians could not directly fire a nurse (although they could threaten to do this), nurses explained that physicians could inform the nurse manager about a nurse's problematic behavior. This could lead to a reprimand or being written up. It is noteworthy that nurses perceived physicians as having sufficient power over them to affect their job status. Indeed, Mary C. Corley maintained, "physicians are not reluctant to identify nurses as incompetent and to report them to administration."[46] In such situations, perception can be as powerful as reality.

CASES

The following two cases illustrate many of the concerns that nurses identified, including power dynamics and the lack of support from nurse managers, departmental chairs, and administrators when facing ethical dilemmas. Three nurses described these two past situations, still powerful in their minds after many years. In both situations, attending physicians with very good reputations operated on patients who had poor outcomes. These physicians were seen as powerful and intimidating by the nurses, who wanted to call for an EC but did not, for fear of retribution.

In the first case (reported by two nurses), the physician blamed the staff for the patients' poor outcome, but the nurses suspected medical error. As one nurse reported, "I was afraid that I would be reprimanded for second-guessing the surgeon because he . . . was so intimidating." [Case #0313.] In the second case, the nurse became uncomfortable because the patient was clearly dying, yet the physician was telling the patient's wife that the patient would survive the surgery. The nurse talked with the fellow about writing a do-not-resuscitate (DNR) order for the patient. Thereafter, the fellow talked to the patients' wife about this possibility. When the fellow did this, he was reprimanded by the attending physician and removed from the case. Because the nurse witnessed this response, she was even more reluctant to call for an EC.

In both cases, the nurses felt a lack of support from the medical and nursing leadership on their units — as one nurse noted, "the nurse manager did not want to rock the boat or make waves in this case." [Case #0448.] The nurses reported feeling afraid to request a consult because they did not feel that their unit leadership (both physician and nurse) would back them up. One nurse even felt that this lack of support

extended to higher administration. For these nurses, there was a great deal at stake in requesting an EC; they reported feeling powerless and experienced significant moral distress in the aftermath of these cases. One nurse noted:

RN: I felt disappointed with myself because I didn't feel I did the right thing. I felt frustrated, angry, disappointed, sad for the wife and for him [the patient]. [Case #0448.]

As these cases depict, institutional structures, professional roles, and inter-professional relationships have not always been adequate to support nurse respondents who faced moral dilemmas. The nurses' perception of a lack of institutional support and the adverse consequences of requesting an EC strongly affected their decision making. It is clear that many nurses were unable to pursue what they believed to be the morally right course of action and experienced moral distress as a result.

REQUESTING AN EC

Perceptions of Others' Receptivity

Nurses were asked to rate their perceptions of how receptive the other medical team members were to their actual requests for an EC, to measure perceived differences in the team members' responses. Nurses perceived attending physicians, resident physicians, and housestaff as significantly less receptive to their requests for an EC than nurse managers and other staff nurses, respectively (Friedman's *chi*-square = 43.985, $p < .001$, $n = 28$; Wilcoxon's $z = -3.982$, $p < .001$). When a patient's family was involved in the case, nurses rated the family as more receptive to a request for an EC than were physicians (Friedman's *chi*-square = 32.380, $p < .001$, $n = 21$; Wilcoxon's $z = -2.506$, $p < .012$).

Nurses thought that attending physicians were less receptive in terms of two commonly held views of ECs. According to the nurses, attending physicians seemed to consider an EC as a form of defeat, because ECs are often requested late in a patient's stay in the hospital, typically when little more can be done for the patient. ECs are therefore associated with "giving up" on the patient. As one nurse noted:

RN: We told him [the attending physician], "We called the ethics consult." And he said, "I don't really think we needed to do that, I think we don't need to give up yet." [Case #0578.]

Nurses also reported that physicians perceived a request for an EC as tantamount to "going over their head" or as interfering with medical decision making. According to one nurse,

RN: As far as risk, it's just the typical risk of, you know, physicians can tend to get a bit defensive sometimes when they feel that somebody is questioning their judgment because it's their patient. And a lot of times, what I've seen, they don't like third parties stepping in and really directing the care because it's their patient." [Case #0593.][47]

These nurses' perceptions of physicians' negative attitudes toward ECs are corroborated by a national study that found that 41 percent of the physicians surveyed were hesitant to seek assistance for ethical dilemmas.[48]

BEING AN ADVOCATE FOR PATIENTS

Given commonly shared perceptions of the attending physician's power over them and fears of potential adverse consequences of calling an ethics consultation, how did the small group of nurses ($n = 40$) decide to request a consult? Nurses who requested ECs indicated that they felt professionally compelled to advocate on behalf of patients against treatment decisions that they perceived to be impeding quality care. Specifically, nursing's professional framework of patient advocacy was understood as enabling informed consent, providing for patient and family choice, and preventing suffering.

CASE

A specific case, representative of other cases, provides insight into the reasons nurses felt compelled to request an EC. In this example, the nurse recounted the second patient case in which she called for an EC for

a little boy who nearly drowned, and for whom the neurosurgeons were asking the parents to consent to the placement of both a tracheostomy and a gastrostomy tube.

RN: The consents were being thrown in their [parents'] face, and they [the parents] did not, per se, ask me. . . . I just felt that they weren't well informed about what this really means. We can tell you we're going to put a hole here and a hole here, but they don't — I just didn't feel like the whole big picture had been given. And so I called. And then apparently over the weekend — this had repercussions. . . . Again, I was scared to call, but I did, and then when I came back to work on Monday, apparently over the weekend, it was terrible. Again, the [physician] found out that the ethics committee was called, and he was livid. . . . But the big question was, "Who did this, who called, who did this?" And, I felt like shit — excuse my French — when I got back to work. I'm not sorry I called by any means, but I did feel . . . like . . . I'm sorry, I didn't mean to cause a ruffle in anybody's feathers. [Case #0781.]

The style with which this nurse recounted this scenario, with false starts and repetition, reflected her discomfort with the experience.

ADVOCACY THROUGH ENABLING INFORMED CONSENT

As with many other nurses, the impetus to request an EC in this case had to do with ensuring that patients and/or families were fully informed of all the available treatment options, and the implications of the treatment options that were offered — or what this nurse referred to as "the big picture." Nurses who initiated ECs generally perceived the consent process as ethically problematic due to patient-physician dynamics that were characterized by poor information giving and questionable voluntariness in patients' decision making. According to a number of nurses who were interviewed, it is common for physicians, particularly surgeons, to focus on "fixing" a patient's immediate, short-term clinical problems, to the detriment of providing information about post-hospital or long-term outcomes and quality of life. In addition, such focus on the immediate clinical problems reflects an atomistic approach toward treatment,[49] which clashes with a holistic approach toward patient care that is characteristic of a nursing perspective.

Another related issue is that nurses were concerned that patients' informed consent was obtained hastily, which could undermine a patient's ability to engage in thoughtful decision making. A key element of informed consent — voluntariness — was not respected by such a hurried approach, nor was self-determination. The nursing literature similarly recognizes that physicians who technically obtain a patient's informed consent, but do not do so in the spirit of informed consent as an interpersonal process, pose an ethical problem for nurses.[50]

ADVOCACY THROUGH PROVIDING CHOICE

In this case and other cases, the nurse wanted to inform the parents about the option to refuse the offered treatment, even though that choice would have resulted in the child's death. One factor that makes providing the option of no treatment difficult for healthcare professionals is the cultural context of avoidance of death. There is still a strong tradition in hospital and biomedical culture to treat at all costs, so as to prevent death from occurring.[51] For many physicians, in particular, death is still equated with failure.[52] As the nurse in the case stated,

RN: And the days of, you know, "let's-not-talk-about-it" *should* be over in my opinion, but they're not. [Case #0781.]

She explained that being able to overcome this ethos by providing the parents with what she later called "choice" made her feel as though she was acting in an ethical way:

RN: For my own ethics — I guess I felt like if I didn't call, or if I didn't somehow just give an option of — well, I guess where I'm coming down to say is an option of not doing these tubes and letting the child die. . . . And nobody talks about it, God forbid, you know. So, for my own sanity and ethics-wise with myself, I felt good about doing it." [Case #0781.]

The "technological imperative" — the proclivity of healthcare professionals to use high technology treatment because it is available — may compel a medical team to pursue treatment even when a patient is

clearly declining beyond medical benefit and there is little possible improvement in the quality of life that can be gained. In other words, the patient's quality of life entered into the nurses' moral reasoning in terms of the right way to care for patients. Recent research and nurse scholars recognize that a value conflict occurs when physicians appropriately desire to use new treatments to improve a patient's condition, but nurses perceive the use of the new technology as prolonging a patient's suffering.[53]

ADVOCACY THROUGH PREVENTING SUFFERING

Another reason nurses gave for requesting an EC was to minimize patients' suffering. This concern is framed in direct contradistinction to the technological imperative, as this statement by a nurse indicates:

RN: I didn't want to see the surgeon, who is like gung-ho surgery, I didn't want her [the baby] to go through a big surgery only to die. It just, it just didn't seem appropriate. . . . [The surgeon] had this thing where, "We should at least try." And you know, sometimes it's just not, it's just not, it's not the moral thing to do, to put somebody through that much pain and that much suffering only if they're going to die anyway. Why do that? And why do that if you're going to be in a bad situation when you get done? Because if she — even if she lived through this heart surgery, she'd still have to go home to an alcoholic mother — I don't think so. I was willing to adopt her, but uh, [chuckling] they [other nurses] called me her mother. You know, I named her. Her mother didn't even name her." [Case #0254.]

The suffering of the patient here is framed in terms of worsening quality of life. The nurse's conception of quality of life is linked to the patient's relationship to her mother. Neonatal intensive care nurses commonly perceive babies who have little parental contact in the neonatal intensive care unit as having a poor quality of life.[54]

Overall, advocating for a patient played a major role in nurses' willingness to request an EC, and provided nurses with a framework to interpret and respond to ethical dilemmas. Acting on their obligation to be an advocate for patients gave nurses the moral fortitude to face and navigate the power dynamics within a situation by initiating an EC. Additional statements by nurses to this effect include the following:

RN: [It was the right thing to ask for an EC] because I would not have been happy with myself sending her off to surgery without making sure. . . . [Case #0469.]

RN: I feel like I'm my patient's advocate, and if he felt that people weren't listening to him, then I get to find somebody who would. [Case #0639.]

Acting as an advocate in the context of asking for an EC seemed to be a strategy some nurses used to ensure that physicians would stop providing what the nurses perceived as false hope in a situation, or that the preferences of the patient and family would be considered more centrally in the treatment plan. On a more subtle level, being an advocate served as a way for nurses to express the moral imperative to do what they considered to be the "right thing."

OVERCOMING FEAR

While nurses were motivated to request an EC by their professional role as patient advocate, understanding how they overcame their fears to do so can shed light on moral distress and the role of moral courage herein. How did some nurses deal with the power dynamics within the cultural context of a hospital that made most nurses too intimidated to pursue an EC? The reasons relate to the nurses' strategies for requesting the EC, their sense of moral outrage about a case, and the degree of family involvement.

Strategies for Making a Request

The nurses said that the strategies they used in requesting an EC enabled them to act. Some nurses said they undermined or bypassed an attending physician's power by sidestepping the hospital's policy to make anonymous EC requests. This meant that they did not disclose to the attending physician that they were the one who requested the EC. Others did not even tell other staff nurses. These actions can be construed as a

form of "responsible subversion," in which nurses "bend the rules" to benefit a patient.[55] Sally A. Hutchinson considered this behavior to be responsible when "nurses use their best nursing judgment to decide what rule to bend, and when and how to do it," based on their knowledge of the patient, their experience, and their ideology or philosophy of care.[56] Such behavior is subversive, as it violates rules made by hospital and nursing administrators or physicians; it occurs in response to conflict between systems or people.[57] Nurses bend rules in three different circumstances, one of which — when nurses "believe their behavior is indicative of good nursing judgment" — is applicable to nurses in this study.[58] Although bending the rules has been touted by some nurse scholars as a requisite to providing "good (ethical) care,"[59] as we discuss below, we do not support responsible subversion in these situations because it does not lead to improved communication within the healthcare team.

Other nurses reported they told their nurse manager about their desire to request an EC, and usually received encouragement to pursue this further. In those supportive situations, nurses reported they called for an EC, but then their nurse manager notified the attending physician. A small subset of the nurses said they felt confident requesting an EC when they had a good working relationship with the attending physician, a supportive nurse manager, the support of other staff nurses who encouraged them to make the call, and when they became nurse managers themselves.

Moral Outrage

Some nurses explained that they overcame their hesitancy to request an EC by the sheer moral outrage generated by a case. One nurse explained how her anger enabled her to pursue an EC:

RN: I was mad that I was hearing one thing and that the family was being told another. I don't want to say the family was given false hope because, you know, who knows what can happen, it's a brain injury, we don't know anything about the brain really, when it comes to it. . . . I talked to the mom after the doctor got done talking to them. I said, "What did you get out of that?" And she said that she thought that from what he said, that she's [the patient's] going to get up and walk right out of here — when there was no way, there was absolutely no way that could happen, no way. If anything, she'll be able to blink her eyes and move a finger or something. And we were told that and . . . then you try to get them [the family] into the thinking that it's not going to be like that. And they're being told one thing [by physicians], and the nurses are trying to portray another. And then so I was angry that the mom was sitting there, you know, "Okay, let's get up and walk out of here," when it wasn't going to happen. . . . The mom asked, you know, if things aren't going to go the way they are, "I'd like to consider pulling her off the ventilator." And so, it was one of those things — quality of life and what's going to go on there — I don't want to say I was "for" pulling her off the ventilator, but I'm all for, you know, good quality of life, and I didn't think there was going to be any. The doctor said to the nurses there probably won't be any, and she [the mother] was prepared to do that, to take her off and let her go peacefully. And then the doctors come in and say, "We've seen kids just bounce right back from this." And then she kind of pulled away from that [decision to withdraw the ventilator]. And now I think she's [the patient's] laying in a [hospital] bed somewhere. [Case #0784.]

This example is noteworthy for the lack of unified communication within the healthcare team. What is especially frustrating to many nurses, including the nurse in the case above, is the tension over who discloses what kind of information to patients. Although nurses may know the prognosis or results of laboratory tests after having discussions with physicians, nurses are not sanctioned to disclose such information to patients. Yet patients and families ask nurses for this information because they are generally more proximate and accessible to patients than are physicians.[60] As such, nurses are "caught in the middle," between upholding their commitment to patients and simultaneously being an agent of physicians.[61] Consequently, in situations of conflicting perspectives and inadequate communication, nurses may struggle with physicians over how information is framed and relayed to patients. In other words, some nurses practiced a sort of "damage control," that included requesting an EC to align patients with their view of medical reality, in an effort to ensure that decisions made by the patient (or family) were more informed.

Involvement of the Family

Nurses pursued ECs with less concern over repercussions for themselves when it was a patient's family who drove the request. In these cases, nurses took the initial steps to request an EC. When families drove a request for an EC, attending physicians seemed to be more aware of, or took into greater consideration, the family's concerns and the poor prognosis of the patient. For example, one nurse described why she did not feel she had anything at stake when she requested an EC for a family:

RN: In that particular case, the surgeon went along, and let us help, you know, because the family was questioning and looking for more help. And I think they saw the ethics consult in that situation as a resource that would take care of the family and make them feel better and all when they [the physicians] didn't have the time or the inclination to spend that kind of time with the family talking to them, you know. . . .

EG: Why was it the case that in this particular case the surgeons were okay with it, but in so many other cases not — ?

RN: Because the CT [computerized tomography] scan had pretty much said, neurologically, this patient is not going to recover, so it doesn't matter what you do.

EG: Given that there were all these complications, and you know, your sense of hesitancy, how did you feel okay enough to go ahead and call this consult?

RN: Because the family was basically struggling so hard with — and saying things, they were verbalizing, "Mom probably wouldn't have wanted this," and asking questions, "What would happen if we didn't do any more?" And, very often, families don't understand you can withhold feeding, you can withhold medication, you can withhold or take off a ventilator that's been started, you can turn off vasoactive drugs if they're only serving to keep a blood pressure artificially elevated in prolonging what's going to be the inevitable anyway. You can do all of that, but patient's families don't understand that. They think death occurs when you've run out of all options and they never think if someone's on a mega dose of Levophed or other vasoactive drugs, to say, "Well, could we turn that off?" Or, they'll ask, "How long do you think it's going to be?" Which you usually can't answer, but you know sometimes, days on those drugs — and the ending is going to be the same. So, when they start asking a lot of questions and all the rest of that, it makes it easier to say — and sometimes it doesn't even go to an ethics consult because you can go to the physician and say, "They're asking questions about what we're doing and all the rest and —" But if the family's forceful enough, lots of times the surgeon will do that [request an EC] without us having to say we need it. [Case #0501.]

Crosscutting all of the ways nurses overcame fears of requesting an EC is the finding that this set of nurses had more years of nursing experience than those who did not request an EC. For most nurses, greater experience enabled them to have established a better doctor-nurse relationship, to have gained more clinical expertise, and to know how a doctor might respond. Experienced nurses who had not requested an EC reported that, despite declining to call a consult in the past, their greater experience gave them (or would give them) the confidence to do so in the future. According to one nurse:

RN: Hindsight is 20/20, and a couple years older, realizing that, you know, he was wrong, not me, and it was not my fault, and that I should have, I should have called. I will in the future if I see something I don't like because it would make — certainly make me feel better. I'd feel like I'd done all I could, and people need to be called on — when they do something wrong." [Case #0313.]

DO NURSES WHO REQUEST AN EC DEMONSTRATE COURAGE?

In this study, given the context of power dynamics in the hospital,[62] and the repercussions that nurses anticipated from requesting an EC, one might ask whether the subgroup of nurses who requested an EC could be characterized as exhibiting moral courage. "Moral courage" can be defined as "a willingness to act — even if against public opinion, authority, tradition or current standards, with acknowledgment of the possible outcome of the choice."[63] Speaking up and consequently risking one's job can be an act of moral courage.[64]

Based on these definitions, it appears that nurses who requested an EC did exhibit courage. One nurse

explained how she was able to set her fears aside and proceed with requesting an EC:

RN: Because I'm gutsy anyway. [laughs] I guess I was standing up for my own personal feelings of trying to help versus, "Oh, let me just pretend this isn't happening and I'll let it slide under the rug." [Case #0781.]

This same nurse also explained how, alternatively, other nurses avoid requesting an EC because they are

RN: Too scared, they're scared of getting in trouble. . . . I think they're afraid of the doctor. Yeah, what, what can they [doctors] do? Nothing, but nurses are just so geared — women, first of all, then nurse— throw it all together, and you've got disaster! [laughs] But that's my perception anyway. They're just — and they're not going to bother. If they can sleep at night without — [calling the consult] — then go ahead. [Case #0781.]

This nurse's reflection on colleagues who "pretend this isn't happening" illustrates that the emotional withdrawal seen in some nurses can be a consequence of unrelieved moral distress.

Another way to view moral courage is to consider how nurses felt about their decisions to request, versus not request, an EC when they thought one was indicated. One might anticipate that courageous people generally do not regret their actions in the face of risks because they perceive their acts as the morally right thing to do. Accordingly, one could expect that nurses who requested an EC, even if they experienced repercussions, would not regret doing so. This hypothesis was supported: nurses who did request an EC reported a significantly lower level of regret in their decisions than the nurses who desired to but did not make a request. This difference suggests two things. First, those who requested an EC did not allow fear to get in their way and were satisfied with their decision to pursue an EC. Second, those who did not request an EC, but who wished that they had, clearly expressed disappointment and regret over their decision. This latter group reported feelings of reactive moral distress from not being able to act on behalf of their patients or to influence ethical decision making, as has been reported.[65] According to one nurse who wanted to, but did not, request an EC, courage was necessary. In the following recollection, the nurse noted various factors, including physicians, timing, and politics, that set the context of adversity and required courage:

RN: But you don't let people die from pneumothoraxes, from air accumulation in the chest. I don't think whether they were DNR, or not. Do you know what I mean?

EG: Mm hm.

RN: That was my opinion. But I was not supported at all. And there really wasn't time to get them a, an ethics consult, you know like to rally an ethics consult.

EG: Really?

RN: I mean, I don't think.

EG: What was the time frame like, how soon — ?

RN: You know maybe there was enough time. And I didn't realize I had that avenue. And I don't know if it was because [one parent] was a physician in the hospital, politically there was just — I don't know. But I was so berated in that situation, I didn't have enough courage to then, you know, I just was like, okay, I'm wrong, I'm bad, that's it. [Case #0256.]

This comment illustrates Jameton's concept of reactive moral distress, especially the regret and self-criticism the nurse felt because she did not act.

DISCUSSION

Our findings indicate that nurses' decisions about whether to request ECs can be embedded in institutional and social processes. Other studies confirm that ECs and clinicians' decisions to request them are complex social processes.[66] Specifically, our findings are similar to Canadian studies that report that nurses lacked knowledge of ECs or were hindered from accessing ethics resources by power dynamics.[67] ECs are meant to be resources to assist healthcare teams who face difficult challenges — in this study, that crucial fact seemed to get lost in the negative inter-professional politics between nurses and physicians.

Key findings are that a lack of awareness of the ethics consultation service and not knowing how to request an EC were major impediments to the use of the EC process. These interrelated factors are arguably the easiest to remedy through education. As many nurses noted, they learned about the EC service through a variety of avenues, both formal and informal; for example, orientation and word of mouth. While exposure to the EC process through multiple sources can reinforce nurses' awareness, it may result in uneven learning and decreased utilization of a crucial resource.

Another key finding is that hospital policy on accessing an EC directly influenced nurses' decisions about requesting one. The process of notifying physicians about an ethical issue, although necessary, presented its own moral dilemma for nurses — particularly in cases when the nurse disagreed with a physician's medical approach. Rather than viewing this step as simply one of notifying a physician, nurses perceived it as attaining a physician's approval to pursue an EC before they could do what they believed was right. For many nurses who participated in this study, there was always the possibility that a physician would not agree to pursue a requested EC or to respond in a way that the nurses feared. As a result, by requiring nurses to initially present their concerns to a physician rather than to an ethics consultant, hospital policy placed some nurses in a difficult position. A physician's decision to not seek an EC or to respond punitively when a nurse requested an EC further undermined the nurses' standing as moral agents. That is, the nurses' moral agency became contingent upon a physician's moral agency. In such situations, nurses' moral concerns were addressed only when a physician concurred with a request for an EC, or the nurse took it upon herself to anonymously request a consult.

It is noteworthy that many times a nurse's request for an EC was based on significant failure in communication between the nurse and the physicians on the team. It was clear that many nurses in this study did not know how to talk to physicians as colleagues, and vice versa. In these cases, nurses either had not openly expressed their concerns to treating physicians, or they tried but did not feel that their concerns were heard or considered. Physicians who were not consulted were understandably angry in cases when a nurse had apparently not discussed her or his concerns before initiating an EC. It is questionable in these cases whether a good outcome resulted — even if the patient was helped, it is clear that the effect on the team itself was negative.

In most situations, requesting an EC seemed to be "a last resort" for nurses, to deal with moral distress and fulfill the obligation to advocate for patients. In this hospital, even the act of notifying a physician about an ethical issue appeared to be difficult, given the negative repercussions, perceived risks, and potential damage that such an action could cause in nurse-physician working relationships. Nurses in this study recognized physicians' negative perceptions of ECs as a challenge to their decisional role, and those prevailing perceptions influenced many nurses to avoid addressing ethically questionable situations. Some of the nurses' narratives are noteworthy for how marginalized nurses felt their concerns were, even though they were deeply involved in caring for their patients. Many nurses who requested an EC had already experienced significant moral distress before they sought an EC, although some had not.

It appears that, regarding gaining access to EC in this hospital, a traditionally structured medical hierarchy continues to exist, and that an institution's policy and structures can perpetuate lack of access to EC in ways that are counterproductive to building collaborative teams and resolving ethical conflicts. Physicians have traditionally had considerable power over nurses in the context of medical care,[68] which has been attributed to traditional differences in gender, age, social status, education, economics, and decision-making authority.[69] Although these power dynamics have diminished somewhat due to nurses' increased professional standing, these power dynamics and their negative repercussions have been noted to resurface in the context of ethical dilemmas.[70] In this study, social structures reflected the ethical climate of the institution, specifically one in which nurses were not always supported to be, and did not act as, full partners in caregiving teams. Daniel F. Chambliss noted the pervasive view of the nurse as subordinate that contributes to a negative cycle of decreased trust and respect within physician-nurse relationships and the impact of this view on the care of patients: "Here, then, may begin a cycle: doctors don't trust nurses; nurses, not trusted even when they are correct, slack off."[71] Specifically, physicians' anger at nurses undermined nurses' capacity to work

collaboratively on the healthcare team. Yet nurses' responses may have strained the physician-nurse relationship, and may have actually hindered providing care. Such interactions are not only a problem for nurses, but also for the team as a whole, and, ultimately, for patients. The lack of administrative support for nurses to request an EC was a further barrier. In systems in which even the act of speaking up is seen as carrying sufficient risk that it requires moral courage, it should come as no surprise that the majority of nurses stay silent.

The professional status and gender of nurses in the present study may have contributed to their reluctance to openly present alternative options to address ethically charged patient cases to attending physicians. Since nurses are predominantly female, gender can compound their interactions with physicians, even during ECs. Some bioethics scholars attribute their finding that staff nurses often "*publicly hide* their ethical concerns out of fear of reprisal" to American patterns of gendered discourse, in which many women seem to require encouragement to voice their opinions (emphasis added).[72] Susan B. Rubin and Laurie Dorfman have observed that nurses are much more "out-spoken" when discussing ethics among other nurses than when physicians are a part of such discussions.[73]

The nurses in this study resorted to a variety of tactics, including responsible subversion, to make their voices, and those of their patients, heard. For many nurses, these tactics were the only ones they felt were available to manage their ethical dilemmas. Although responsible subversion may have had a positive immediate affect on nurses and their patients, we do not condone these tactics because of the negative long-term effects they incur. Specifically, this practice, because it does not lead to open and responsible communication, perpetuates a dysfunctional team by creating an adversarial dynamic between physicians and nurses. Recall that the nurse who requested an EC during a weekend did not foster communication within the team. Responsible subversion can reinforce negative stereotypes of nurses. Moreover, and perhaps most importantly, the net result of such tactics is that no needed changes occur within the healthcare institution and the inter-professional dynamics of healthcare teams; consequently, nurses' moral distress may continue unabated, with damaging effects.[74]

In light of these findings, the question emerges whether nurses' courage in the face of ethical dilemmas and policy constraints is necessarily good. At least two views are possible. In one view, nurses' courage can be helpful to the patients and their families who need advocates. But a broader perspective is that the very need for courage to address an ethical dilemma reflects a problem with the larger hospital environment that created the need in the first place. It should not require an act of courage for any healthcare professional to do what he or she thinks is the right thing for patient care, much less to raise a question or a concern.

A team model cannot exist when recourse to resolving dilemmas with equal respect for members is not available to each member of the team. When all team members have equal access to EC, they can better address their own moral distress, reinforce inter-professional and intra-professional relationships, and, most importantly, better serve patients. The benefits of having access to EC services go beyond obtaining help to resolve ethical quandaries. One study noted that beneficial reasons for requesting ECs were to clarify ethical issues, make management decisions, document support for decisions already made, clarify options for the care of patients, lessen fear of legal liability, improve communication, and mediate disputes.[75]

Hospital policies that encourage open access to EC services may serve to reduce nurses' moral distress.[76] By focusing on the experience of nurses, our research responds to what has been recognized as a myopic perspective within bioethics, namely, down playing the importance of nurses in ethical decision making.[77] As Chambliss notes, "medical ethics is geared primarily to physicians. . . . nursing, which will actually carry out many of the decisions [of physicians], has no place in the discussion."[78] Our findings indicate that even if nurses are not granted "a place in the discussion," they still feel compelled to act in ways that ensure their moral integrity and improve the care of patients. The context of ethical dilemmas and professional obligations gives some nurses the moral impetus to challenge the power of physicians and their control over the decision-making process, by requesting ECs, while other nurses are unable or unwilling to do this. As such, the findings of this study contribute to nursing's perspective of how power relationships between nurses and physicians affect responses to ethical dilemmas.

LIMITATIONS OF THIS STUDY

Several limitations of the study must be noted. First, the results of this study may not be generalizable to nurses at other hospitals.[79] As noted, hospital policies vary regarding who is entitled to request an EC, and the procedures that address ethical issues.[80] The nurses' reports in this study must be interpreted within an institutional context that some nurses viewed as suppressive and hierarchical. Hospitals with more egalitarian organizational structures may exhibit different patterns in nurses' experiences of requesting ECs. The views expressed by the nurses included in our study may not be generalizable to nurses treating out-patients, since the ethical issues that arise in an out-patient environment will likely differ from those that emerge in an in-patient setting. Additionally, our interviews did not include the actions that nurses took prior to requesting an EC; thus, the extent to which these nurses made efforts to communicate with physicians about ethical dilemmas could not be determined.

This study focused on the nurse-respondents' points of view. Further research on physicians' perspectives on nurses' efforts to address ethical dilemmas would complement these findings. It is interesting that a recent study found that physicians seek ECs infrequently despite encountering ethical difficulties daily, partly due to a desire to avoid conflict.[81] Physicians' interactions with nurses are only mentioned twice in the study, one of which was an explicit decision by a physician to leave "nurses and other people out of the process."[82] As with our findings, these authors found that, for physicians, ethics consultation is also seen as a last resort, rather than as a primary source of help in ethically problematic situations.

RECOMMENDATIONS

Greater efforts must be taken by hospital administrators to ensure that healthcare professionals are aware of the services available to resolve ethical issues. This awareness depends on learning how to identify ethical dilemmas, which is not a straightforward task, particularly because physicians and nurses tend to identify and respond differently to ethical dilemmas.[83] Organizations must ensure that EC services are made available to nurses as well as to other healthcare providers who are directly involved in patients' care. Institutions can become more responsible by establishing mechanisms to ensure that attending physicians, nurse managers, and administrators support nurses' access to the EC resources that are needed to resolve ethical dilemmas. In one important sense, such support can help improve team communication by encouraging all clinicians to openly discuss their concerns with ethics consultants. In addition, impediments to utilization of EC services should be reduced. The negative perspective of physicians and other caregivers should be directly addressed, to clarify the goals and utility of ECs as a resource to aid and support providers faced with difficult ethical situations. As discussed in the context of residents who faced similar problems as nurses in gaining access to EC, to "effectively provide such services, institutions must recognize and be responsible for the culture of authority that inhibits the use of ethics consultation services. . . ."[84] Other scholars support similar proposals to address power structures in institutions.[85]

Open acknowledgment and discussion of moral distress among all careproviders can do much to diminish the intensity of this phenomenon. Strategies for both nurses and physicians to use to deal with moral distress should be discussed and implemented in caregiving teams.[86] Addressing ethical concerns openly and promptly is especially important to minimize the damaging effects of moral distress. Nurses must take responsibility for bringing their concerns to physicians and to the team, without waiting for situations to become emotionally charged and fraught with moral distress. Any careprovider who requests an EC should be supported, and the request should be seen as no different from seeking any consultative resource for a vexing clinical problem.

Mutual respect and healthy role modeling by senior clinicians, nurse managers, and attending physicians may serve to encourage early and open communication of concerns, build collaborative processes within teams, clarify role expectations, and address any fears about requesting an EC. Such activities could be designed as role play exercises, and be videotaped and used to educate nursing staff and physicians. Most

of the successful interventions to improve decisions made at the end of life in ICUs have involved nurses in structured ways that improved communication between physicians and nurses, and brought nursing and physician perspectives together with those of patients and their families.[87] Eric J. Thomas and colleagues recommend that nurses and physicians receive training in conflict resolution, methods to improve assertiveness, listening skills, and conducting collaborative rounds.[88] Such training should ideally occur in interdisciplinary educational forums, beginning with initial professional education. Interdisciplinary ethics education can help careproviders learn to appreciate the roles, responsibilities, and perspectives that each discipline brings to the care of patients and to resolving ethical dilemmas. Such education can empower nurses with strategies to initiate communication with physician colleagues, and alert them to alternative ways to resolve ethical dilemmas. This recommendation is reinforced by Gordon DuVal and colleagues, who found that physicians who were more knowledgeable and experienced in ethics were significantly more likely to request an EC.[89] We anticipate that the same would be true for nurses as well.

CONCLUSION

Requesting an EC is a social process that can have real consequences for nurses, healthcare teams, and patients. Most of the nurses in this study either lacked knowledge of EC or were hindered in requesting an EC because of powerful institutional and inter-professional obstacles. The nurses who requested an EC demonstrated an essential feature of courage in the service of advocacy: doing what they believed was the right thing, regardless of potential adverse consequences. But this courage came at a price, and frequently was only invoked when a nurse struggled with moral distress and communication in the healthcare team had broken down. Moral courage should not be required of healthcare providers to obtain an EC, given the value of ECs to those involved in the care of patients.

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NOTES

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86. Corley, "Nurse Moral Distress," see note 37 above; Hamric, "Moral Distress in Everyday Ethics," see

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