CHAPTER 4

FINDINGS AND DISCUSSION

This phenomenological study aimed to describe and explain ethical dilemmas experienced by nurses in intensive care units. Ten participants were registered nurses at two public hospitals in Medan, Indonesia. Data were collected by individual in-depth interviews. Colaizzi's method was modified to analyze the data.

1. Findings

1.1 Characteristics of Participants

Ten participants were selected based on the inclusion criteria and their willingness to participate in this study and they signed a consent form before the interview was conducted. Nine participants were female and one was male. Their ages ranged from 30 to 41 years old and the mean of their age was 34.9 years. Five participants were Muslim and the other five participants were Christian. They had worked in an ICU for 1 to 10 years and the mean working experience in ICU was 6.1 years. All participants were diploma graduates. Six participants were staff nurses while four participants were head nurses. None of them had training in ethics after they graduated from diploma in nursing school.

A brief description of each participant follows: Participant A was in the mid-30s and had worked in an ICU for 1 year. Participant B was in the early 40s and had worked

in an ICU for 7 years. Participant C was in the mid-30s and had worked in an ICU for 7 years. Participant D was in the mid-30s and had worked in an ICU for 6 years. Participant E was in the early 30s and had worked in an ICU for 7 years. Participant F was in the early 30s and had worked in an ICU for 4 years. Participant G was in the early 40s and had worked in an ICU for 4 years. Participant H was in the mid-30s and had worked in an ICU for 10 years. Participant I was in the late-30s and had worked in an ICU for 4 years. Participant J was in the early 30s and had worked in an ICU for 9 years.

Table 4.1 Characteristic of Participants

Age	
Range	30-41
Mean	34.9
Sex	
Female	9
Male	1
Religion	
Muslim	5
Christian	5
Education	
Diploma in Nursing	10
Years in ICU	
Range	1-10
Mean	6.1
Position	
Head Nurse	4
Staff Nurse	6
Training in Ethics	None

1.2 Meaning of Ethical Dilemma

Two themes of the meaning of ethical dilemma according to the participants were identified: (1) how to choose between two choices, and (2) a problem that cannot be resolved.

(1) How to Choose between Two Choices

As a nurse, the participant was in conflict when she was confronted with two difficult options to choose between. Eight participants described the meaning of ethical dilemma as how to choose between two choices. They perceived that when dealing with a situation which they called an ethical dilemma, they had two choices to choose between. However, they were uncertain which choice was better. As one participant stated:

> *It is an uncertain situation when facing a difficult problem. It means difficulty to make decision from two choices which can produce good and bad outcomes.*
>
> (Participant J)

One participant stated:

> *It means difficulty to make a decision when I face two options that I don't know which is the right option I should choose.*
>
> (Participant C)

(2) A Problem that cannot be Resolved

Two participants described the meaning of ethical dilemma as "a problem that cannot be resolved" because they thought that it was difficult for them to resolve it. They explained that the problem was difficult because they lacked power and knowledge

regarding ethics and ethical decision making. In addition, there were few clinical protocols as a guide for practice. When they were asked to describe the meaning of ethical dilemma, one participant stated that:

> *Ethical dilemma is a problem which cannot overcome and can risk for others. It is a problem that can not be resolved and cause negative impact. I studied ethics many years ago and my knowledge was inadequate to deal with the problem.*
>
> (Participant D)

Another participant stated:

> *It is a problem that cannot be resolved by me and it is a conflict. It is a difficult situation because I do not have knowledge to handle it and as a staff nurse, my power is limited.*
>
> (Participant F)

1.3. Ethical Dilemmas

Five themes of ethical dilemmas experienced by nurses in intensive care units in Medan were identified: (1) continue or stop treatment, (2) who should get the ventilator, (3) want to take an action but beyond authority, (4) to tell or not to tell the truth, and (5) acting as patient advocate for patients versus maintaining relationships with the health team.

(1) Continue or Stop Treatment

Five participants stated "continue or stop treatment" was an ethical dilemma they experienced in intensive care units. They perceived that there was a conflict between their responsibility to help patients and the moral obligation not to take human life. They felt

that when a patient's family wished to discontinue treatment of the patient because the family could not afford the cost of care, they were in a dilemma. One participant reported a case of discontinuation of treatment which came from the need of patient's family. She had a conflict between continuing the treatment which she believed was good for the patient and discontinuing of the treatment as desired by the patient's family, which she believed was not beneficial for the patient. She stated that:

> *A severe asphyxia patient was in ICU for a couple days and there was no progression. Patient's family knew that the patient was still alive because of ventilator assistance. The family decided to stop the ventilator. "Let the patient die. We could not afford for the cost." It was a dilemma for me. I believed the treatment must be continued because I had duties to help the patient to survive. If the patient would die, it was not our will. But, I had to follow the patient's family. Why they didn't want to continue the treatment? Even though the possibility of being survive for the patient was low, I did not want to disconnect the tube. It seemed like I killed the patient.*
>
> (Participant D)

Another participant reported a case of discontinuation of treatment which came from a "do not resuscitate" (DNR) order. She was in conflict because she believed that, according to her religion, it was not her duty to facilitate the death of her patient although at the same time she perceived that if the treatment was continued, it would just prolong the patient's suffering. She stated:

> *I had a conflict when looking at the patient's condition... ventilator and administration of medicines such as dopamine were ordered to stop. If I stopped the ventilator and medicines, it meant I killed the patient. It is conflicting with my beliefs which my religion is not allowed us to take people's life. But if I continued it, it seemed that patient was suffering.*
>
> (Participant E)

(2) Who Should Get the Ventilator?

Five participants perceived "who should get the ventilator" as an ethical dilemma when they took care of critical ill patient in intensive care units. This dilemma resulted from the limited number of ventilators in the intensive care units. When two patients needed two ventilators but only one was available, participants were forced to make a decision as to which patient would receive the ventilator. They thought that every patient had a right to good treatment and all should be treated equally. One participant reported:

> *There were two patients, head injury and brain tumor patients, admitted to ICU. Head injury patient was coma, had high level of PCO2, and RR 32 times per minutes. Brain tumor patient was also coma, RR 26 times per minutes, and sometimes he had apnea attack. They needed ventilator at the same time. We just had only one ventilator. At that time, it was difficult to decide which patient should get the ventilator. Which patient I had to help first?*
>
> (Participant C)

(3) Want to Take an Action but Beyond Authority

Four participants perceived "want to take an action but beyond authority" as an ethical dilemma when providing care for critically ill patients in intensive care units. Participants felt that they had a professional obligation to save their patient's life in an emergency situation, however, sometimes they found themselves in a difficult position to initiate any action to save their patient because of a lack of authority. One participant reported:

> *I had a situation when the patient's blood pressure was dropped and I wanted to take action to help the patient immediately but I could not do it without reporting to doctor first...I had to wait for order from doctor because it was beyond my responsibility.*
>
> (Participant F)

Participants also stated that they often had to do something to alleviate or reduce a patient's suffering but they faced a problem when they wanted to take an action due to lack of power. One participant stated:

> *The critical patient had to wait for long time for treatment. I was in a very uncomfortable position because I knew that the patient had right for better treatment...I wanted to help him by taking an action. If I took an action that was doctor's responsibility which I knew it was beyond my job description I had to break the rule but if I was just waiting, the patient condition was getting worst and worst. So what should I do? Taking an appropriate action which beyond my responsibility or just letting the patient suffer?*
>
> (Participant J)

(4) To Tell or Not to Tell the Truth

To tell or not to tell the truth was another ethical dilemma experienced by four participants during their work in intensive care units. They had a conflict: if they told the truth, some truth was bad news which could harm the patients, if they did not tell the truth they felt guilty because of conflict with personal values. One participant reported:

> *A patient's husband asked me not tell his wife that their baby died during caesarian section. He was afraid it would make his wife's condition worst. So at that time it was difficult for me to make a decision. Then his wife came to me and asked about her baby. It was difficult whether or not to tell the truth to her. Her husband asked me not to tell her. He wanted to tell his wife at their home. If I didn't tell her, I felt guilty because it conflicted with my values. Meanwhile, doctor also suggested not telling the patient because he was worried that she would be shock and it would affect her condition.*
>
> (Participant A)

Another participant stated truth-telling would create a dilemma when they considered the patient/family's right to information. She was in conflict between

respecting the right to information, and acting professionally by not discussing things with a patient or family that was the job of a different professional. One participant described:

> *Craniotomy patient's family asked me about patient's prognosis and the opportunity of being survived. The patient was coma and ventilator was on. BP was under normal level and unstable, no urinary output. I could not tell the truth about patient's condition to the family because it was beyond my responsibility. I knew that it was family's right to know about the patient's condition. So I was confused. Should I tell the truth? In fact, doctor did not tell the truth but only reassure the family, meanwhile the family kept asking me.*
>
> (Participant F)

(5) Acting as Patient Advocate versus Maintaining Relationships with Health Team

Three participants perceived "acting as patient advocate versus maintaining relationships with health team" as an ethical dilemma they had experienced when they took care of critically ill patients in intensive care units. Sometimes they thought that the treatment that was prescribed by other health team members was inadequate for their patients. Participants perceived that they had to promote their patient's best interests or safeguard a patient's right to quality health care. At the same time, they felt that if they did not carry out the treatment already prescribed by other health team members, it would produce a risk of poor relationships with other health professionals. One participant reported:

> *...patient was poor and could not afford for prescribed drug. I was in a difficult situation whether I administered the drug or not. If I didn't administer it, it was doctor's order and he might be angry with me and it*

would produce bad relationship with him. I needed to talk to doctor about this and asked him to prescribe another drug that could be afforded by the patient, but I was afraid...

(Participant J)

Another participant felt that she had to be an advocate for her patients. She experienced a dilemma when patients were treated inappropriately. As patient advocates, critical care nurses are concerned about how to promote the interests of their patients. One participant commented:

Toradol 30 mg was prescribed for my patient. Based on my experience, patient with this condition didn't need high dose of analgesics. Toradol was expensive. I thought it was unnecessary. A cheaper analgesic like Antalgin was enough. What should I do? Administer it or change with the cheaper one? If I changed it, the doctor would be angry with me and it would produce bad relationship with him.

(Participant F)

1.4 Feelings of Ethical Dilemma

The four themes of feelings of ethical dilemmas experienced by nurses in intensive care units were: (1) confusion, (2) discomfort, (3) uncertainty, and (4) powerlessness.

(1) Confusion

When confronting ethical dilemmas in taking care of their patients, five participants felt that the situation made them confused. They were confused in making a

decision because they had to choose between options but they were unsure which one was the best choice for their patients. One participant stated:

> *I was confused. What should I do? I was confused to make a decision, to choose an option which was the best for my patient.*
>
> (Participant F)

(2) Discomfort

Four participants were uncomfortable when dealing with ethical dilemmas. When ICU nurses were in dilemmatic situation, sometimes they didn't know what to do. This situation made them uncomfortable, especially when a decision had to be made promptly in an emergency. They were uncomfortable because they were expected to carry out some intervention to help the patient, but they did not take action. They did not want to break rules by performing an action without a doctor's order, but they wanted to help the patient. One participant reported:

> *A patient with respiratory failure admitted to ICU. Lab result showed that PCO2 level was high and it was indication for ventilator assistance. Doctor could not be contacted. It was an emergency situation and I wanted to take an action to safe patient's life. Nurses were not given authority to perform ETT insertion. I was uncomfortable: performing an intervention beyond my authority or letting the patient die.*
>
> (Participant B)

Three participants felt uncomfortable because they had to do something which was not their responsibility, or they were forced to do another profession's duties. One participant supported this statement:

A patient with dropped BP and I believed that the patient needed fluid therapy to prevent shock...if I did not give the fluid therapy, the patient would become e worst but it was not my responsibility and I might do the wrong thing. I felt very uncomfortable. It was not my work, but I was forced to do it. ICU nurses are demanded to work like that.

(Participant H)

(3) Uncertainty

Three participants felt uncertainty when confronted with ethical dilemmas in intensive care units. Feelings of uncertainty had many causes. As ICU nurses, they are supposed to work in a quick, precise manner in order to handle critical conditions of the patients appropriately. However, because of a lack of authority, sometimes they were in a difficult situation whether or not to take an action which was beyond their responsibility. Another reason why the participants felt uncertainty was a lack of clinical guidelines to guide them in making decision. This put them in an uncertain situation. One participant reported:

A terminal cancer patient was admitted to ICU from medical ward. I thought that the patient should be brought close to his family, not admitted to ICU. It would give more burden and stress to his family and also the cost was high, if admitted. But doctor suggested transferring him to ICU. There was no written clinical guideline for admission of patient to ICU. I felt uncertainty. I wanted to refuse but I could not.

(Participant B)

(4) Powerlessness

Powerlessness was another feeling experienced by three participants when confronting ethical dilemmas. Participants were powerless when the resolutions for the dilemmas were not within the nurse's ability to perform. One participant stated:

I took care of a severe asphyxia patient. After one week, there was no improvement. The family asked to bring the patient home. I thought the patient still needed critical care in ICU. I felt powerless because I could not help the patient anymore in ICU since the family has a right to bring the patient home. There was no ability because it was patient's right to go home.

(Participant C)

1.5. Resolutions of the Ethical Dilemmas

The four themes of resolutions of ethical dilemmas experienced by ICU nurses were: (1) consultation with doctor and/or nurse supervisor, (2) discussion with colleagues, (3) performing professional intervention, and (4) religious practices.

(1) Consultation with Doctor and/or Nurse Supervisor

Consultation with doctor and/or nurse supervisor was stated by seven participants as resolution they used to deal with an ethical dilemma when they could not resolve it by themselves. Participants stated that sometimes they needed to seek help from someone who had more authority and competency for resolution of ethical dilemmas. They perceived that doctors and nurse supervisors were the appropriate resources. They also thought that doctors and nurse supervisors had the decision-making authority to resolve the dilemmas. One participant stated:

I took care of a metastatic cancer patient. There was an order to put ventilator on him. I thought it did not help much. It just prolonged suffering for the patient and also produced high cost. I consulted with the attending doctor and discussed the dilemma with him. He convinced me to follow the order for overcome the respiratory problem and reassure the family. I came up with a decision to put ventilator on.

(Participant F)

Another participant also consulted with a nurse supervisor to resolve the dilemmas. She perceived that the nurse supervisor had more authority and was a competent person who could help them. As she stated:

> *Streptokinase was prescribed for an MI patient who got attack 12 hours ago. This drug was very expensive. I thought it was too late to administer it because its effectiveness was less after MI attack 4-6 hours. The patient was not rich. I came to my supervisor and discussed the problem and we came up with the solutions. The drug was not given to the patient and my supervisor told me that she would talk to doctor about this problem.*
>
> (Participant J)

(2) Discussion with Colleagues

Six participants stated that they discussed with their colleagues ways to resolve the ethical dilemmas they had experienced. They perceived that it would help them and they stated that their colleagues were always available and willing to discuss a problem with them. Participants reported that they tended to discuss the resolutions of ethical dilemmas with their seniors or other nurses who had a close relationship. They believed that senior nurses had more clinical experience and they were a good resource for consultation to resolve ethical dilemmas that were encountered. As one participant stated:

> *A critical patient admitted to ICU and he needed prompt treatment. There was no doctor at that time. I was in a dilemma to initiate treatment or not. And then I discussed with my colleague and asked her the way out of this problem. She suggested me to initiate the treatment promptly and then reported to doctor.*
>
> (Participant J)

(3) Performing Professional Intervention

Performing professional intervention was another resolution used by five participants to deal with ethical dilemmas. They performed nursing actions that they believed would be helpful for their patients. They decided that they could not stop caring when they were facing ethical dilemmas. Even though they had to choose difficult options, they did take an action to protect the patient, and to support the patient psychologically. As one participant mentioned:

> *I took care of a patient whom experiencing pain. He was very poor and could not afford to prescribed analgesics. I wanted to help him to relieve his pain but I could not give the analgesic. So how could I help the patient? Yea, I kept helping him by doing the distraction. It might be helpful.*
>
> (Participant I)

Another participant described how they had taken an action immediately in order to deal with a critical situation. As the participant commented:

> *Two critical patients who had respiratory problem needed ventilator assistance. At that time, it was difficult to decide which patient should get the ventilator. Which patient I had to help first? I gave ventilator to head injury patient and the other patient we helped by doing Ambu. This decision was based on laboratory findings which indicated the head injury patient had very high PCO_2 level.*
>
> (Participant C)

(4) Religious Practices

Religious practices were used by three participants to deal with ethical dilemmas. Participants perceived that religion could help them to resolve the dilemmas because religion provides some rules and beliefs which direct them in answering questions about

the nature of human life. When dealing with a dilemma concerning end of life, some participants stated that they prayed before they took an action or made a decision. One participant stated that when she faced a dilemma of whether to stop or continue treatment, she resolved the dilemma by praying to Allah and asking for the best solution. She said:

> *A stroke patient admitted to ICU. He had stayed in ICU for 3 weeks, but there was no improvement. The patient was still coma. Ventilator was on. The family asked to bring the patient home. I could not stand to pull the ventilator out, also infusion, and catheter. The family insisted to stop the treatments. So what should I do? Before I made decision I did sholat (praying) and asked to Allah to give me the best solution for this problem.*
>
> (Participant A)

The religious approach has another benefit when ICU nurses use it in dealing with ethical dilemmas which is that it can also relieve distress. According to participants, discussing their problems with a religion leader (scholar) and performing religious activities such as *sholat* (praying) were ways of reducing an uncomfortable feeling resulting from a dilemmas. As one participant stated:

> *I did not tell the truth to the patient. I was being forced to tell a lie to her. I tried to forget it and I prayed to Allah and wish Him to forgive me for mistakes I had done. After praying I felt more peaceful.*
>
> (Participant A)

2. Discussion

2.1 Meaning of Ethical Dilemmas

Intensive care unit nurses in this study who provided care for critically ill patients encountered many ethical dilemmas. When they were asked to describe the meaning of ethical dilemma, they described it as a problem that could not be resolved and a difficulty in choosing between two choices. Their meanings of ethical dilemma were similar to the definition of ethical dilemma defined by David and Aroskar (1991), who defined ethical dilemma as situations involving conflicting moral claims and giving to rise to such questions as "what ought I to do?", "what is the right thing to do?", and "what harms and benefits result from this decision or action?". Similarly, Ericksen (1989 cited by Common & Baldwin, 1997) defined an ethical dilemma as a problem of two moral claims. Two or more ethical principles, personal values or responsibilities are in conflict.

In this study, participants perceived that it was difficult for them to solve or to choose because of a lack of knowledge or skills for addressing ethical dilemmas, due to having no ethics course after they graduated from diploma nursing school. In addition, the ethics teaching given to diploma graduates was limited and did not focus on dealing with ethical dilemmas. Exposure to ethics courses after graduation from diploma nursing is important for nurses because the curriculum of diploma nursing in Indonesia includes ethics, but only an introduction, and it addresses few ethical concepts. It does not cover how to deal with ethical dilemmas or ethical decision making. In a study of ethical conflicts experienced by certified nephrology nurses practicing in dialysis settings, Redman, Hill, and Fry (1997) found that participants who were exposed to an ethics

course after their basic nursing preparation were more likely to experience the conflicts described as an ethical dilemma because they had the ability to identify an ethical dilemma.

2.2. Continue or Stop Treatment

Issues of withholding and withdrawing of treatment in an ICU are commonly found. The decision not to employ measures or discontinue treatment is always difficult and stressful for ICU nurses. Islam has a rule about human life. The Quran teaches acceptance of life, not rejection or withdrawal. The Qur-an says (Holy Qur-an, Surah Al-Israa verse 33, translated by Ali, 1982):

> "Nor take life - which Allah Has made sacred - except For just cause. And if Anyone is slain wrongfully, We have given his heir Authority (to demand Qisas Or to forgive): but let him Not exceed bounds in the matter Of taking life; for he is helped."

In this study, ICU nurses also perceived "continues or stops treatment" as an ethical dilemma. The participants were confronted with this dilemma when the family asked them to stop or discontinue treatment for the patient, but the participants disagreed. A family frequently asks to stop treatment in the ICU because seriously ill and dying patients often do not have the capacity to make decisions for themselves. An adult patient who no longer can make a decision has the same right to refuse or withdraw treatment by proxy (American Thoracic Society, 1991 cited by Rieth, 1999). Clarke (2000) also stated that decisions concerning treatment options are left to the parents or surrogate to make when in fact no real choice exists. In Indonesian culture, this is not surprising because the

family has a strong influence on any patient decision. Therefore, the family assumes responsibility for ensuring that the patient receives appropriate care. It creates a dilemma for nurses in intensive care units when they believe that the family wishes will potentially harm the patient.

ICU nurses also experience dilemmas arising from their responsibility to alleviate patient suffering and the moral obligation not to take human life (Fry, 1994). This type of ethical dilemma was also reported in the study of Redman, Hill, and Fry (1997) which found that 69% of certified nephrology nurses encountered an ethical dilemma concerning whether to discontinue or not initiate treatment. Soderberg and Norberg (1993), in their study of situations of ethical difficulty in intensive care, found that their participants (40 RN and 20 physicians) also confronted withholding and withdrawing of treatment as an ethical dilemma. A similar result also found in the study of Cassels and Redman (1989). They studied ethical dilemmas encountered by RN students in clinical practice and found that of 742 respondents, 671 perceived issues in regard to initiating resuscitation or discontinuing live-saving treatment as an ethical dilemma.

Issues of withdrawing or withholding of treatment are closely related to euthanasia. Nurses are confronted with an ethical dilemma when they feel that withdrawing or withholding of the treatment of life-sustaining measures is a form of passive euthanasia (Davis & Aroskar, 1991; Fry, 1994). For example, to withdraw a patient from a ventilator may be an act to allow the patient to die. Many studies have been done to address these issues. Asch (1996, cited by Matzo & Emanual, 1997) surveyed 1.600 critical care nurses, asking them to describe requests that they had

received for assistance with euthanasia. Those who responded had received request to engage in assisted euthanasia, 13% received requests from patients themselves, and 12% received requests from family members.

Davis et al. (1995) studied nurse's attitudes about active euthanasia and specifically on their ethical justification for their position. They found that only 17 of 80 respondents ethically justified active euthanasia. More than half of the nurses opposed to active euthanasia cited religious beliefs about death and often referred to active euthanasia as "playing God." Those opposed to active euthanasia were four times more likely to discuss the principle of double effect as an ethical problem than were those who could ethically justify it. Seven respondents mentioned specifically that it was not ethical for a health professional to make a decision about active euthanasia while six respondents believed they could ethically justify such a decision for themselves or a member of their family. They also found that five nurses opposed to active euthanasia said they would leave the profession if asked to participate in such an act.

In the study of euthanasia, nursing, and care of the dying, Aranda and O'Conner (1995) found that of the 90 nurses who had requests to forego life-sustaining treatment, 16% had complied with the patient's request without having been asked to do so by a doctor. All of them believed their action to be morally right. Of those who did not comply with euthanasia requests, 46% said that morality was not at all a reason for their noncompliance while 28% said morality was the sole or primary reason. Eleven percent said their noncompliance was because they considered active euthanasia morally wrong. Requests to forego life-sustaining treatment involved ceasing chemotherapy and

radiotherapy treatments. In their study, many respondents questioned the labeling of withdrawal of life-sustaining treatment as passive euthanasia. In the study of Kuhse and Singer (1993), they found that kinds of life-sustaining treatment foregone referred to cardiopulmonary resuscitation, giving antibiotics or other medications, and withdrawing nasogastric feeding.

In Davis et al. (1993), 319 nurses working in seven countries were interviewed using a structured interview guide. This study found that 73% respondents could not ethically justify active voluntary euthanasia under any circumstances. They basically said that active euthanasia is wrong and cannot be ethically justified whether the patient wants it or not.

2.3. Who should Get the Ventilator

Another ethical dilemma experienced by nurses in intensive care units was "who should get the ventilator." In the two hospitals where this study took place, the availability of facilities in the ICU was limited, much of the equipment was malfunctioning, and there was only a limited budget for new equipment. Limitation of facilities in hospitals in Indonesia may result from the economic crisis which influenced the hospital budgets. Recently, the health care sector budget has been decreasing.

A problem resulting from scarce resources in the ICU may occur when certain equipment is needed by two or more patients at the same time. The dilemma also occurs when many patients are admitted to the ICU at the same time, such as New Year's Eve when a lot of accidents happen. Most participants were concerned about this issue.

In this study, participants had a dilemma concerning how to distribute a ventilator in the fairest way to patients who needed it. They believed that, based on principles of justice, patients have a right to be treated fairly and justly. They considered this principle to determine which patient deserved to get the ventilator based on the clinical criteria and on the most benefit. Bunch (2000) studied ethical dilemmas in the context of ambiguity in a critical care unit in Norway. Using a qualitative comparative design with participant field observations and interviews with 15 ICU staff, she explored the clinical discussions providers engaged in, it terms of continuing or terminating treatment. She found that resource allocation was also perceived as an ethical dilemma by nurses in intensive care units in Norway. Post (1996) reported similar findings in her study of 124 perioperative nurses, where 12 nurses perceived allocation of scarce resources as an ethical dilemma. In Borawski's (1995) study of ethical dilemmas for nurse administrators, of 103 respondents, 75% stated that they encountered allocation of scarce resources as an ethical dilemma when they worked in nurse administrator settings.

2.4 Want to Take an Action but Beyond Authority

Participants stated that "want to take an action but beyond authority" was an ethical dilemma they experienced in intensive care units. They felt that they became a nurse in order to help patients and they had professional duties towards their patients. However, in certain situations they were in a dilemma when the intervention they had to perform was not their responsibility. Nurses have both an independent and a dependent role in the ICU. Many of nurses' roles in the ICU are dependent roles such as

administering medicines or performing invasive procedures like ETT insertion. Nurses had a dilemma when the critically ill patient needed prompt intervention to save his life, but which was a dependent role of nurses and beyond their authority.

Participants stated that they faced such dilemmas because there were no clinical guidelines for many procedures which were needed in critical situations. The clinical guidelines or policy guiding their daily practice put them in a dilemma. Participants were worried or felt uncertain about initiating an intervention to help the critically ill patients. Not having written clinical guidelines could induce a dilemma because nurses were unsure of when or how to initiate an intervention for a critical patient. They were in doubt and in conflict whether or not to take action. They realized that they had to help patients, but no written clinical guideline meant that they could not perform a particular intervention, such as giving emergency medicines. The availability of written clinical guidelines could help ICU nurses to direct their actions and avoid them from undertaking an intervention beyond their responsibility. By following the guidelines, nurses will feel secure of what should be done in relation to their role to help and save patient's life. To date in Indonesia, there is no legislation to regulate nursing practice such as a Nursing Practice Act. Every hospital develops its own standard of care and also develops policy and clinical guidelines as a guide for nursing practice. However, nurses perceived that the guidelines were still inadequate for guidance in complex critical care settings. However, to deal with ethical dilemmas, critical care nurses can use the Indonesian Nurses Code of Ethics in guiding their practice.

Findings from a study conducted by Redman and Fry (1998) tend to support this. They studied ethical conflicts experienced by registered nurse/certified diabetes educators. They found that institutional constraints such as lack of institutional policy, created a conflict for nurses. Erlen (1994) suggested that policies and procedures need to be written that clearly demonstrate lines of authority and the agency's scope and standards of nursing practice also need to include statements about ethical practices in nursing.

2.5 To tell or not to Tell the Truth

Truth-telling is one of the common ethical dilemmas experienced by nurses in intensive care units. Because of intense interaction with patient and family, and also as coordinator of care in ICU, nurses frequently have a lot of information about their patients. In this study, participants also encountered "to tell or not to tell the truth" as an ethical dilemma when they took care of critically ill patients. The participants perceived a conflict between the principles of veracity (truthfulness) and beneficence (doing good). They believed that lying to patients was against the basic ethical principle of veracity, but they were forced to tell a lie because it benefited for the patients and prevented harm. Looking at the benefit for the patients, in this study, some participants might be willing to tell a lie and thus violate the principle of veracity. This may be related to religious influence, because believers in the Islamic religion are taught not to tell a lie to anybody. The Muslim is truthful with all people, as the Holy Prophet taught His believers to absorb and implement the Islamic values, which encourage truthfulness. Lying is forbidden and

regarded as the source of all evils. The Muslim believes that truthfulness naturally leads to goodness, which will admit the one who practices it to Paradise, while falsehood leads to iniquity which will send the one who practices it to Hell. The Holy Prophet said (Muslim, 1978):

> "It is obligatory for you to tell the truth, for truth leads to virtue and virtue leads to Paradise, and the man who continues to speak the truth and endeavors to tell the truth is eventually recorded as truthful with Allah, and beware of telling of a lie, for telling of a lie leads to obscenity and obscenity leads to Hell-Fire, and the person who keeps telling lies and endeavors to tell a lie is recorded as a liar with Allah."

And the Qur-an says (Holy Qur-an, Surah Al-Ahzab Verse 24, translated by Ali, 1982):

> "That Allah may reward The men of Truth for Their Truth, and punish The Hypocrites if that be His Will, or turn to them in Mercy: for Allah is Oft-Forgiving, Most Merciful."

These two statements show that truth-telling is an important and serious matter for Muslims. It can create suffering for a person who tells a lie, such as feelings of guilt or shame. Some participants felt guilty and restless when they didn't tell the truth to their patients even though their intention was to prevent harm to the patient.

The findings related to truth-telling in this study were congruent with a study conducted by Gold, Chamber, and Dvorak (1995) on ethical dilemmas in the lived experience of nursing practice using semistructured interviews with 12 nurses delivering direct patient care in acute, long-term, and home care settings. They found that withholding of information and truth-telling was an ethical dilemma experienced by nurses in their practice. Similarly, a study of Chaowalit, Suttharangsee, and Takviriyanun

(1999) on ethical problems in nursing practice experienced by nursing students in Southern Thailand also found that truth-telling versus withholding the truth was an ethical problem experienced by nursing students in Southern Thailand.

2.6 Acting as Patient Advocate versus Maintaining Relationships with Health

Another ethical dilemma experienced by nurses in intensive care units in this study was "acting as patient advocate versus maintaining relationships with health team". ICU nurses work together as a team with other health professionals. In order to deliver high quality nursing care for their patients, good relationships with other health professionals are very important. Participants in this study frequently encountered this dilemma in their practice, related to doing good for their patients versus maintaining good relationships especially with doctors.

Nurses serve as patient advocates. As a patient advocate, the nurse becomes the instrument of the patient, and acts to fulfill the patient's wishes and desires (Liaschenko, 1995). Nurses also have to promote the best interests of the patients to the best of their nursing ability (Fry, 1994). This finding is consistent with the result of Redman and Fry's (1998) study of ethical conflicts reported by registered nurses/certified diabetes educator. They found that 7% of participants perceived doing good for patients versus maintaining relationships with physician or other nurses as an ethical conflict.

2.7 Resolution of Ethical Dilemmas

The resolutions of ethical dilemmas experienced by participants included various strategies: "consultation with doctor and/or nurse supervisor," "discussion with colleagues," "performing professional intervention," and "religious practices." Participants in this study used consultation with doctors and nurse supervisors as a resolution for ethical dilemmas. For those who felt lack of authority, this method of resolution was very helpful. They believed that doctors had more power and authority in the ICU to make clinical decisions. Nurse supervisors were also used by participants as resources to deal with ethical dilemmas. Hierarchically, nurse supervisors have more authority than staff nurses. Usually, in Indonesia, nurse supervisors are selected from senior nurses who have experience in clinical practice as well as in ethical decision making. In a study by Huijer et al. (2000), 8% of participants consulted with their supervisor to address ethical dilemmas they faced. Penticuff and Walden (2000), in their study of influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas, also found that the most frequently reported action to resolve clinical ethical dilemmas was to discuss the dilemma with other nurses (94%), the head nurse (79%), or physicians (72%).

In this study, discussion with colleagues was often used by participants to resolve ethical dilemmas. If they felt that the dilemmas could not be resolved by themselves, they tried to seek assistance or support to help them in making decision. Discussion with colleagues was the first alternative before they sought further resources. They relied on colleagues because colleagues were always available and they believed that colleagues,

especially senior nurses, had more experience regarding how to resolve difficult ethical dilemmas. This study finding was consistent with the study done by Huijer et al. (2000), who studied medical students' cases as an empirical basis for teaching clinical ethics and found that the residents had discussed their ethical dilemmas mainly with resident and other interns. Kuhse and Singer (1993) conducted a survey on voluntary euthanasia and the 943 registered nurses in Australia. They found that when the nurses were asked to forego life-sustaining treatment, 92% of them discussed the requests with other nurses, 90% with medical staff, 68% with a relative or close friend, 44% with a religious advisor, and 35% with someone else.

In dealing with an ethical dilemma, participants tried to resolve it and continue to take care of the patient. They performed various professional nursing interventions to protect patients. They took any positive action to resolve the conflict they felt. Similarly, Redman and Fry (1998) identified that taking action to protect patients or educating them to take action such as to question their physicians was the most frequent resolution used by nurses in dealing with conflict. They also found that 29% of the participants took steps to empower a patient to change a problematic situation as a resolution to deal with conflict.

Participants in this study used religious practices such as praying when dealing with ethical dilemmas. Indonesia has been influenced by Islamic culture. In Muslim rules, it is believed that when a person has a difficult problem, they can pray to Allah (God) for a resolution of the problem. Doing *sholat* (praying) is widely used as a method of getting inspiration or ideas about how to find a resolutions for a problem. Religious

practices are also believed to have power to reduce uncomfortable feelings resulting from ethical dilemmas.

The resolutions used by the participants in this study were not congruent with ethical decision-making. This was because of a lack of knowledge and skills in ethics, especially how to deal with an ethical dilemma. Ethics courses have been taught for diploma and bachelor students in Indonesia, however, the contents of the courses do not cover all ethics subjects and little known regarding ethics expert who teach ethics in nursing school in Medan.

Surprisingly, when encountering ethical dilemmas in intensive care units, no participants removed themselves from ethical conflict situations. They did not stop caring for their patients, but rather tried to use a combination of resolution strategies as discussed above. In contrast, a study conducted by Redman, Hill, and Fry (1997) found that some nurses reported that they occasionally removed themselves from ethical conflict situations by setting limits, by leaving a position, or by expressing their opinions only when they were safely out of a role. In addition, participants in this study did not refer to codes of ethics, ethical principles, or ethical theories. However, they referred to their personal and religious values. In Indonesia, Islamic values and norms are widely accepted as universal guidelines to daily life. These values and norms express the duties of people in their daily life. Fry (1994) stated that personal values are influenced by religion, culture, education, and life experiences.

This study also revealed that the participants did not use an ethics committee in resolving ethical dilemmas, even though such a committee is available in their hospitals.

Ethics committees in Indonesia are established mainly in the big hospitals and are known as Panitia Etika Rumah Sakit (PERS) (Hanafiah & Amir, 1999). The members of PERS are physicians, nurses, administrators, and other parties working in the hospital. The major function of PERS is to help doctors, nurses, or other health care members in dealing with ethical problems including breaches of the code of ethics and in implementing the code of ethics. PERS is useful in:

1. serving as a resource to get relevant information to solve ethical problems in the hospital.

2. identifying breaches of the code of ethics and giving opinions to resolve them.

3. giving suggestions to the director of the hospital whether or not to consult the breaches of the code of ethics to higher level.

In this study, nurses might have been reluctant to bring ethical dilemmas to their ethics committee due to a long bureaucratic process, whereas the participants needed to make a decision promptly. This finding is congruent with a study conducted by Redman and Fry (1998), which found that the ethics committee was almost never used by participants to resolve ethical conflicts. Penticuff and Walden (2000) also found that nurses were reluctant to communicate their ethical concerns beyond their own units.

As a summary, the findings of this study regarding ethical dilemmas experienced by nurses in intensive care units in Medan were described as a diagram in Figure 4.1 and also Table 4.2. This diagram shows that participants in this study experienced real ethical dilemmas when providing care for critically ill patients in intensive care units. The meaning of ethical dilemma, the experiences of ethical dilemmas, the feelings of ethical

dilemmas, and the resolutions they used in dealing with ethical dilemmas were explored and discussed. The diagram also shows the lack of ethical decision skills. It also was found that some dilemmas still remain.

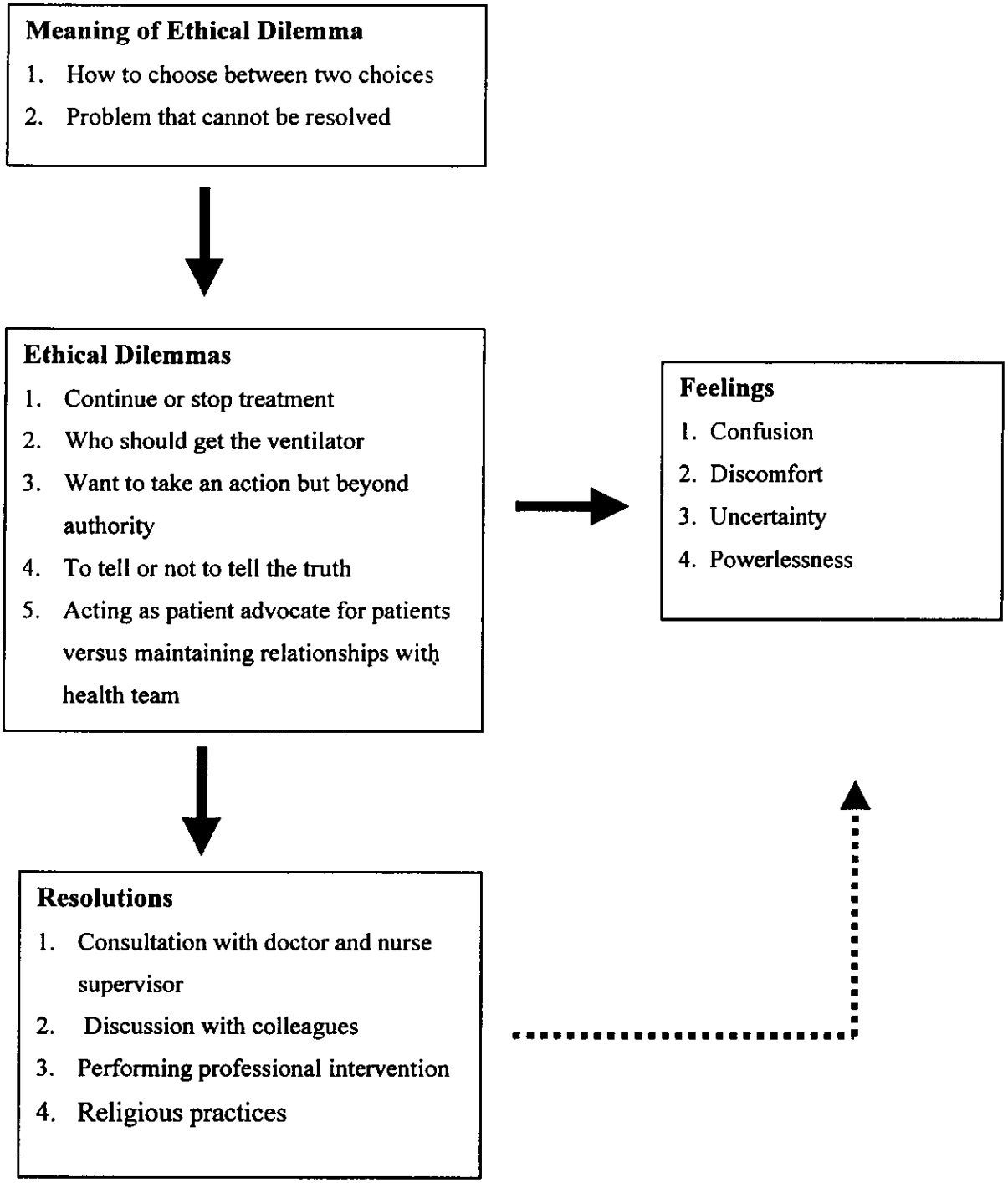

Figure 4.1 Summary of participants' experiences in ethical dilemma when taking care of ICU patients.

Table 4.2 Frequency of participant in ethical dilemmas and the resolutions experienced by the participants

Dilemmas/Resolutions	Consultation with doctor & nurse supervisor (N)	Discussion with colleagues (N)	Performing professional interventions (N)	Religious practices (N)
Continue or stop treatment	1	2	-	2
Who should get the ventilator	1	2	2	-
Want to take action but beyond authority	1	-	3	-
To tell or not to tell the truth	1	2	-	1
Acting as patient advocate vs. maintaining relationship with health team	3	-	-	-