CHAPTER 2

LITERATURE REVIEW

This study aimed to explore ethical dilemmas, ethical decision making, and outcomes of ethical decision making in nursing administration of head nurses in regional hospitals of Southern Thailand through critical incident analysis. Related literatures was reviewed and grouped under five aspects as follows:

1. Ethical dilemmas

    1.1 Definition of ethical dilemma

    1.2 Ethical dilemma in nursing

2. Ethical dilemma in nursing administration

3. Ethical decision making

    3.1 Definition of ethical decision making

    3.2 Ethical decision making model

    3.3 Outcomes of ethical decision making

    3.4 Theoretical foundations of ethical decision making

        3.4.1 Ethical theories

        3.4.2 Ethical principles

        3.4.3 Ethical concepts

        3.4.4 Nurses' Code of Ethics

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4. Ethical decision making in nursing administration

5. Critical incident analysis technique

    5.1 Philosophical perspective

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Ethical dilemmas

Definition of ethical dilemma

The term "dilemma" is defined as "a difficult problem seemingly incapable of a satisfactory solution or a situation involving choice between equally unsatisfactory alternatives" (Davis, Aroskar, Liaschencko, & Drought, 1997). The concept of dilemma was analyzed by Sletteboe (1997). Three conditions of dilemma were: 1) two or more alternatives to choose between, 2) a wanted option leads to an unwanted consequence, and 3) a choice where one does not know what is the right thing to do. In addition, five defining attributes were proposed. There were engagement, equally unattractive alternatives, awareness of the alternatives, the need for a choice, and uncertainty of actions.

There are several dilemmas in daily life and in the context of nursing. Phenomena of dilemmas happen every day in nursing and its concept central to nursing practice (Sletteboe, 1997). However, not all dilemmas are ethical in nature (Davis et al., 1997). An ethical dilemma is a situation involving conflicting moral claims and gives rise to such questions as "What ought I to do?" and "What is the right thing to do?" and "What harm and benefit result from this decision or action?" (Davis et al., 1997). Ethical dilemmas usually have no perfect solution, and those making a decision may find themselves in the position of having to defend their decisions (Ellis and Hartley, 2004).

Beauchamp and Childress (2001) clearly stated that "ethical dilemmas are circumstances in which moral obligation demands or appears to demand that a person adopt each of two or more alternative actions, yet the person cannot perform all the required alternatives. Ethical dilemmas occur in at least two forms: 1) some evidence or argument indicates that an act is morally right, and some evidence or strength of argument on both sides is inconclusive, 2) an agent believes that, on moral ground, she or he is obligated to perform two or more mutually exclusive actions".

Ethical dilemma in nursing

In the nursing profession, nurses are constantly experiencing new ethical dilemmas as a result of the global changes in health care (Noureddine, 2001). Nursing is a profession that deals with the most personal and private aspects of patients. Today's nurses are challenged to provide nursing care in a dynamically changing social and health care environment, with increasing patient acuity, advances in science and technology, resulting longer life span, and higher health care costs (Burkhardt & Nathaniel, 2002; Ellis & Hartley, 2004; Wood, 2001). Nurses are faced with ethical dilemmas in their daily nursing practice. Many studies have focused on ethical dilemmas in nursing practice faced by practical nurses and nursing students in different settings. Redman and Fry (2000) conducted a systematic analysis of five studies and found that ethical conflict themes underlying four specialty areas (diabetes, education, pediatric nurse practitioner, rehabilitation and nephrology) included: differences in the definition of adequacy of care among professionals, the institution and society; difference in the philosophical orientation of nurses, physicians and other health professionals involved in patient care; a lack of respect for the knowledge and expertise of nurses in specialty practice; and difficulty in carrying out the nurse's advocacy role for patients.

In Thailand, studies on ethical dilemmas have focused on issues/dilemmas in patient care encountered by staff nurses and nursing students. Ethical issues in nursing practice showed that staff nurses encountered eight major ethical dilemmas including balancing professional obligations vs. protecting self from harm, prolonging life vs. prolonging dying, maintaining patient confidentiality vs. warning others, intradisciplinary vs. interdisciplinary conflicts, truth telling vs. benevolent lying and withholding information, end of life issues, and discrimination vs. obligation to provide care equally (Chaowalit, et al., 2002). In a study regarding ethical dilemma and ethical decision making, it was found that all subjects of 110 registered nurses had experiences in encountering ethical dilemmas (Wipamat, 2001). A study in pediatric wards, all nurse respondents (n=64) in regional hospitals of southern Thailand were faced with ethical dilemmas including acting as patients' advocacy but conflicting with others, respecting families' autonomy but doing harm to patients, who should decide to stop prolonging life?, conflict when patients receive biased care, having to choose whether to tell or not tell the truth, willing to take action to help patients but not authorized, lacking power to change inappropriate behaviors of health personnel, prolonging life or prolonging suffering?, and wishing to refuse care but having obligation to care (Jantarapratin, 2005). Ethical dilemmas experienced by nurses working in intensive care units included being willing to help but unable to do, acting as patients' advocacy vs. maintaining relationship, prolonging life or prolonging suffering, who should make decision, how to give information that is good for everyone, professional obligation and duty to self, and being forced to comply with a decision due to lack of authority (Rukchart, 2000). Another study by Chaleawsak (2001) found that nurses who cared for terminal ill patients were faced with ethical dilemmas including prolonging life or ending life, maintaining patient

confidentiality or telling the truth to patients' families, having different criteria for value judgments, and deciding who should receive scarce resources. In addition, nurses also experienced ethical dilemmas in providing care for patients during the critical situation of disaster. Intawong (2006) found that ethical dilemmas experienced by nurses in providing care for patients during the tsunami disaster included how to provide quality nursing care under a critical situation and limitations, too few personnel to save all patients, focusing on life saving under scarce resources that may violate patients' rights, how to promote patients' best interest for too many patients, who should be the first priority under limited time and resources, and having to tell a lie for the patients' best interest.

In addition, nursing students also experienced ethical dilemmas in nursing care practice. Nursing students in Southern Thailand were faced with ethical dilemmas including protecting patient rights vs. lack of self autonomy, values conflicts in professional roles, professional obligations/respect of authority vs. duty for self, truth telling vs. withholding the truth, maintaining patients' confidentiality vs. protecting others from harm, prolonging life vs. prolonging suffering, and lack of cooperation/relationship (Chaowalit, Suttharangsee & Takviriyanun, 1999).

Ethical dilemma in nursing administration

In nursing administration, nurse administrators are confronted with ethical dilemmas when making daily administrative decisions that require choices of a moral and ethical nature. Zeccolo's (1996) study of the ethics for nursing administration asserted that ethics of staff nurses have a distinctive nature compared to the ethics of nurse administrators and that the ethics of the traditional staff nurses are inappropriate

for nurse administrators. This can be explained by staff nurses and nurse administrators having different roles, functions, and responsibilities. Staff nurses are directly responsible for patient care, whereas head nurses have managerial roles as well as roles in providing direct care for patients. Therefore, ethical dilemmas of head nurses are quite different from those of staff nurses. As shown in a study by Chaowalit, et al. (2002); Jantarapratin, (2005); and Wipamat (2001) that ethical dilemmas of staff nurses included respecting families' autonomy but doing harm to patients, who should decide to stop prolonging life?, conflict when patients receive biased care, have to choose whether to tell or not tell the truth, willing to take action to help patients but not authorized, prolonging life or prolonging suffering?, and wishing to refuse care but having obligation to care, balancing professional obligations vs. protecting self from harm, prolonging life vs. prolonging dying, maintaining patient confidentiality vs. warning others of harm, advocating for patients vs. maintaining relationship with others, truth-telling vs. benevolent lying and withholding information, end of life issues, and discrimination vs. obligation to provide care equality.

Studies regarding ethical dilemmas faced by nurse administrators revealed that nurse administrators experienced ethical dilemmas regarding allocation of resources, quality of care issues/patients care standards, issues relating to staffing and mix, a concern for fairness, using power for good ends, treatment vs. non treatment, conflict between organizational and professional philosophy and standards, and lack of knowledge or skills to competently perform one's duties, fairness, concern with preventing harm, consumer/patient choice, balancing needs of different groups of patients, conflict between financial incentives and patient needs, and professional autonomy (Bantz, 1999; Camunas, 1991; Camunas, 1994a; Colvin, 1998; Cooper,

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Frank, Gouty, & Hanson, 2003; Cooper, Frank, Gouty, & Frank, 2004; Cooper et al, 2002; Cooper et al, 2004; Harvey, 1997; Lemieux-Charles, Meslin, Aird, Bager, & Leatt, 1993; and Sietsema and Spradley, 1987).

Since head nurses have managerial roles including planning, organizing, staffing, directing, and controlling, as well as roles in providing direct nursing care for patients (Saminpanya, 1996), ethical dilemmas they experience are related to their roles as follows:

1. Ethical dilemma related to allocation of scarce resources

The recent economic changes have forced healthcare administrators to be concerned about allocating of health care resources; man, money, and material. Sebastian and Stanhope (1999) asserted that controlling the rising cost of care remains a challenge for administrators and clinicians. Nurse administrators have responsibility for allocating existing resources as well as maintaining the quality of care for patients.

Nurse administrators have duty to the organization as a whole, and also have a duty to the needs of patients. Based on the principle of justice, nurse administrators have a duty to allocate health care resources fairly. However, nurse administrators are faced with an ethical dilemma of how to allocate the resource fairly when there are limits on health care resources and an imbalance exists between available health care resources and patients' needs/quality of nursing care (Camunas, 1994a; Camunas, 1994b; Lemieux-Charles et.al, 1993; Marquis, 2000).

Allocation of scarce resources in health care can occur at the political, organizational, and personal level (Lemieux-Charles; Meslin; Arid; Baker;& Leatte (1993); Sarikonda-Woitas & Robinson, 2002). The results of a study by Meslin; Lemieux-Charles; & Wortley (1997) supported this statement. They surveyed 3,000 clinician managers (most often physicians and nurses); the findings indicated that

respondents reported some degree of involvement in making ten types of resource allocation decisions in their hospital that occurred on all three levels; the political, organizational, and personal level. Those were how to decide which group of patients should receive care, reduce individual patients' length-of-stay, substitute professional staff with less well-trained staff in order to contain costs, limit use of resources for terminally ill patients when another group of patients might benefit more, admit elective patients versus others given everything being equal, limit access to units for resource-intensive patients, use standardized treatment protocols for patients with the same problem, close beds, limit access to unit for patients who may not benefit as much as other patients in the long run, and limit expensive treatments that are only slightly more beneficial than existing ones. In resource allocation decisions, those clinician managers faced many ethical issues, such as fairness, consumer/patient choice, needs of different groups of patients, conflict between financial incentives and patient needs, and professional autonomy (Lemieux-Charles et.al, 1993).

Financial issues faced by nurse executives in a study by Camunas (1994a) were found in role conflicts concerning access to care for patients who were medically indigent. At times, putting the patient first is not always in the best interest of the hospital. The difficulty comes in maintaining the financial integrity of the hospital versus providing expensive care for patients who have no means to pay. Nurse executives encounter this dilemma when they are the administrator on call and have to make a decision whether to allow or deny admission of these patients. The dilemma also arises after indigent patients are admitted and have long-term care needs that require increased or extended use of resources.

An ethical dilemma of nurse administrator related to allocation of scarce material was described in the study by Katsuhara (2005). There was a flow of patients

being admitted to an accident and emergency hospital while all beds were already occupied. After having been treated by doctors, the patients had to be transferred to another hospital which was short of nursing resources. Furthermore, the patients' lives may have been threatened during the transfer.

Another ethical dilemma faced by nurse administrators is related to shortage of nursing staff. When a high number of patients flow to the hospital, nurse administrators have a conflict to balance between protecting patients' lives and allocating limited human resource (Katsuhara, 2005).

2. Ethical dilemma related to adhering organizational policies/ regulations/ commands

Policies are plans reduced to statements or instructions that direct organizations in their decision making (Marquis & Huston, 2003). After policy has been formulated, administrators must determine how those policies will be implemented in their units. It is the leadership role of administrators to communicate that policy to all who may be affected by it (Marquis & Huston, 2003). Not only should hospital policies be adhered to, but also head nurses have to follow regulations of the nursing department and their superiors' command. Ethical dilemmas may arise when those policies/regulations/commands result in negative consequences to patients, nurses, colleagues, ward, or the head nurses themselves.

An ethical dilemma related to following organizational policies was presented in a study by Katsuhara (2005). A public hospital needed to follow a local government's instruction to reduce the staffing level against the will of the hospital president and nurse administrator in order to solve financial deficit.

Another issue that induces ethical dilemmas for head nurses may arise from those who have power/authority in the organization. Brosnan and Roper (1997) stated

that the hospital is an extremely political environment and a political ethical conflict occurs when what one is told to do by those having more power in the organization or what one feels compelled to do by the organization is in conflict with one's ethical belief structure. As an administrator, the head nurse has to collaborate with other administrators who have more power in the organization; supervisors, nurse director, and hospital director. These have different values, beliefs, and ways of managing their units. Head nurses encounter dilemmas when they are told to perform action against with their personal values or professional values.

3. Ethical dilemma related to staffing

Staffing is the management activity that provides for appropriate and adequate personnel to fulfill the organization's objectives (Grohar-Murray & Dicroce, 1992). Staffing is a complex process that provides a plan for the allocation of adequate number and capability of personnel to do the work of the organization. Staffing is the important managerial function of head nurses. Its goal is to provide the appropriate number of nursing staff to match patient care need that will lead to the provision of effective nursing care (Sullivan & Decker, 2004). Staffing comprises recruiting, selecting, and developing staff to achieve the goals of the organization (Cuthbert, Duffield, & Hope, 1992).

According to the study of Camunas (1994a), nurse executives had the greatest ethical dilemma in making decision about staffing. These decisions involved skill, experience, education level, and number of nurses. The researcher stated that restrictions on using more skilled, educated and experienced nurses could occur because of the economic constraints. Furthermore, staffing issues were a cause of ethical conflict between role obligations of nurse executives. That was the conflict between nurse roles; to provide a high level of experienced staff/ highest quality, and

administrative role; to maintain financial integrity of hospital/staff at most cost-effective levels/meet legal requirement.

Ethical dilemmas of nurse administrators can result from recruitment of assistants because of under staffing. For example, a nurse administrator was struggling to provide appropriate nursing care for patients while these were a shortage of nurses. This issue is described in a study of Katsuhara (2005). A nurse, who worked for a hospital with a low staffing level, felt that recruiting more nurses was essential to ensure the quality of care. However, she was persuaded by business personnel to employ assistants instead of qualified nurses to keep costs down. She knew the importance of budgeting, but struggled with reduced pride having to provide care which was, in her opinion, substandard.

Nurses have the right to expect a reasonable workload. Head nurses must ensure that adequate staffing exists to meet the needs of staff and patients. Head nurses who constantly expect employees to work extra shifts, stay over time, and carry unreasonable patients assignments are not being ethically accountable (Marquis & Huston, 2003). An incident of over workload of nurses was described in a study by Katsuhara (2005). There was a doctor who was enthusiastic about accepting serious cases one after another with a sense of mission. A nurse administrator was impressed by his commitment. However, she was at the same time concerned that the workload of the nurses was increasing to an unreasonable level because of the doctor's actions. A night shift may be covered by two nurses and it was very heavy for them to carry such responsibility and deal with the flow of serious cases. It was not safe practice in case of emergencies.

The profession faces the challenge of providing sufficient numbers of nurses to meet increasing public health care needs. In addition, nursing also faces a

critical protective task. The public must be protected from inadequate and poor quality health care services that occur when ill-prepared persons deliver those services (Leddy & Pepper, 1993). In the study of Camunas (1994b), it was found that nurse executives encountered ethical dilemmas regarding staff nurses' poor judgment, incompetence, and errors in nursing care. Errors involving medications sometimes occurred when incompetent nurses were assigned to give medications instead of assigning skillful intravenous nurses.

4. Ethical dilemma related to collaboration with patients/health team to manage conflict

The differences in attitudes, values, beliefs, and behaviors induce conflict among individuals. Conflicts can arise when individuals involved do not have the same facts, define the problem differently, have different pieces of information, place more or less importance on various aspects, or have divergent views of their power and authority. Variation in personal value systems or perceptions of ethical responsibilities can lead to conflict (Tomey, 2004). Various types of conflict occur in the workplace, such as conflict within the person, conflict between two or more people with different values, goals, and beliefs, and conflict between two or more groups of people (Marquis & Huston, 2003; Tomey, 2004). Nurses enter into relationships with patients and their families, and typically engage in more continuous interaction with them than any other member of the healthcare team (Redman & Fry, 2000). All of them are individual with personal and professional values, work with the healthcare team that has different values, and provide nursing care to patients who often have religious, cultural, and moral values quite different from their own. These diversely held values can and often do conflict with one another.

Nurse administrators, in their daily work, cannot avoid conflict and at the

same time they have responsibility to manage conflict. The nurse administrators' goal is to manage the conflict in a manner that lessens the perceptual differences that exists between the involved parties. They should recognize which conflict management or resolution strategy is most appropriate for each situation (Marqis & Huston, 2003). Collaborating is one of the common conflict management strategies (Marqis & Huston, 2003; Tomey, 2004).

Collaborating is an assertive and cooperative means of conflict resolution that results in a win-win solution (Marquis& Huston, 2003). It contributes to effective problem solving because both parties try to find mutually satisfying solutions (Tomey 2004). In collaboration, all parties set aside their original goals and work together to establish a supraordinate or priority common goal. In doing so, all parties accept mutual responsibility for reaching the supraordinate goal (Marquis & Huston, 2003).

In collaboration, problem solving is a joint effort with no superior/ subordinate, order-giving/order-taking relationship. True collaboration requires mutual respect, open and honest communication, and equitable, shared decision-making powers. Collaboration remains the best alternative for problem solving involving others (Marquis & Huston, 2003).

In healthcare, the concept of collaboration has been widely applied to nurse-physician relationships. Collaboration requires that nurses and physicians share responsibility and accountability for patient care (Pike, 1991). Code of ethics for nurses in Thailand states that the nurse always maintains collaboration with others in order to promote the nursing profession (The Nurses Association of Thailand, 2003).

In managing conflicts among colleagues, and patients and health team, nurse administrators take action as a mediator to collaborate between involved parties. As a mediator, nurse administrators helps the parties define the problems, identify the

issues, and prioritize multiple issues. The mediator is an educator who facilitates the bargaining process and helps each parties consider how to achieve his or her objectives (Tomey 2004).

Being a collaborator or mediator, the nurse administrator must be knowledgeable and skillful in managing conflict properly. Marquis and Huston (2003) stated that if the conflict is managed well, people involved in the conflict will believe their position was given a fair hearing. If the conflict is managed poorly, the conflict issues frequently remain and may return later to cause more conflict. Collaboration involves others over which the nurse administrators have no control, even though collaboration is the best method to resolve conflict to achieve long-term benefit, nurse administrators face difficulties in being a collaborator.

5. Ethical dilemma related to quality control

Many changes in health care system in Thailand are calling for quality of care for patients such as the Declaration of Patient's Rights and Hospital Accreditation Policy. Hospital Accreditation is a process that induces hospital quality improvement along with accreditation from outside institutions (Anuwat, 2001).All hospitals in Thailand are required to be accredited hospitals. Therefore, hospital administrators and nurse administrators play an important role to control quality of health care services. Quality control is a specific type of controlling which refers to activities that evaluate, monitor, or regulate services rendered to patients. In nursing, the goal of quality care is to ensure quality while meeting intended goals. Important factors influencing quality of care include financial support and human resource (Marquis & Huston, 2003). A study of Camunas (1994a) found that nurse administrators experienced conflicts between their professional values in providing high-quality care to all patients and the fiduciary responsibilities of their

administrative position. The economic constraints of cost containment and reduction lead to the need to decrease staff costs and maximize earnings and profit. As administrators, they perceived difficulty to maintain standard of care while they were forced to maintain high quality under limitation of staff and financial support. One nurse executive reported that the substance abuse program at her hospital was cancelled because of the lack of funds (Camunas, 1994b).

The nursing shortage has an impact on quality of care for patients as limited number of nursing staff leads to clinical errors or poor standard of care. In the study of Ludwick and Silva (2003), most of the staff nurses (69%) believed that clinical errors/untoward clinical incidents were somewhat/strongly related to the nursing shortage. Those clinical errors were: not giving medications and/or treatments, and/or giving them in the wrong times. And also, 65% of them experienced untoward clinical incidents related to patient falls, pressure ulcers, unplanned patient readmissions, restraint use, and nurse injury. In addition, 73% staff nurses reported that they felt some/strong moral distress as a result.

6. Ethical dilemma related to performance appraisal

Performance appraisal is a periodic formal evaluation of how well personnel have performed their duties during a specific period (Tomey, 2004). Performance appraisal is a major responsibility in the controlling function of management (Marquis & Huston, 2003). Performance evaluation can be used for many purposes such as determining job competence, enhancing staff development and motivating personnel toward higher achievement, and selecting qualified nurses for advancement and salary increase (Tomey, 2004).

Criteria involving judgments are used for performance evaluation. A number of errors may affect performance rating as human judgment is subject to the

influence of prejudice, bias, and other subjective and extraneous factors (Tomey, 2004). Nurse administrators should be aware and try to minimize all errors to enhance job performance evaluation correctly and justly. Therefore, the ethical principle of justice plays an important role in performance evaluation. According to Beauchamp and Childress (2001), justice is fair, equitable, and appropriate treatment of what is due or owed. An injustice involves a wrongful act or omission that denies people benefits to which they have a right or distributes burdens unfairly. Philosophers have proposed six principles as a valid material principle of distributive justice: (1) to each person an equal share, (2) to each person according to need, (3) to each person according to effort, (4) to each person according to contribution, (5) to each person according to merit, and (6) to each person according to free-market exchange (Perelman, 1963 cited in Curtin, 1994).

Among those six principles, three principles - distribution to each person according to an effort, to contribution, and to merit-are considered to be a guide for performance evaluation. However, nurse administrators may face conflicts among these principles. Beauchamp and Childress (2001) proposed that conflicts among the above principles create a serious priority problem as well as a challenge to a moral system that aims for a coherent framework of principles. These conflicts indicate the vital need for balancing of these principles.

7. Ethical dilemma related to advocacy role

Advocacy is a leadership role and head nurses must be advocate for patients, subordinates, and the profession (Marquis & Huston, 2003). Patient advocacy is required in health care because the process of becoming a patient results in a reduction of autonomy and a patient's rights or interests may not be respected. Some patients will lose autonomy due to the nature of illness such as conditions that

cause unconsciousness or severe mental in capacity (Willard, 1996).

The problem of advocacy arises from the uncertainty of what is right, moral, legal and ethical. The dilemma occurs where there is conflict between personal values and perceived professional obligations. This conflict can occur either among nurses, between nurses and other health care personnel or between nurses and the institution. It is evident that the role of patient advocate is one of much controversy, but nurses as professionals must examine their beliefs about advocacy and act accordingly (Segesten & Fagring, 1996). The ability to be an advocate for the patient without being an adversary to others in the health care system is the challenge for the nurse who is a patient advocate. Advocacy efforts can cause problems and constraints because nursing care is carried out within the boundary of hospitals and extended care facilities creates some problems for the patient advocate. The nurse is an employee of the institution, not the patient. The employee status of nurses presents conflicts for them when there appears to be a question of priority or a choice between what is perceived to be best for the patient and what is institutional policy and expectation. The professional nurse is obligated to assign priority to the patient. Assuming that obligation may put the nurse as employee at risk (Leddy & Pepper, 1993).

In most healthcare delivery systems, advocacy efforts are challenged by the nurse's lack of equality in authority. Authority in responsibility is more likely to be evident among healthcare disciplines. However, authority is more commonly dispersed in a hierarchical manner, in which nursing may occupy a position of disadvantage (Leddy & Pepper, 1993). The ethical problems associated with advocacy arises because of performing an advocacy role is difficult and sometimes threatening, because it promotes patient's self-determination and because the professional's associate moral rights and obligations may not be compatible with institutional

policies or legal regulations (Corcoran, 1988 cited by Leddy & Pepper, 1993).

Assuming the role of advocate on behalf of a patient can give rise to ethical and legal concerns related to differing moral values of the nurse and the patient and the interaction of the nurse with other nurses and allied health professionals (Leddy& Pepper, 1993; Willard, 1996).

Ethical decision making

Definition of ethical decision making

Ethical decision making refers to a process of moral reasoning that one makes a choice of a moral justification in dealing with ethical issues. It ends in the choice of a morally justifiable action to be taken in a given situation. Ethical decision making process in nursing incorporates a moral reasoning process by which nurses are able to satisfactorily work through the ethical dilemmas and obligations/duties with which they must deal. It provides a method for nurses to answer key questions about ethical dilemmas and to organize their thinking in a more logical and sequential manner (Thompson & Thompson, 1992).

Model of ethical decision making

Models of ethical decision making in nursing are presented from the study of Murphy (1976 cited in Pinch, 1985) and Swider, et al (1985). They comprise three models-patient-centered model, physician-centered model, and bureaucratic-centered model.

1) Patient-centered model refers to decisions reflecting nursing responsibilities to patient/family and their welfare, rights, and best interest (Swider, Mcelmurry, & Yaling, 1985). In patient-centered model, Murphy (1979 cited in Pinch, 1985) stated

that "the nurse considers her moral authority to be as great as any other health professional and sees her first responsibility to and for the patient as a unique human being…to help facilitate the patients' efforts to obtain whatever care is needed, even if it means going against the doctor or the hospital administration."

2) Physician-centered model refers to decisions that reflect nursing responsibilities to a physician's attitudes or authority, or those of the medical community (Swider, Mcelmurry, & Yaling, 1985). In this model, the nurses' goal is to maintain a truthful and harmonious relationship between herself and the physician even at the expense of the nurse-patient relationship (Murphy, 1979 cited in Pinch, 1985).

3) Bureaucratic-centered model refers to decisions reflecting primary responsibility /accountability to the hospital structure and institutional authority (Swider, Mcelmurry, & Yaling, 1985). In this model, the nurse maintains the social order of the institution at the expense of the individual patient's welfare and emphasizes teamwork with no consideration of the individual nurse-patient relationship and accountability (Murphy, 1979 cited in Pinch, 1985).

Outcomes of ethical decision making

A successful process of ethical decision making does not always result in a satisfactory outcome (Hamric; Spross & Hanson, 1996). These can be desirable and undesirable outcomes. Occasionally the outcome reveals the need for changes within the institution or healthcare system. In ethical decision making, outcome evaluation is important as it acknowledges creative solutions and celebrates moral action, and can be used to minimize the risks of a similar event by identifying predictable patterns and thereby averting recurrent and future dilemmas (Hamric; Spross & Hanson, 1996).

Findings from previous studies showed positive and negative outcomes from

ethical decision making of nurses. A study by Rukchart (2000) found that the positive outcomes of ethical decision making of nurses working in intensive care units included   being proud when helping patients, feeling good, at least to maintain relations, and   patients receiving good care. In addition, the positive outcomes of ethical decision making of nurses in providing care for terminally ill patients were patients receiving good care, good relationship with others, and pride in the professional role (Chaleawsak, 2001). The negative outcomes included an unresolved feeling due to lack of a proper solution, poor relationship, low self-esteem, and being blamed by patients, patients' needs not being met, stress/anxiety with outcomes, and feeling worthless (Chaleawsak, 2001; Jantarapratin, 2005).

Theoretical foundations of ethical decision making

Theoretical foundations of ethical decision making in this study comprise ethical theories, ethical principles, ethical concepts, Nurses' Code of Ethics, and The patient's rights.

1. Ethical theories

An ethical theory is a moral principle or a set of moral principles that can be used to assess what is morally right or morally wrong in a given situation (Ellis & Hartley, 2004). Theories of ethics are classified in many ways. These are classical and modern theories; western and eastern theories; Buddhist ethics, Hindu ethics, and Islamic ethics; and consequential and nonconsequential theories (Fry & Johnstone, 2002). The most widely used ethical theories are Natural Law (Objectivism), Deontology, Utilitarianism, Social Equity and Justice, and Ideal Observer (Ellis & Hartley, 2004). In health-care professions, however, the most directly concerned with ethical decision making are utilitarianism and deontology (Catalano, 2003). They are the theories most frequently discussed in bioethics and health care over the past two

decades to assist in determining what is right (Aroskar, 1998).

1) Utilitarian theory

Utilitarian theory sometimes is called utilitarianism, consequentialism, teleology, or situation ethics (Burkhardt & Nathaniel, 2002; Catalano, 2003). Utilitarianism began with David Hume (1711-1776) and was developed by Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873) (Bandman & Bandman, 2002).

Utilitarian theory refers to the ethical system of utility using the single principle of utility. Bauchamp & Childress (2001) stated that "The principle of utility is the ultimate standard of rightness and wrongness for all utilitarian". Utilitarian theory considers primarily the consequences of action and claims that actions are judged as right or wrong in relation to the balance of their good and bad consequences (Bauchamp & Childress, 2001; Burkhardt & Nathaniel, 2002). Utilitarianism defines "*good*" as happiness or pleasure, and *"the right"* as maximizing the greatest good and least amount of harm for the greatest number of persons. Utilitarianism is based more on the collective good rather than on the value of the individual. The main principle driving utilitarianism is "the greatest good for the greatest number", so the welfare of society takes precedence over that of individuals (Noureddine, 2001). It is based on two underlying principles: 1) the greatest good for the greatest number, and 2) the end justifies the means, therefore, sometimes there are two basic types of utilitarianism: act-utilitarianism and rule-utilitarianism (Catalano, 2003).

Act-utilitarianism emphasizes on the greatest general good in a particular situation and justifies actions by using directly the principle of utility whereas rule-utilitarianism emphasizes on the moral rules that maximize the greatest good for the greatest number and justifies actions by adopting rules (Bauchamp & Childress,

2001).

The utilitarianism has both advantage and disadvantage. Gibson (1993) asserted that "the advantage of utilitarianism is that the consequences of actions are taken seriously and the disadvantage is that the concern with aggregate happiness overlooks the value of the individual who, although in a minority, may deserve help".

2) Deontology theory

Deontology is a system of ethical decision making based on moral rules and unchanging principle, also called the formalistic system, the principle system of ethics, or duty-based ethics (Catalano, 2003). The deontological theory place a higher values on duty or obligation without consideration of consequences (Aroskar, 1998; Noureddine, 2001). It takes the view that human beings have the ability to ascertain which actions are morally right and wrong through the use of reason. Deontology is based upon the rationalist view that the rightness or wrongness of an act depends upon the nature of the act, rather than the consequences of the decision (Burkhardt & Nathaniel, 2002).

There are two types of deontology; act-deontology and rule-deontology. The difference is the application of moral demands to a specific act in a specific situation or the rule of conduct that determines the rightness or wrongness of an act (Silva, 1990). The four major principles in deontology are autonomy, nonmaleficence, beneficence, and justice (Noureddine, 2001).

Deontology theory has some problem in practice. Gibson (1993) asserted that "the limitation of the deontological position is that its application is sometimes impractical. The application of rigid principles can have negative consequence."

3. Ethical principles

The important ethical principles include autonomy, justice, fidelity, beneficence, nonmaleficence, veracity, standard of best interest, and obligation (Catalano, 2003). Ethical principles in this research comprise of four principles presented for nurse administrators: autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2001; Silva, 1990).

1) The principle of autonomy

Autonomy is one of the ethical principles commonly mentioned in bioethical discussion. The term "Autonomy" literally means self-governing (Burkhardt & Nathaniel, 2002), as it is derived from Greek, "autos" refer to self and "nomos" refer to rule/governance/law (Beauchamp& Childress, 2001). Catalano (2003) defined the term "autonomy" as the right to self-determination, independence, and freedom. To be autonomous means to be in control of one's life.

The principle of autonomy essentially recognizes the individual's right to self determinism and is associated with the concept of respect for persons. According to Beauchamp and Childress (2001), the principle of autonomy claims that individuals ought to be permitted personal liberty to determine their own actions according to plans that they have chosen. This principle requires that there must be sufficient justifying reasons for violating a patient' rights to privacy or overriding a patient's wishes in matters of their own health and well being (Davis et al., 1997).

In nursing, autonomy refers to the clients' right to make health care decisions for him or herself, even if the healthcare provider does not agree with those decisions (Catalano, 2003). The implication in the concept of autonomy has four basic elements; 1) the autonomous person is respected, 2) the autonomous person must be able to determine personal goals, 3) the autonomous person has the capacity to decide

on a plan of action, and 4) the autonomous person has the freedom to act upon the choice (Burkhardt & Nathaniel, 2002). Therefore, it is important in cultures where all individuals are considered to be unique and valuable members of society (Burkhardt & Nathaniel, 2002).

2) Beneficence

The principle of beneficence involves the duty "to do good". This principle is one of the oldest requirements for healthcare providers that view the primary goal of healthcare providers as acting in way that benefits patients (Catalano, 2003). In a nursing context, beneficence is considered a duty (Gibson, 1993) as it is one that requires nurses to do good for patient (Burkhardt & Nathaniel, 2002). The principle of beneficence refers to the moral obligation to act for the benefit of patients and establishes an obligation to help patients further their important and legitimate interest (Beauchamp & Childress, 1998). It has three major components: doing or promoting good, preventing harm, and removing evil or harm (Burkhardt & Nathaniel, 2002). The difficulty in implementing the principle of beneficence is in determining what exactly is good for another and who can best make the decision about this good (Catalano, 2003).

3) Nonmaleficence

The principle of nonmaleficence involves the duty "to do no harm". According to this principle, the nurse administrator refrains from doing harm to others and does not actively seek to improve the circumstances of individuals. Although the principle of nonmaleficence is closely related to beneficence, Beauchamp and Childress (2001) pointed that the duty to do no harm is viewed as a stronger obligation in health care. Following this principle, nurse administrators have a duty to create practice settings in which nurses can deliver safe, quality patient care consistent

with acceptable standards,. The nurse administrator's primary ethical responsibility is to reduce error, assure safe care for patients, and provide an adequate staff.

4) Justice

Justice is the obligation to be fair to all people (Catalano, 2003; Ellis& Hartley, 2004). The ethical principle of justice relates to fair, equitable, and appropriate treatment, which focuses on giving persons what they are due or owed (Burkhardt & Nathaniel, 2002). The principle of justice mandates that people are treated according to what is fair, due or owed. The application of justice principle in health care is concerned with the allocation of goods and services, called distributive justice (Gibson, 1993). Distributive justice states that individuals have the right to be treated equally regardless of race, gender, marital status, medical diagnosis, social standing, economic level, or religious belief (Catalano, 2003).

According to Burkhardt & Nathaniel (2002), decision about distributive justice is made on a variety of levels. The government is responsible for deciding policy about broad public health access issues. Hospitals and other organizations formulate policy on an institutional level and deal with issues such as how decision will be made concerning who will occupy intensive care beds and which types of patients will be accepted in emergency rooms. Nurses and other health care providers frequently make decisions of distributive justice on an individual basis such as nurses decide to allocate their time for each patient.

Philosophers have proposed six principles as a valid material principle of distributive justice: (1) to each person an equal share, (2) to each person according to need, (3) to each person according to effort, (4) to each person according to contribution, (5) to each person according to merit, and (6) to each person according to free-market exchange (Perelman, 1963 cited in Curtin, 1994)

4. Ethical concepts

Ethical concepts provide the foundation for ethical decision making. Ellis & Hartley (2004) stated that the most frequently addressed concepts were rights, autonomy, beneficence, nonmaleficence, justice, fidelity, veracity, and the standard of best interest. Ethical concepts in this study are selected from four ethical concepts for nursing practice proposed by Fry and Johnstone (2002). Those concepts compose of advocacy, accountability /responsibility, cooperation, and caring.

1) Advocacy

Advocacy is one of the fundamental values of professional nursing. Fry (1994 cited in Fry & Johnstone, 2002) defined advocacy as the active support of an important cause. In the legal context, advocacy refers to the defence of basic human rights on behalf of those who cannot speak for themselves (Annas, 1974 cited in Fry & Johnstone, 2002). In nursing, advocacy is also used to describe the nature of the nurse-patient relationship. It can be described in three ways (Fry & Johnstone, 2002). The first interpretation, the right protection model, views the nurse as the defender of patient rights in the healthcare system. The second interpretation, the values-based decision model, views the nurse as the person who helps the patient discuss his or her needs, interests and choices consistent with the patient's values and lifestyle. The third interpretation, the respect-for-person model, views the patient as a fellow human-being entitled to respect.

2) Accountability /responsibility

Responsibility means being able to answer for one's conduct and performance, and accountability refers to being answerable and culpable for an outcome. Therefore, accountability is related to both responsibility and answerability (Burkhardt & Nathaniel, 2002). Accountability can be defined as being answerable

for one's actions, and entails giving satisfactory reasons and explanations for one's actions or how one has carried out one's responsibility (Fry-Revere, 1992 cited in Fry & Johnstone, 2002).

Accountability is an important ethical concept for nurses both in nursing practice and nursing administration. In nursing practice, nursing accountability is focused on the nurse-patient relationship. The ICN Code of Ethics for Nurses (ICN, 2000 cited in Fry & Johnstone, 2002) stated that the responsibility of the nurses is to promote health, prevent illness, restore health, and alleviate suffering. In nursing administration, nurse administrators are responsible to patients, staff, organization, profession, and society.

3) Cooperation

Cooperation is a concept that central to nursing administration as nurse administrators have to cooperate with patients, subordinates, staff, and director in order to meet the goal of the organization. Concept of cooperation consists of active participation with others to obtain quality care for patients and reciprocity with those with whom nurses professionally identify (Fry & Johnstone, 2002).

4) Caring

Caring is defined as a complex, transcultural, relational process, grounded in an ethical, spiritual context (Ray, 2006). The ethical concept of caring is valued in the nurse-patient relationship and caring behaviors are often considered fundamental to the nursing role. Caring can be defined as a moral obligation or duty among health professional and is claimed as a moral foundation for the nursing ethic that will protect and enhance the human dignity of patients receiving healthcare (Fry & Johnstone, 2002).

Nurses' Code of Ethics

A code of ethics refers to a written list of a profession's values and standard of conduct, and provides a framework for members of the profession in ethical decision making (Catalano, 2000). In the nursing profession, nurses have developed codes for nurses that state nurses' responsibility to patients, co-workers, society, and the nursing profession, which can be used as guidelines in making ethical decisions.

The International Council of Nurses (ICN) developed The International Council for Nurses Code of Ethics to be a guideline for conduct for nurses all over the world   (Bandman& Bandman, 2002; Catalano, 2000). It was first adopted by the International Council of Nurse (ICN) in 1953. It has been revised and reaffirmed at various times since, most recently with this review and revision completed in 2005 (http://www.icn.ch/icncode.pdf).

Preamble

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health, and to alleviate suffering. The need for nursing is universal.

Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity, and to be treated with respect. Nursing care is respectful of and unrestricted by consideration of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.

Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

Elements of the code

The ICN Code of Ethics for Nurses has four principal elements that outline the standards of ethical conduct.

1. Nurses and People

The nurses' primary professional responsibility is to people requiring nursing care.

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse holds in confidence personal information and uses judgment in sharing this information.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction.

2. Nurses and Practice

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.

The nurse maintains a standard of personal health such that the ability to provide care is not compromised.

The nurse uses judgment regarding individual competence when accepting and delegating responsibilities.

The nurse at all times maintains standards of personal conduct that reflect well on the profession and enhance public confidence.

The nurse, in providing care, ensures that use of technology and scientific

advances are compatible with the safety, dignity, and rights of people.

3. Nurses and Profession

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.

The nurse is active in developing a core of research-based professional knowledge.

The nurse, acting through the professional organization, participates in creating and maintaining equitable social and economic working conditions in nursing.

4. Nurses and Co-workers

The nurse sustains a co-operative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

Thailand is also the member of The International Council of Nurses (ICN). The Nurses Association of Thailand developed the Code of Ethics in 1985 and revised it in 2003 (The Nurses Association of Thailand, 2003). .

1. The nurse has responsible for people who need nursing care and health care in order to promote health, prevent illness, rehabilitation, and decrease suffering. People who need nursing care and health care include individual, family, community, and country.

2. The nurse provides nursing service with compassion, respect for value of life, healthy, and well being of people.

3. The nurse has professional interaction with consumers, colleagues, and people with respect for human dignity and human rights.

4. The nurse always focuses on justice and equity in society.

5. The nurse always maintains a highest standard of nursing service.

6. The nurse is obligated to prevent harm to consumers' health and life.

7. The nurse assumes responsible to make people trust nurses and the nursing profession.

8. The nurse always maintains collaboration with others in order to promote the nursing profession.

9. The nurse assumes responsibility to herself as well as to others.

The patient's rights

In Thailand, the patient's rights was developed in 1998. Elements of The patient's rights are as follows:

1. The patient has a right to receive health care services as mentioned in the Thai Constitution.

2. The patient has a right to receive health care services from health care professions equally.

3. The patient has a right to obtain sufficient information about him/herself in order to make decision, unless in case of emergency treatment.

4. In case of crisis, the patient has a right to receive treatment immediately.

5. The patient has a right to know the name and roles of health care providers who care him/her.

6. The patient has a right to consult the external health care providers.

7. The patient has a right to guarantee of confidentiality about him/herself unless he/she has given permission to release information.

8. The patient has a right to consent or decline to take part in research.

9. The patient has a right to know his/her individual health record.

10. Patient's parent/surrogate has a right to decision on behalf of pediatric/ psychiatric patients.

Ethical decision making in nursing administration

Decision making in administration is a complex, cognitive process often defined as the process through which one identifies a set of feasible alternatives and chooses a course of action to resolve problems and capitalize opportunities (Lewis, Goodman, & Fandt, 2001; Marquis & Huston, 2003; Pierce, Gardner, & Dunham, 2002). Victor Vroom and Philip Yetton (Rue & Byars, 1995; Lewis et al., 2001) developed a basic model of decision making in administration composed of individual decision making, consultative decision making, and group decision making. This is very useful for administrators when decision is made by two or more than two persons. They expanded the three basic decision-making methods to five styles of possible decision participation. The decision styles can be arranged from the highly autocratic style (AI: A=Autocratic), in which the administrator decides alone, to the consultative style (CI: C= Consultative), in which the administrator consults the group before making a decision, to the group style (GI: G=Group), in which the administrator support a group decision making.

AI**:** The manager makes the decision alone, with little or no input from subordinates.

AII**:** The manager asks subordinates for information that he or she needs to make a decision, but still makes the decision alone. Subordinates may or may not be

informed of the decision. The role played by subordinates is clearly one of providing information as opposed to generating or evaluating alternative solutions.

CI: The manager shares the situation with selected subordinates and asks them individually for information and advice. The manager still makes the final decision, which may or may not reflect the   subordinates' influence.

CII: The manager meets with subordinates as a group to discuss the situation. Information is freely shared, although the manager still makes the final decision, which may or may not reflect the subordinates' influence.

GII: The manager and subordinates meet as a group and freely share decision making in nursing administration

Research studies related to decision making in nursing administration of nurse administrators were studied in terms of decision making skills, decision making behaviors, decision processes, and decision making model (Corcoran, 1981; Nagelkerk, 1988; Nagelkerk & Henry, 1990).

Corcoran (1981) surveyed 97 head nurses in the Army Nurse Corps and found that the number of workshops and conferences attended in management and/or nursing administration account for increased decision-making skills, administrative experience also plays a role in increasing scores on the decision-making behavior scale, higher decision-making ability scores were related to high scores for motivation to manage, and many nurses lacked the motivation to manage and needed to be more adequately prepared for their managerial roles. Nagelkerk (1988) analyzed the decision-making processes nurses in administrative positions used in unstructured strategic decisions for allocation of resources. The decision processes used by participants included identification of presenting problem through diagnosis of the courses of problems; development of novel, innovative solutions through searches of

information sources, screening and designing potential solutions; selecting the optimal solution from among the alternatives, and using all available resources.

In Thailand, there are some studies in administrative decision making that focused on Thai head nurse. Saminpanya (1996) studied decision-making behaviors of the head nurses in government hospitals in Bangkok Metropolis. She found that 1) the appropriateness of the decision-making behaviors of the head nurses as reported by them and as evaluated by their subordinates was at a low level, 2) the management pattern in the organization of the head nurses was consultative pattern, 3) the head nurses' activities covered the management function of planning, organizing, staffing, directing and controlling as well as giving nursing care and educational activities, 4) the major problems that the head nurses faced were related to personnel, patients, allocating equipment, communication, technique in giving nursing care and recording and reporting of nurses' activities, 5) the decision-making behaviors of the head nurses were consultative II and group II.

Ethical decision making is central to nursing administration. Nurse administrators stated that they had a moral responsibility to identify ethical issues related to their administrative practice (Sietsema and Spradley, 1987). However, research studies in this area are very limited. The studies focused on ethics knowledge, resource used, and factors influencing ethical decision making. Participants of the studies were the nurses in various levels of nursing administration from nurse manager, nurse supervisor, nurse executive, and director of nursing/ director of patient services.

Ethics knowledge is very significant to ethical decision making in nursing administration. Fonville (2002) used a constructivist paradigm to explore how nurse executives learned and used ethics knowledge in management decision making and

found that they maintained a focus on and allegiance to patient welfare throughout their careers. They had high regard for caring and competence because of the competence of these attributes to patient welfare. In addition, nurse executives professed fundamental loyalties to nursing values rather than institutional values.

There are various recourses used in ethical decision making of nurse administrators in the nursing administration arena. Those are personal values, The Patient's Bill of Rights, ANA Code for Nurses, institutional ethics committee, Ethical Conduct Standards, religion, nursing colleagues, administrative colleagues, and CEO/board of trustees (Borawski, 1994; Blancett & Sullivan, 1993; Camunas, 1991; Camunas, 1994a; Colvin, 1998; Sietsema & Spradley, 1987).

Even though the previous studies did not proove how nurse administrators made ethical decisions in dealing with ethical dilemmas in nursing administration, it can be assumed from those findings that ethical decisions made by nurse administrators especially head nurses focused on the organization, higher authorities, patients, and subordinates. Their decision-making style could be autocratic style, consultative style, and group style. In addition, ethical decision making included patient-centered decision making, bureaucratic-centered decision making, physician/ colleague-centered decision making, and consultative decision making.

1. Patient-centered decision making

1.1 Patient advocacy

An advocate is one who expresses and defends the cause of another. A patient advocate is an advocate for patient's rights. The health care system is complex and many patients are too ill to deal with it. Advocacy requires accepting and respecting the patient's right to decide, even if the nurse believes the decision to be wrong (Kozier, Erb, Berman, & Burke, 2000). Advocacy implies more than merely

speaking to other colleagues on the patient's behalf, there is a strong implication that the advocate or representative will have sufficient knowledge, power and authority to make a difference to what may happen to the patient (Willard, 1996). Nurses have always acted as patient advocates to some extent (Leddy & Pepper, 1993). Nurses can enhance their ethical practice and patient advocacy by clarifying their own values, understanding the values of other health care professionals, becoming familiar with nursing codes of ethics, and participating in ethics committees and rounds (Kozier, Erb, Berman, & Burke, 2000).

The over all goal of the patient advocate is to protect patient's rights. Actions to achieve this goal include informing, supporting, and mediating (Nelson, 1998; Kohnke, 1982 cited by Kozier, et al., 2000). A study by Promtape (2004) on nurses' moral actions in patient advocacy in Thailand found that nurse's roles in supporting and informing were at a high level with the highest mean scores among advocacy roles perceived staff nurses.

Decision to advocate for patients is supported mainly by the ethical principle of autonomy. The principle of autonomy is associated with the concept of respect for person and recognizes the patients' right to self-determination. Based on this principle, nurse administrator acknowledges the patient's right to hold views, to make choices, and to take actions based on patient values and beliefs.

1.2 Improving quality of care

The primary goal of the health care profession is to keep people alive and well or, if we cannot do this, to help them live with their problems and die peacefully (Tappen, Weiss, & Whitehead, 2004). Nurse administrators have an obligation directly to manage the quality of care for patients. In order to improve the quality of care, nurse administrators must determine what standards will be used to

measure quality of care in their units and then develop and implement quality control programs that measure results against those standards. All nurse administrators are responsible for monitoring the quality of the product that their units produce; in healthcare organizations, that product is patient care. Nurse administrators also must assess and promote consumer satisfaction whenever possible (Marquis & Huston, 2003). Many strategies can be used by nurse administrators to improve the quality of care, cognizant of rapidly changing quality control regulation, and proactively adjusting unit standards to meet these changing needs, encouraging nurses to seek maximum rather than minimum standards, and balancing between quality and cost containment (Marquis & Huston, 2003).

Decision to improve quality of care is supported mainly by ethical principles of beneficence and nonmaleficence. Beneficence entails doing good in the active sense while nonmaleficence refers to the non-infliction of harm. Acting on these principles can mean either helping patients gain what is beneficial to them and taking action that prevents or reduces the risk of harm to patients (Fry & Johnstone, 2002). Based on these two principles, nurses must actively promote patients' welfare and well being by providing good care, and reduce risks which could cause physical, psychological or spiritual injury to patients (Fry & Johnstone, 2002). These two principles play an important role in nursing care. Chantagul (2000) studied nurses' moral actions experienced by hospitalized adult patients and found that the patients' demand for nurses' moral actions of beneficence consisted of the need for nurses to be concerned and take care of the patients (66.67%), and the need for help from nurses (20%). The patients' demand for nurses' moral action of nonmaleficence was to do no more harm/pain (92.22%), whereas nurses' moral actions of beneficence were to help the patients (90%) and to be concerned and take care (47.78%), and nurses' moral

actions of nonmaleficence were to cause no more harm/pain (94.44%).

2. Bureaucratic-centered decision making

As an employee of the hospital, nurses and nurse administrators are expected to represent and advocate for the hospital administrator; interpret and implement appropriate hospital policies and procedures in the care of patients and the management of the nursing unit in rendering this care (Beaugard, 1990).

2.1 Adhering to the policies of the organization

Policies are standards that deal specifically with conduct or plans reduced to statements (Marquis & Huston, 2003). Within the organization, policies refer to rules and regulations that regulate aspects of an employee's position (Grohar-Murray & DoCroce, 1992). Head nurses, as a unit manager, must determine how those policies will be implemented on their units. After policy has been formulated, the leadership role of managers includes the responsibility for communicating that policy to all who may be affected by it (Marquis & Huston, 2003). Head nurses and their staff have to follow the policies/regulations of their organization. Therefore, following the policies of the organization can be used by head nurses in making ethical decisions. Murphy (1978, cited in Gibson, 1993) stated that each ethical issues require an independent ethical judgment and a nurse must be able to engage in ethical reasoning that is based on moral values and principles that are separate from institutional norms and authority, but nursing has espoused the values of unquestionable obedience to authority and strict adherence to fixed rules and regulations (Murphy, 1978 cited in Gibson, 1993).

2.2 Following higher authorities

In the bureaucratic context, the value is for operational efficiency based on history and tradition. Implementation of change is through use of routines as

determined by policies and procedures that lead to predictable outcomes and only slight adaptations to operations (Tomey, 2004).

A person's response to authority is conditioned early through authority figures and experiences in the family unit (Marquis & Huston, 2003). In the hospital, the hospital director is perceived as the most powerful person. The nursing director is the highest position in nursing department and usually is more capable and competent than head nurses. In addition, regional hospitals are bureaucratic organizations. Within the bureaucratic hospital hierarchy, the subordinates tend to follow the superiors' opinions. Therefore, head nurses made ethical decision by following the hospital director and the nursing director. Not surprisingly, head nurses decided to follow higher authorities because Thai people are socialized very early to follow superiors or higher authorities. They are socialized to follow their parents when they were young, follow their teacher when being a student. Decision making which goes against the higher authorities may result in negative consequences such as in relationships and career development. A study by Camunas (1994) showed that the most important factors influencing decisions that have ethical implications were the superiors of the nurse executives and the politics within the institution. These two factors can be either facilitating or inhibiting, depending on the attitudes and behaviors of the people involved.

3. Physician/colleague-centered decision making

3.1 Maintaining good relationships

Conflict is inherent in all organizations. In nursing, managing conflict is an important part of the nurse administrator's job (Sullivan & Decker, 2005). Nurse administrators are responsible for not only managing conflict created by changes external to the organization, but also managing interpersonal conflict created within

the organization and among a variety of health care workers such as patient/family-healthcare team, nurse-other healthcare professions, and staff member-supervisor. Sullivan and Decker (2005) mentioned that conflict management begins with a decision regarding if and when to intervene. Failure to intervene can allow the conflict to get out of hand, whereas early intervention may be detrimental to those involved, causing them to lose confidence in themselves and reduce risk-taking behavior in the future.

Conflict management is a difficult process and unresolved conflicts have potentially harmful effects on people involved such as difficulty in concentration, anxiety, sleep disorder, withdrawal, and poor interpersonal relationship (Sullivan & Decker, 2005; Tappen, Weiss, & Whitehead, 2004). Therefore, nurse administrators and staff nurses must be concerned and committed to resolving conflict by being willing to listen to others' positions and to find agreeable solutions (Sullivan & Decker, 2005).

Several strategies can be used by nurse administrators to manage conflict. Those are confrontation, negotiation, collaboration, compromise, competing, avoiding, accommodating, suppression, withdrawal, smoothing, and forcing (Sullivan & Decker, 2005). In nursing, however, the goal in dealing with conflict is to create an environment in which conflicts are dealt with in as collaborative a way as possible rather than in competition in order to be of greatest benefit to the people involved (Tappen, Weiss, & Whitehead, 2004). Resolution of a conflict, when it is done well, can lead to improved working relationships, more creative methods of operation, and higher productivity (Tappen, Weiss, & Whitehead, 2004).

Decision to maintain good relationships with physician/colleague is supported mainly by the ethical concept of collaboration. Based on this concept,

nurses and nurse administrators participate with other health team to obtain quality of care for patients. The study by Intawong (2005) found that two out of ten participants who were nurses working in a provincial hospital in southern Thailand and proving care for patients during The tsunami disaster made ethical decisions by focusing on relationship for cooperation.

3.2 Following physician's orders

As a hospital employee and a registered nurse and nurse administrator, it is also expected that she/he implement the medical treatment determined by physicians, yet at the same time question any such treatment that she/he considers inappropriate (Beaugard, 1990). This role necessitates the nurse having knowledge and expertise about medical and pharmacological treatment, the ability to make observations about the patient's condition and ongoing response to illness and treatment, and the ability to synthesize these data and make judgments about the implementation of the medical treatment ordered by the doctor (Beaugard, 1990). This role affects nurses and nurse administrators in decision making related to physician's order/treatment. In addition, nurses report to and are accountable to physicians because of the hospital hierarchy. Therefore, they tend to make their decision by following the physicians' order, even though nurses are held accountable as patient advocates and hospital representatives not to follow the doctor's orders if the nurse believes that these orders are inappropriate for the patient's well-being.

4. Consultative decision making

Consultation differs from collaboration in that the goal of consultation is to provide advice and assistance with problem solving, the goal of collaboration is to work together to jointly define and resolve issues. However, effective consultation uses collaboration as the means to achieve the goal of solving problems and

developing innovations (Lancaster, 1999).

In dealing with ethical dilemmas, it is difficult for nurse administrators to decide what is right or wrong. Feeling toward ethical dilemma reflected by nurses were any choices, any actions inducing stress; uncertainty with the selected choices; feeling guilty over what had been done; and frustration with a decision (Chaleawsak, 2001). Therefore, nurse administrators have to consult someone who has higher experience in the organization to guide their ethical decision making.

Sietsema and Spradley (1987) surveyed chief nurse executives and found that resources most often used in ethical decision making were administrative colleagues, personal values, and nursing colleagues. Camunas (1994a) surveyed 500 nurse executives and found that personal values, administrative colleagues, and nursing colleagues were used as resources for ethical decision making. More than half (57%) of the nurse executive respondents did not perceive that an administrator must ultimately rely on some document, law, or rule when making decision. Similar to the study by Borawski (1995), resources most often used in ethical decision making of chief nurse executives were nursing colleagues, administrative colleagues, and personal values.

Critical incident analysis technique

Philosophical perspective

In the 1950s, many scientific researchers focused their studies on human behavior. Behaviorists sought to analyze and synthesize observations into a set of relationships that could be quantified, validated, and generalized independent of conscious experience. The research of this time was to facilitate procedures for

selecting, training, classifying, and evaluating performance standards for specific occupational groups. Critical incident technique emerged from assumptions that the scientific method could facilitate the observation and categorization of all human behaviors (Byrne, 2001). It was devised by Flanagan and various collaborators during World War II in order to develop procedures for the selection and classification of flight crews (Flanagan, 1954). As there was an urgent need to train flight crews in a very short time and to understand the specific behaviors that led to the success or failure of a mission, traditional research methods were found to be too complex and needed too much time (Kemppainen, 2000).

When it was first published in the Psychological Bulletin in 1954, Flanagan pointed out that the critical incident analysis technique consisted of a set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles. This technique outlined procedures for collecting observed incidents having special significance and meeting systematically defined criteria. In addition, he defined an incident as any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act. To quality as critical, the incident must occur in a situation where the purpose or intention of the acts seems clear to the observer and consequently definitive as to leave little doubt concerning its effects.

Critical incident technique is suitable to explore ethical dilemmas and ethical decision making in nursing administration because ethical dilemma is a critical incident for nurse administrator. Nurse administrators believe that they have a moral responsibility to identify ethical problems related to their administrative practice and they experience ethical dilemmas in their practice (Camunas, 1994a; Camunas,

1994b; Sietsema & Spradley, 1987).

The assumption underlying critical incident analysis is that inferences can be made about a person's general competence on the basis of the person's performance, the general aim being to classify effective or ineffective behavior (Rich & Parker, 1995). It could be something good or positive, or could be a situation where someone has suffered in some way and, therefore, may be seen as negative. Even though ethical dilemmas present moral conflict causing head nurses to feel unhappy, guilty, angry, frustrated, and powerless, ethical decision making, however, may result in either desirable or undesirable alternatives. Thus, critical incident technique is suitable to explore ethical dilemmas and ethical decision making of head nurses.

Critical incident analysis, as qualitative research, is similar to phenomenology in that it focuses on human experience. The aim of phenomenology is the description of an experience as it is lived by the participants under study and interpreted by the researcher. The researcher's experiences, reflections, and interpretation during the study constitute the data, and the outcomes are based on the researcher's interpretations and perceptions of reality (Burns & Grove, 2001). In addition, assessing the most important relationships across the components of the essence, and sufficient data must be collected to ensure all relevance essences that contribute to the phenomenon are included (Arslanian, 1998). Thus, using phenomenology in exploring ethical dilemmas and ethical decision, we can hope to understand and explain the meaning of these experiences to head nurses. In contrast, critical incident is an incident in which the purpose or intent of the act is clear to the observer and the consequences are definite. Critical incident technique captures the participant's own reality by fostering such reflection. The critical incident tool includes short, clear instructions to the participant and can result in a vivid exemplar that portrays the heart

and soul of the event from the participant's perspective (Brookfield, 1990b cited in Rosenal, 1995). In addition, analysis in critical incident technique usually takes the form of inductive classification of the information into categories which enables descriptions of this information to be made at different levels of specificity or generalization (Cox, Bergen, & Norman, 1993).

Methodology

Flanagan (1954) identified five steps involved in critical incident analysis technique. The first step is determining the general aim of the study. According to Flanagan, the general aim of an activity should be a brief statement obtained from the authorities in the field which expresses in simple terms those objectives to which most people would agree. The second step is to plan and specify how factual incidents regarding the general aim of the study will be collected. This stage involves addressing the issues of who should be informants, which situations should be observed, and what activities should be noted. The third step is to collect the data (either through interview or written up by the observer). The fourth step is to analyze the data as objectively as possible. The fifth and final step is to interpret and report the requirement of the activity being studied.

This method uses factual accounts of actual events in which the purpose and consequence of the behaviors are clear, focusing on the specific reason for actions and behaviors. In addition, it is recognized as a useful method where the subject matter is complex and when investigators want to understand the reasons for certain behaviors (Fitzpatrick & Boulton, 1994 cited in Allery, Owen, & Robling, 1997).Thus, it is suitable in exploring ethical dilemma and ethical decision making in nursing administration.

Data collection in critical incident technique differs from other qualitative

methods in that respondents are not asked to relate a broad experience or to interpret their interaction, but merely to describe a focused incident.

Validity and reliability

Validity refers to the instrument's ability to measure what it is supposed to measure. However, Martin and Mitchell (2001) suggested that the traditional notions of validity are about methods and not much about people. Critical incident technique differs from other self-report approaches in that it focuses on something specific about which the respondent can be expected to testify as an expert witness (Von post, 1996). In the critical incident technique, the researcher can ask the respondent in order to confirm what the data is supposed to measure.

Analysing critical incidents involves an interpretive approach with similar contents being coded and categorized. The process requires identifying and then clustering similar themes or concerns, naming the themes or concerns as clearly as possible, and nothing similarities and differences between the findings and related literature (Rosenal, 1995).

The categorization of critical incidents can be noted as very subjective and difficult; thus it is possible that different people will categorize them differently (Martin & Mitchell, 2001). However, to solve this problem, independent raters can be used to classify data in order to establish inter-rater-reliability (Martin & Mitchell, 2001).

Application of critical incident technique in nursing

The critical incident technique has been used in many disciplines and widely used in health services research. For example, in medicine, the critical incident technique was used to describe the complete range of factors which doctors recognize as changing their clinical practice and provide a measure of how often education is

involved in change (Allery, Owen, & Robling, 1997). It was also used to explore the quality of the dilemma experienced by physicians when prescribing benzodiazepines (Bendtsen, Hensing, McKenZie, & Stridsman, 1999).

1. In nursing research, the critical incident technique is widely use in many areas. In nursing education, the critical incident technique is used to explore the learner's world in two studies. In Rosenal's study, novice nurses evaluated the impact of their enriched orientation program and reflected on their initial experiences in the profession, while staff nurses who served as preceptors described moments that made them feel good about precepting and the times when they felt discouraged or frustrated (Rosenal, 1995). The researcher mentioned four potential ways of using the critical incident technique in educational practice: to foster learners' self reflection, to inform educators of the reality and impact of nurses' experiences, to conduct learning needs assessments, and to acquire examples useful in teaching. In another study on nursing care quality research, Kemppainen (2000) reviewed previous applications of the critical incident technique to the study of health care quality and proposed that critical incident technique offers the following important advantages to the study of nursing care quality: identifying patients' experiences in health care settings, exploring nurse-patient interactions, and identifying patient responses to illness and health care treatment.

Application of the critical incident technique as a research method in exploring ethical dilemmas and ethical decision making is just beginning to appear in nursing literature. From literature reviewed, the critical incident technique was used in only the study of Von Post (1996), which explored ethical dilemmas in perioperative nursing practice through critical incidents. In this study, ethical dilemmas in perioperative nursing practice were explored through critical incidents. The aim of the

study was to elicit the ethical dilemmas that arise in perioperative nursing practice and addressed what incidents in the experience of Swedish anaesthetic and operating theatre nurses were encountered as ethical dilemmas. The participants, 48 anesthetic nurses and 76 operating theatre nurses, were asked to describe critical incidents. Findings gave four domains of ethical dilemmas which arose: value conflicts in the intraoperative phase of surgery; the patient's right to self determination; caring for the patients; and the allocation of scarce resources and the demands of increased effectiveness.

2. In nursing practice, the critical incident technique has been widely used as a method of data collection, and has been defined as a 'snapshot' view of the daily work of nurses (Clamp, 1980 cited in Martin & Mitchell, 2001).

3. In nursing education, Rosenal (1995) presented four potential ways in which nurses can use critical incidents in educational practice; to foster learners' self-reflection, to inform educators of the reality and impact of nurses' experiences, to conduct learning needs assessments, and to acquire exemplars useful in teaching.

Limitation of Critical incident analysis

One major disadvantage of the use of critical incidents is that when instructions are unclear, subjects may be confused and unclear about what the researcher is interested learning. In this study, that was not a problem. The critical incident was tested and found to be satisfactory to elicit the information that was need.

Another concern of the critical incident is that the question be framed in such a manner that they do not intimidate or alienate the respondents or induce anger based on the circumstances. In this study the nature of the problem is such that subjects may indeed feel threatened by exposing this kind of information about themselves. In this

study, the participants were head nurses who willing to be interviewed.

In conclusion, the critical incident technique is very suitable for exploring ethical dilemmas and ethical decision making in terms of philosophical orientation, methodology, validity and reliability, and application in nursing research.