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Ethical Dilemmas in Nursing: an Integrative Review

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Abstract

Aims: The purpose of this integrative review was to identify themes and gaps in the literature to stimulate researchers to develop strategies to guide decision-making among clinical nurses faced with ethical dilemmas.

Background: The concept of ethical dilemmas has been well explored in nursing because of the frequency of ethical dilemmas in practice and the toll these dilemmas can take on nurses. Although ethical dilemmas are prevalent in nursing practice, frequently leading to moral distress, there is little guidance in the literature to help nurses resolve them.

Design: This paper is an integrative review of published research from 2000 to 2017.

Methods: The keywords ethics, ethical dilemmas and nurs* were searched in CINAHL, PubMed, OVID, and SCOPUS. Exclusion criteria were sources not available in English, not in acute care, and without an available abstract. Seventy-two studies were screened; 35 were retained. Garrard's matrix was utilized to analyze and synthesize the studies.

Results: Ethical dilemmas arose from end-of-life issues, conflict with physicians or families, patient privacy concerns, and organizational constraints. Differences were found in study location, and yet international research confirms that ethical dilemmas are universally prevalent and must be addressed globally to protect patients and nurses.

Conclusions: This review offers an analysis of the available evidence regarding ethical dilemmas in acute care, identifying themes, limitations, and gaps in the literature. The gaps in quantitative intervention work, U.S. paucity of research, and lack of comparisons across practice settings/nursing roles must be addressed. Further exploration is warranted in the relationship between ethical dilemmas and moral distress, the significance patient physical appearance plays on nurse determination of futility, and strategies for pain management and honesty.

Relevance to Nursing Practice: Understanding and addressing gaps in research is essential to develop strategies to help nurses resolve ethical dilemmas and to avoid moral distress and burnout.

Keywords**:** nursing ethics, professional burnout, terminal care

Introduction

An important characteristic of a profession is the existence of defined standards of ethical behavior. For nursing, principles of ethical behavior are found in the ANA Code of Ethics for Nurses, which has been recently updated (ANA, 2015). The ANA ethical provisions above are derived from the four primary principles of bioethics: autonomy, beneficence, non-malfeasance, and justice (Seaman and Erlen, 2013). Within these provisions, nurses frequently struggle with ethical decisions where various principles may conflict. Nurses need strategies to address these conflicts.

Background

In healthcare situations, ethical principles are often competing priorities, which creates a dilemma. For example, patients may have religious beliefs that prevent them from seeking life-sustaining treatment (autonomy). In this instance, nurses might struggle with the principle of autonomy versus the principle of doing no harm (non-maleficence) or providing benefit (beneficence). Another ethical dilemma may be when privacy (autonomy) conflicts with safety

concerns (beneficence) for a suicidal teenager. Also, dignity and protection may have equal and opposing desirability in patient care where restraints may be indicated to maintain life-sustaining treatment. Ethical dilemmas occur frequently in nursing practice and present multiple challenges.

In addition to the conflict created by opposing ethical principles, there can also be conflict between different ethical traditions. *Deontology* judges the quality of ethical decisions based on adhering to rules, where *Teleological ethics* evaluates the decision based on the outcome (Illingworth and Parnet, 2006), frequently referred to as "the end justifies the means." Utilitarianism is a sub-type of teleological ethics where the greatest good for the most people is the best possible outcome (Illingworth and Parnet, 2006). International spread of emerging infectious diseases is a very current example of applying the utilitarian ethical view. If more people benefit overall by abandoning a community in need of help (e.g. due to a high risk of an epidemic spread of disease) then the ethical course of action from a utilitarian perspective is to deny care to those in need.

Another ethical tradition is *virtue ethics*. According to Voet (2011), where deontology is associated with the duty to act and teleology is associated with the most benefit to the most people, virtue ethics is primarily concerned with the individual's character as the fundamental component of ethical reasoning while making decisions. Virtue ethics often comes into play when there are no existing guidelines to steer/drive/guide decisions and decision makers rely strictly on their own values. This type of ethical tradition is particularly relevant in healthcare where the decision-maker is usually a physician, who is in a position of authority. When nurses disagree with physicians' clinical decisions, this is a source of ethical conflict or dilemma under virtue ethics because the nurse is not the person making decisions, but the person who executes on those decisions. However, virtue ethics also directly applies to nurses when they lack external guidance on tough decisions or choices.

Ethics should not be confused with morality; an ethical dilemma is distinct from a moral dilemma. Ethical decision-making requires choosing between two equally good or poor choices. Moral decision making is influenced by personal and/or religious beliefs (ANA, 2015), whereas ethical principles that guide decisions are not necessarily moral principles. The Code of Ethics for Nursing (ANA, 2015) makes a clear differentiation between morality and ethics, where morality is related to individual or personal beliefs and values, and ethics defines right and wrong by an external source or code of behavior.

The principles discussed above illustrate that resolving ethical dilemmas is complex and requires an understanding of ethical principles to guide the decision-making process. The problem, however, is that although ethical dilemmas are prevalent in nursing practice and frequently lead to moral distress (Huffman and Rittenmeyer, 2012; Sauerland et al., 2014) there is little guidance in the literature to help nurses resolve these dilemmas. The purpose of this integrative review was to identify themes and gaps in what is known about handling ethical dilemmas in clinical nursing practice. The hope is to stimulate researchers to develop strategies to guide decision-making among nurses handling ethical dilemmas in clinical practice.

Methods

Utilizing the 12-step search strategy proposed by Kable, Pick and Maslin-Prothero (2012), ethics, ethical dilemma, and nurs* were searched as key terms in CINAHL, PubMed, Ovid, and Scopus with an initial return of over 13,000 sources. Exclusion criteria were studies not available in English, conducted in non-acute care settings or in niche specialties, and without an available abstract. Because of the strong evidence of the causes of ethical dilemmas in neonatal care due to the plethora of available evidence, neonatal studies were also excluded. The remaining studies exceeded 250, and because ethical dilemmas reflect societal advances and issues changing over time, studies were narrowed further to include the years 2000 to the present to capture the most current ethical

dilemmas. The remaining 72 studies were read by one single reviewer who reviewed them for quality and relevance. Of those, 39 were eliminated for lack of relevance to the topic (for example, not involving RNs, secondary sources/reviews, or meeting exclusion criteria), leaving 33. Two studies were added from citations found in reference lists, for a final number of 35 studies that met the criteria for this review (See Prisma Figure 1). Garrard's (2014) matrix method was utilized to analyze and synthesize the studies that were included. The evidence matrix included 10 topics: author alphabetically, year of publication, study aim, design, location, sample description, sample size, findings, limitations, and level of evidence (See table 1 for the evidence matrix). Seven key themes were identified across all studies by categorizing similar data. Studies were further rated for quality based on Melynk and Fineout-Overholt's (2015) levels of evidence.

Results

The research designs of the 35 studies incorporated were quantitative (*n*=11), qualitative (*n*=20), mixed methods designs (*n*=3), and 1 meta-analysis. Studies were conducted in the U.S. (*n*=9), Europe (*n*=10), Asia (*n*=6), South America (*n*=3), Australia (*n*=2), Canada (*n*=2), and the Middle East (*n*=5). Several studies were conducted in multiple countries (*n*=4). Settings included critical care, ambulatory, mental health, and acute care (oncology, surgical, and neuroscience).

Some researchers did not specifically aim to explore ethical dilemmas, although findings were very relevant to ethical dilemmas. For example, some researchers addressed whistleblowing and the issues surrounding why nurses would whistle-blow when faced with poor practice (Ahern & McDonald, 2002; Jackson et al., 2010). A few researchers were primarily concerned with moral distress (Barlem et al., 2013; Choe, Kang, and Park, 2015; Lutzen et al., 2003; Shorideh, Ashktorab, and Yaghmaei, 2012; Wadenstein et al., 2008), although the causes of moral distress were often due to an ethical dilemma or a negative patient outcome.

Overall, the studies demonstrated moderate to strong evidence. When evaluating the level of evidence in the quantitative studies, the strongest evidence based on Melnyk and Fineout-Overholt (2015) evidence hierarchy was the meta-analysis by de Casterele et al. (2008) with a sample of 1592. Next in strength of level of evidence as well as the largest sample sizes are Pang et al. (2003), Ferrell et al. (2001), Kinoshita (2007). Other level three studies with smaller samples are Ahern & McDonald (2002), Barlem et al. (2012), Chui et al. (2009), Cooper et al. (2004), Ersoy and Goz (2001), Ganz and Berkovitz (2012), Gaudine and Thorne (2012), Ham (2004), and Konishi et al. (2002).

End-of-Life Care

The most frequently cited ethical dilemmas were related to end-of-life issues and this prevalence of end-of-life issues is not surprising given that technological advances continue to extend life. The issues cited included communication about prognosis, inadequate palliation, questions of potential healing, and futility (Blasszauer and Palfi, 2005; Blondal and Halldorsdottir, 2009; Bosek, 2009; Carvalho and Lunardi, 2009; Chiu et al., 2009; Eriksson et al., 2014; Fernandes and Moreira, 2013; Harris, 2002; Jackson et al., 2010;Kinoshita, 2007; Pavlish et al., 2012; Shorideh et al., 2012; Silen, Tang and Ahlstrom, 2009; Wadensten et al., 2008). Nurses are frequently confronted with situations where they believe dying is not being handled with sufficient attention to comfort or when further treatment is futile. In one study, researchers mentioned that emergency care was given because end-of-life discussions had not happened prior to the emergent threat to life (Pavlish et al., 2012). A few researchers specifically discussed the distressing appearance of the dying patient related to changes in skin or fluid shifts. Descriptors such as “rotting” and “already dead” were verbalized in these qualitative studies (Harris, 2002; Kinoshita, 2007; Melia, 2001), where the physical decay of patients was a key element in nurses’ ethical distress and further evidence of the ethical dilemma the nurses faced when providing end-of-life care. A common theme for nurses was that they generally accepted the dying process before physicians, who may consider palliation or

hospice care a failure on their part (Blasszauer and Palfi, 2005; Chaves and Massarollo, 2009; Chiu et al., 209; Eriksson et al., 2014; Jackson et al., 2010; Pavlish et al., 2012; Wadensten et al., 2008). In an exemplar in Melia's work a nurse stated, "I sort of get the feeling that often it's the nursing staff who will reach the conclusion quicker than the medical staff that enough is enough." (Melia, 2001, p. 712).

Physician Conflicts

Conflict regarding end of life ties closely with ethical dilemmas created by physician issues. Cited in half of the studies, physician issues encompassed the lack of authority of the nurse, conflict over patient treatment plans, lack of teamwork, and the nurses' inability to advocate for their patients (Ahern and McDonald, 2002; Barlem et al., 2013; Blondal and Halldordottir, 2009; Chavez and Massarollo, 2009; Eriksson et al., 2014; Fernandes and Moreira, 2013; Harris, 2002; Jackson et al., 2010; Kinoshita, 2007; Silen et al., 2009; Silen et al., 2008; Wadensten et al., 2008). Although nurses' conflict with physicians frequently related to over-treating at end of life, other sources of angst included concerns regarding physician competency, physician communication, changes in treatment plan with rotating physician coverage, and concerns of under-treatment of illness (Blasszauer and Palfi, 2005; Blondal and Halldorsdottir, 2009; Bosek, 2009; Carvalho and Lunardi, 2009; Chaves and Massarollo, 2009; Chiu et al., 2009; Eriksson et al., 2014; Ersoy and Goz, 2001; Ferrell et al., 2001; Jackson et al., 2010; Kinoshita, 2007; Konishi, Davis, and Alba, 2002; Melia, 2001; Pavlish et al., 2012; Silen et al., 2009; Wadensten et al., 2008).

Patient or family autonomy may be in conflict with preventing suffering if the patient or family desire to continue futile care causes suffering and lack of dignity in the process. Regarding pain, some nurses discussed drug-seeking behaviors or questioned the veracity of patients' reports of pain. Struggles to control pain in drug seekers were also verbalized as an ethical dilemma (Blondal and Halldorsdottir, 2009).

Organizational Constraints

Another recurrent theme was related to organizational constraints (Ahern and McDonald, 2002; Barlem et al., 2013; Blondal and Halldordottir, 2009; Bosek, 2009; Carvalho and Lunardi, 2009; Cooper et al., 2004; Ganz and Berkovitz, 2012; Gaudine and Thorne, 2012; Jackson et al., 2010; Pavlish et al., 2012; Silen et al, 2009; Silen et al., 2008; Wadensten et al., 2008). For example, staffing shortages that did not allow nurses to give the best care often led to ethical dilemmas as nurses tried to determine what they could omit or which patients needed the most care. This is referred to as rationing or missed care (Balls et al., 2014).

Other organizational issues included negative cultures that discouraged or punished nurses who spoke up for patient safety and patient rights (Ahern & McDonald, 2002; Barlem et al., 2013; Bosek, 2009; Chaves & Massarollo, 2009). In one international study, researchers found that patients' ability to pay was a factor in access to care (Wadensten et al., 2008). In that study, nurses reported ethical dilemmas when patients were denied care due to poverty. (Although not reported in the U.S. literature, it can certainly be argued that ability to pay is also a factor in access to care in the States). This lack of access was attributed to organizational or cultural barriers (Silen et al., 2009; Wadensten et al., 2008).

Family Conflicts

Families of patients also created ethical dilemmas for nurses (Bosek, 2009; Chaves and Massarollo, 2009; Choe et al., 2015; Fernandes and Moreira, 2013; Kinoshita, 2007; Pavlish et al., 2012; Rejeh et al., 2009; Silen et al., 2009; Silen et al., 2008). Some researchers reported this as conflict with the healthcare team in regard to the best treatment plan (Chaves and Massarollo, 2009). For example, some families may want aggressive treatment when the healthcare team recommends hospice; other families refuse intubation for a patient who should easily wean from mechanical ventilation once the acute issue is resolved. Some researchers reported that families

were unrealistic regarding prognosis or in denial about their loved ones' end-of-life status (Chaves and Massarollo, 2009; Kinoshita, 2007; Silen et al., 2008). Sometimes families were inappropriate or hostile to nursing staff, resulting in conflict in how to care for them and their patients (Choe et al., 2015; Silen et al., 2009). Other researchers reported that family needs frequently conflicted with those of the organization (Rejeh et al., 2009). For example, ethical dilemmas arose when patients were not the decision-makers (Kinoshita, 2007) or when the family's need to be present was physically challenging to the nursing staff providing critical care (Chaves and Massarollo, 2009).

Privacy and Dignity

Patient privacy and dignity were also identified as a cause of dilemmas. A simple example would be when a feeble or impulsive patient wants to be alone in the bathroom and the nurse recognizes the risk that if she leaves the bathroom the patient will likely fall. Although wanting to provide patients with privacy and dignity, the nurse also recognizes the risk of injury (and therefore suffering) if she leaves the patient unattended. Autonomy, suffering, and dignity are all potential elements of end of life care but were reported by many researchers as separate issues leading to ethical dilemmas and, as a result, moral distress (Chiu et al., 2009; Fernandes and Moreira, 2013; Illingworth and Parnet, 2006; Kinoshita, 2007; Silen et al., 2009).

Other Identified Themes

Of the studies reviewed here, not all of the researchers aimed to identify situations that led to ethical dilemmas for nurses. Some focused on nurses' responses to ethical dilemmas or their thoughts related to ethical dilemmas. Several researchers sought to understand what led nurses to speak up (whistle-blowing) to protect patients (Ahern and McDonald, 2002; Jackson et al., 2010; Shapira-Lishchinsky, 2009). Ahern and McDonald found that whistleblowers had a less traditional view of authority than those who remained silent; that is, whistleblowers did not automatically defer to persons in positions of authority (Ahern and McDonald, 2002). Jackson et al. (2010) found a

relationship between whistleblowing behaviors and organizational culture where the nurses were employed; stronger safety cultures encouraged speaking-up behaviors. de Casterle et al. (2008) sought to understand how nurses act when faced with ethical dilemmas. They identified the development of ethical reasoning as an influencing factor where nurses rank on a continuum of mature ethical thought. More ethically mature nurses made better decisions when faced with ethical dilemmas. Ersoy and Goz (2001) were primarily concerned with ethical sensitivity (defined as awareness of ethical situations). They found that more experienced nurses valued veracity and patient autonomy and exhibited higher levels of ethical sensitivity overall than their less experienced peers. In contrast, Ham (2004) found that nursing students were more advanced in what the researcher called principled thinking than experienced nurses.

Cultural Parallels and Dissonance

Several researchers examined ethical dilemmas in nursing in several different countries and most identified parallels between the various international settings. However, researchers in Hungary (Blasszauer and Palfi, 2005), Israel (Ganz and Berkovitz, 2012), and Iran (Rejeh et al., 2009), discussed findings largely different from U.S. nursing experiences. For example, the Iranian researchers (Rejeh et al., 2009) discussed ethical issues such as giving placebos or diluting pain medication. Similarly, the Hungarian researchers (Blasszauer and Palfi, 2005) reported instances of gross nursing negligence that would not be tolerated in the heavily regulated and publicly reported U.S. environment. Despite these differences, there are many parallels between international and domestic studies included in the review. For example, to be discussed more fully later in this manuscript, the concept of truth telling was identified in studies across countries and practice settings (*n*=7). Further, despite their differences, the international researchers demonstrate that ethical dilemmas are an international as well as domestic nursing issue and must be addressed globally to protect nurses and patients. Researchers specifically compared ethical situations and dilemmas in different countries. Pang et al. (2003) studied a sample of 1243 nurses from three

countries (U.S., China, and Japan). The U.S. sample of nurses were older, more of them were in leadership roles, and there were more men in the sample than in the Chinese and Japanese samples. This may have influenced the results, where U.S. participants were overall more principle-based in ethical decision making, in contrast to the Chinese virtue-based and Japanese sense of responsibility-based decision-making. Silen et al. (2008) compared ethical dilemmas of nurses in Sweden and in China. Primarily female, with a 10-year mean age difference between the two groups (Swedish nurses were older), both groups reported the most significant dilemmas were workload related. The Chinese also reported lack of experience and conflicts with families, Swedish nurses reported end-of-life issues and physician conflicts as the next most significant source of ethical dilemmas. Lastly, in a qualitative study, Wadensten et al. (2008) found that Swedish nurses worried more about life sustaining treatment, whereas Chinese nurses reported dilemmas related to patients' ability to pay as a factor in access to care. Both groups reported having little authority and regular conflicts with physicians.

Looking at just the American studies, ethical issues included the inability to provide quality care related to many constraints (whether physician related, conflict with families over goals of care, or organizational lack of resources; Cooper et al., 2004; Ferrell et al., 2001; Pavlish et al., 2012; Urlich et al., 2010), not meeting patient desires/rights (Cooper et al., 2004; Ulrich et al., 2010), poor communication or lack of communication/honesty (Cooper et al., 2004; Ferrell et al., 2001; McLennon et al., 2013; Pavlish et al., 2012), family conflicts (Cooper et al., 2004; Ferrell et al., 2001), end of life or pain management concerns (Cooper et al., 2004; Ferrell et al., 2001; McLennon et al., 2013; Pavlish et al., 2012; Ulrich et al., 2010).

Terminology Confusion and Inconsistency

The studies reviewed demonstrated inconsistent use of terminology. Ethical dilemmas were described as challenges, issues, problems, conflicts, and concerns (Cooper et al., 2004; Ersoy and Goz, 2001; Langeland and Sorlie, 2011; Pavlish et al., 2012; Silen et al., 2008; Ulrich et al., 2010). Although these terms have slightly different meaning and suggest various levels of intensity, they were used interchangeably in the literature. The concept of ambivalence in relation to ethical dilemmas was introduced but not clearly defined (Choe et al., 2015). If ambivalence is defined as being torn between two poor choices, it is actually an ethical dilemma (Chaves and Massarollo, 2009). Ambivalence may also be over two good choices, which is a very different issue. Researchers used the terms of ethical dilemma (a situation) and moral distress (a feeling) interchangeably (Choe et al., 2015). Gaudine and Thorne (2012) describe ethical conflict as "when there are value differences between individuals and the values espoused by organizations, typically manifested through the actions of the organizations' administrators" (Gaudine and Thorne, 2012, p. 727). Traditionally however, an ethical dilemma is when there are two equally good or poor choices (someone does not know what to do). A morally distressing situation is when someone knows what action should be taken to protect a patient, but organizational constraints prohibit speaking up (Calleja-Sordo et al., 2015; Repenshek, 2009).

One Swedish research team's (Eriksson et al., 2014) sample was primarily composed of male nurses but the researchers did not have a clear understanding of hospice versus palliation. This was evident by utilization of the terms end of life and palliation interchangeably. Palliation is symptom control that can happen at any stage of an illness, not just at end-of-life/hospice stages (Wang et al., 2016). This is important because palliation and hospice underutilization are key issues in ethical dilemmas around end-of-life and because it provides further evidence of the inconsistent terminology found in these studies.

Discussion

Although a few researchers specifically identified power struggles with physicians or organizational leadership as a cause of ethical dilemmas (Blasszauer and Palfi, 2005; Blondal and Halldorsdottir, 2009; Choe et al., 2015; Melia, 2001), nurses' lack of authority with physicians (over goals of treatment) and hospital leaders (regarding staffing or resources) emerge as a broader problem. Power struggles blanket the smaller themes of end-of-life care dissention, physician incompetence, lack of communication, conflict over goals of care, and organizational constraints. While many researchers (Ahern and McDonald, 2002; Barlem et al., 2013; Blondal and Halldorsdottir, 2009; Chaves and Massarollo, 2009; Eriksson et al., 2014; Fernandes and Moreira, 2013; Ferrell et al., 2001; Harris, 2002; Jackson et al., 2010; Kinoshita, 2007; Silen et al., 2009; Silen et al., 2008; Wadensten et al., 2008) argue that these power struggles with physicians were the cause of ethical dilemmas for nurses, one might argue that rather than creating an ethical dilemma, these power struggles actually create moral distress. That is, nurses do not experience confusion over what is the right thing, they become distressed when faced with barriers to doing the right thing. For example, when nurses are torn between poor choices of following physician orders or challenging them, an ethical dilemma would occur when nurses do not know the right thing to do or are torn by duty to the patient vs. duty to the medical staff. Knowing the right thing to do but being impeded from doing the right thing is, in fact, the definition of moral distress (Corley, 2002). Moral distress is generally more closely tied to organizational constraints or end-of-life issues than with physician conflict because they are impeded from doing what they know is right. And yet, it is logical that an ethical dilemma can lead to moral distress, suggesting that the definition of moral distress is too narrow as it does not allow for distress from poor choices or distress from dissatisfaction with the alternatives. In fact, Kalvemark et al. (2004) defined moral distress as any stress that is "related to an ethical dilemma" (Kalvemark in Choe et al., 2015, p. 1685). This is a distinction that perhaps should be further explored with additional study.

Congruent with this problem regarding the relationship between ethical dilemmas and moral distress, Paley (2004) and Repenshek (2009) caution that moral distress is misused when referring to physician relationships, staffing issues, and resource shortages. The moral distress concept "has been used by some nursing researchers to support a discourse of 'whining' about nursing issues of medical oppression" (Vanderheide et al., 2013, p. 107). While Vanderheide et al. specifically contend that working conditions are not a factor in ethical dilemmas, the counterargument from the work reviewed here is that lack of sufficient resources does cause the ethical dilemma of how to distribute care (Barlem et al., 2013; Cooper et al., 2004; Gaudine and Thorne, 2012; Urlich et al., 2010). Rationing or missed care (Ball et al. 2014) has been only moderately explored in the U.S. literature. The reason for this is likely multifactorial including, perhaps a taboo subject in the U.S., general denial of the issue, a litigious culture, or other factors. As missed care is recognized as a real and present danger to quality nursing care and positive patient outcomes the connection to ethical dilemmas in work environments is unmistakable.

Another theme that emerges from the literature and can be broadly applied to the sub themes of family conflict, end of life, and physician issues, is lack of honesty or truth telling (Barlem et al., 2012; Blasszauer and Palfi, 2005; Blondal and Halldorsd, 2009; Chiu et al., 2009; Choe et al., 2015; de Carvalho and Lunardi, 2009; Eriksson et al., 2014; Ersoy and Goz, 2001; Fernandez and Moreira, 2012; Ferrell et al., 2001; Kinoshita, 2007; Konishi et al., 2002; Melia, 2001; Pavlish et al., 2012; Shapira-Lishchinsky, 2009; Shorideh et al., 2012; Silen et al., 2008; Ulrich et al., 2010; Wadensten et al., 2008). The flavors of truth telling reported in the studies vary from vanilla to dark chocolate: lies of omission or giving incomplete information (McLennon et al., 2012), dishonesty about a prognosis due to physician pressures or the conflict with wanting to give hope (Pavlish et al., 2012), failure to disclose (Rejeh et al., 2009), and failure to report (Shapira-Lishchinsky, 2009). Pavlish et al. (2012) shed light on both the complexity and the nuance of shades of honesty in identifying the concepts of speaking up, around, and sideways. Their sample included educators,

nurse practitioners, and administrators in addition to bedside nurses, demonstrating that truth telling is not just an issue for front line nursing staff. This construct of truth telling was found in both U.S. and international settings and is alarming when we consider that, at least in the U.S., nursing is still considered the most ethical profession (Brenan, 2017).

Related to end of life, the issue of patient appearance emerged (Harris, 2002; Kinoshita, 2007), and generated the following question: Are patients' deteriorating appearances a factor in nursing's determination of futility? Futile care is a common source of ethical dilemmas for nurses who want to ease end-of-life suffering. Is it that the patient already looks dead that causes distress or is the nurse's distress from distaste of caring for what appears to be a rotting body? This concept should be further explored as to how the physical appearance of patients factor into the futility determined by nurses caring for those patients at the end of life.

It is worth noting that the majority of the studies were conducted in international settings. In general, the non-U.S. nurse participants were younger with less years of clinical experience and were more likely to be women than the U.S. participants (de Casterle et al., 2008; Pang et al., 2003). Counting mixed methods in both qualitative and quantitative categories, of the 15 quantitative studies, only six were in U.S. settings; and for the 23 qualitative studies, only three were conducted in the U.S., a mere 25%. Also, when looking at studies that were conducted in only the U.S. and not a combination of domestic and international settings, the count shrinks to seven. This suggests that ethical dilemmas are better acknowledged in non-U.S. nursing environments and should be further studied in U.S. settings.

Related to both end of life and honesty, pain issues and pain management emerged (Blasszauer and Palfi, 2005; Blondal and Halldorsd, 2009; Chaves and Massarollo, 2009; de Calvalho and Lunardi, 2009; Ferrell et al., 2001; Rejeh et al., 2009). While there is no question that end of life

pain should be aggressively treated, the discussion by Rejeh et al. (2009) regarding diluting medication or giving placebos due to scarcity, is in stark contrast to the current U.S. opiate crisis, one of the most significant government agendas because of the prevalence as well as mortality associated with opiate overdose (Bartolone, 2018; National Institute on Drug Abuse, 2018).

Limitations

It is of note that there is more qualitative research in this review than quantitative. It can be argued that more qualitative work is appropriate because ethical dilemmas are the nurses' experiences and stories, stories that need to be told. However, the lack of quantitative work speaks to the lack of interventional studies, which are necessary to provide strategies to address ethical dilemmas in the workplace. In the qualitative studies, there are clearly limitations. DeWolf Bosek (2009) asked open ended questions of 17 nurses in acute and ambulatory care. Without collecting demographics, it is unclear if the participants had a larger presence in either practice setting, which is an important missing element to put the findings in proper context. Further, several qualitative researchers did not explain their recruitment strategies or address saturation (Chaves and Massarollo, 2009; Carvalho and Lunardi, 2009; Eriksson et al., 2014; Shapira-Lishchinsky, 2009), another limitation of the qualitative work.

The limitations of the quantitative studies include the usual threats to validity, including self-selection bias (Ahern and McDonald, 2002; Chiu et al., 2009; Ersoy and Goz, 2001; Guadine and Thorne, 2012), moderate or low power (Ahern and McDonald, 2002; Ganz and Berkovitz, 2012), heterogeneity of subjects or homogeneity (Blondal and Halldorsd, 2009; de Casterle et al., 2008; DeWolf Bosek, 2009; Ersoy and Goz, 2001). For an example of heterogeneity, Blondal and Halldorsd's sample ranged from nurses with 2 to 30 years of experience, and for demographics, Ersoy and Goz (2001) did not address gender.

Gaps and Potential Strategies

A gap identified relates to the paucity of U.S. studies. It is possible that U.S. work is focused on practice areas not included in this review (such as neonatal ICU), but clearly there is less U.S. work in general acute care practice settings than in the international nursing research community. Men, as usual in the female dominated nursing profession, are underrepresented in the studies reviewed here. Do men in nursing believe they encounter the same number and severity of ethical dilemmas as their female counterparts? Further, the similarities and differences between nurse educators or nurse leaders and staff are inadequately explored in these studies and addressed in only a few (Cooper et al.,2004; Konishi et al., 2002; Shorideh et al., 2012). Are these differences in reported ethical dilemmas related to role, experience level, or education? This question was not adequately answered as Ham (2004) reported student nurses had higher levels of principled thinking, and yet Ersoy and Goz (2001) reported more experienced nurses had a higher regard for truth and patient autonomy.

Another gap identified in this review is the lack of interventional studies to identify strategies that nurses can employ to resolve ethical dilemmas. Specifically for end of life issues, researchers' lack of discussion regarding ethics committees or consults suggests under-utilization of such resources which may provide support to nursing staff. Another potential strategy for organizations, not explored in this literature, is use of rounds that are designed to provide clinical staff with a forum to discuss ethically distressing situations (Schwartz Center for Compassionate Healthcare, 2017). Founded in the mid 1990's by a forty-year-old patient dying from advanced lung cancer only days before he died, the Schwartz Center in Boston, Massachusetts, seeks to keep compassion and kindness in healthcare by providing a place for healthcare workers to share their feelings and experiences with complex and ethically challenging clinical situations.

One strategy to assist nurses in resolving physician issues or organizational constraints include strengthening the organizational culture and ensuring a strong chain of command. There must be structure and organizational support or nurses will not feel safe in reporting ethical issues. Nurses need tools to effectively address organizational constraints and conflict with families that are resulting in dilemmas, distress, and ultimately burnout. Examples of these tools are implementation and testing of a user friendly and robust anonymous event reporting system, instituting a complaint hotline, ensuring a non-punitive culture with supporting policies, maintaining a strong ethics committee, providing nurses with pastoral care support, and/or maintaining an internal grievance process. Although organizations are required to have these things in place due to regulatory requirements, whether they are utilized must also be evaluated as a reflection of the strength of the organizational culture. These tools requires training, resources, and support.

Although many of the researchers identified power struggles or unequal power as contributors to ethical dilemmas for nurses, they do not suggest how increased power would help nurses determine priorities or resolve the dilemmas (Pavlish et al., 2012). Interventions specific to nurse authority need to be explored and tested. Potential strategies would include use of scripting (providing verbiage to nurses to guide them through tough conversations), crucial confrontations training (Patterson, 2012), role playing using the chain of command, reviewing chain of command procedures, and training/policies/support for reporting uncivil or bullying behaviors.

Lastly, although this review focused on acute and critical care settings, ethical dilemmas are experienced in any and all nursing practice settings. While DeWolf Bosek (2009) studied acute care and ambulatory, there is a clear lack of research comparing different practice settings.

Conclusions

This review offers an analysis of the available evidence regarding ethical dilemmas in acute care, identifying both themes, limitations, and gaps in the literature. Clearly, the gaps in interventional work, paucity of U.S. research, inadequate quantitative evidence, and comparisons across practice settings and nursing roles need to be addressed. Other needs identified in this review are for further exploration of the relationship between ethical dilemmas and moral distress, the significance physical appearance of a patient plays on nurse determination of futility, and interventional work around pain management and honesty or truth telling.

Further, terminology needs to be more tightly defined as there is confusion over morality, ethics, stress, and distress. The concept of ambivalence and nursing ethics need further clarity, as does the use of ethical dilemmas versus ethical conflicts or concerns, or even moral distress.

Relevance to Clinical Practice: End-of-life issues, the predominant cause of dilemmas found in this review, are ever increasing as life-sustaining technology increases. The future of the profession is dependent upon recognition and action to address ethical dilemmas in the workplace to prevent burnout. Future researchers should focus on developing and testing strategies to help nurses identify and resolve these dilemmas in collaboration with organizations and other practice disciplines.

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Table 1: Characteristics of Selected Studies

Author	YR	Study aim	Study type	Location	Sample	Sample size	Findings	Limitations	Level of Evidence
Ahern & McDonald	2002	Review thoughts of nurses who experienced an ethical dilemma	Quantitative cross-sectional	Australia	Mental health and acute nurses, 73% female, ages 36-50,84% in nursing more than 10 years (half more than 16)	95	Nurses who had a higher score on patient needs over other considerations (vs. nurses with higher traditional authority respect) more likely to whistle blow, seriousness of the misconduct not different b/w groups--authors say non-whistleblowers may have interpreted the severity wrong	Includes mental health nurses too, lower power than desired due to 20% response rate, power 67	III
Barlem et al	2012	Explore moral distress in Brazil nurses	Quantitative cross sectional	Brazil, 2 hospitals	19% nurses, 12% auxiliary nurses, 68% techs, 86% female, 52% over 30, 6 years exp	247	All of the MD was caused by ethical dilemmas, namely : 1)competency concerns, 2) unable to advocate for pt, 3) unable to advocate for terminal, 4) work conditions limiting ability to give best care, 5) not respecting pt wishes	Included "auxiliary" nurses and nursing techs--difficult to determine the voice of RN this study was not about ethical dilemmas, but all of the causes of MD presented are consistent with factors of ethical dilemmas presented in the other sources	III

Blasszauer & Palfi	2005	Enlighten readers on the limitations of terminal care in Hungary	Qualitative	Hungary	76 nurses and another 250 students (nurses and other healthcare students)	76 plus 250	Related to lack of authority, patient suffering, lack of education of ethical principles (?), ethical issues with dying pts, conflict with MDs,	Does not explain demographics, writing style sometimes unclear on study findings vs. author commentary, includes non-ethical issues for nurses, states education would eliminate ethical issues where it probably would not, excuses neglectful behavior—very different culture	VI
Blondal & Halldorsd.	2009	To explore experience of nurses who care for patients in pain	Qualitative phenomen.	Iceland	Acute care med/surg, 2 yrs exp minimum, (range 2 to 30), mean age 41.7	10	Looked at ethics around caring for pts in pain, addicts in pain particularly stressful dilemma, fear of over sedating, concerns over honesty/med seeking, palliative pts refusing pain meds, MD gate keeper issues, poor management of pain from discontinuity, dying, time constraints	All female sample, exp. 2 to 30 is a huge range in a small group. Recruitment criteria unclear	VI
Chaves & Massarollo	2009	Explore thoughts on dilemmas in terminal pts for icu nurses	Qualitative	Brazil	Nurses with over 4 yrs exp, general icu, 100% female, 90% post grad degree.	10	Dilemmas from 1) values conflict with terminal care, 2) professional responsibility conflicts with terminal, 3) conflict with family not accepting dying, 4) difficult to accommodate family presence, 5) conflict from prolonged suffering	All women, 10 included to reach saturation	VI

Chiu et al	2009	Evaluate ethical dilemmas in terminal cancer pt care	Quantitative cross	Taiwan	MDs and oncology nurses, 67% female, 35.27 avg yrs old, 32% in oncology, 61% nurse, exp. 10.667 yrs	505	Primary dilemmas around clinical management: 1) artificial nutrition, 2) antimicrobial use, 3) palliative sedation, 4) blood, 5) opioid use, 6) steroids, and after clinical management communication with truth telling, appropriate level of care, hospice referral, and euthanasia	Some issues not congruent with US, cause of dilemmas not separated by discipline, but related variables were, stat analysis provided for predictive variables, but not for the causes of dilemmas. Did not share power analysis	III
Choe et al	2015	To understand MD is Korean ICU nurses	Qualitative phenomen.	Korea	ICU nurses	14	MD from 1) ambivalence, 2) suffering from lack of "ethical sensitivity of peers", 3) dilemmas from lack of nurse autonomy, 4) conflict with MDs, 5) conflicts with institutional policy. Offers broader defin of MD than traditional which sounds like ethical dilemmas. Concept of ambivalence.	Term confusion -- ethical dilemma and MD not the same things--one is where you don't know what to do and one is where you can't do the right thing. Good design with follow-up interview	VI
Cooper et al	2004	Compare results of two surveys on ethics	Eval of quant work	USA	ANA members and AONE members survey results	295 from ANA, 2000 AONE	Biggest concerns lack of quality of service from economic constraints # 1 in both studies, failure to meet nursing standards tied for #2, #3 for ANA was conflict with personal and org standards, AONE #3 failure to give quality care in eyes of providers--top 8 of 10 in ANA also in AONE	ANA sample	III

de Casterle et al	2008	Report study of nurses reactions to ethical dilemmas	Meta-analysis	4 countries: Belgium (4), Switzerland (2), USA (2), Japan (1)	9 studies: subjects primarily female, mean ages 28-39	1592 nurses	Ethical reasoning scores varied among groups, of the six kohlberg stages, nursing importance of them similar to bell curve	Reported as lack of situational factors. Most included studies were prior to 2000	I
de Carvalho & Lunardi	2009	Understand how nurses handle futile treatment	qualitative	Brazil, 2 hospitals	Nurses working more than 1 year,	6	Ethical issues of prolonged suffering, potential for healing, resource use appropriately, concern for humanized care. Dignity and autonomy can still exist when death is inevitable	Not purely about ethical dilemmas, very little on nurse demographics, only 6 interviews	VI
DeWolf Bosek	2009	Explore ethical issues encountered and evaluate decision making factors	Qualitative phenomen.	USA	Staff nurses	17	Dilemmas related to 1) not meeting patient wishes, 2) poor communication of prognosis, 3) family conflicts, 4) fear of retribution if requesting an ethics consult. Differentiation of clinical, professional and organizational/societal ethical dilemmas	Inpatient and ambulatory. 2% response rate. No demographic data provided to protect participants	VI
Eriksson et al	2014	Explore ethical dilemmas and the consequences of them on dying stroke pts	Qualitative	Sweden	Neuro nurses and others, (therapists, MDs, and CNAs) median stroke exp. 7 yrs, 12 were men	13 nurses/ 41 total participants	Dilemmas around change in treatment plan, artificial nutrition, aggressive tx vs hospice, lack of influence with MDs, communication issues. Palliation and hospice used interchangeably.	Included non-nurses too. Large sample for qualitative. Findings by discipline well defined	VI

Ersoy & Goz	2001	Gain insight into ethical sensitivity of bedside nurses	Quantitative cross sectional	Turkey	Bedside nurses in three teaching hospitals/67% 25 or younger, 63% surgical, 66% with under 5 years of exp,	165	In four scenarios, many would lie to protect a patient in a parental model, or lie trusting in the doctor's decision to withhold info, nurses with more experience were more likely to respect patient autonomy and veracity. Different scenarios had different responses from the nurses	Construct validity concerns--are they measuring recognition of an ethical dilemma or just the decision made based on what-ever ethical principle? Concerns with term of ethical sensitivity—recognition only. Does not address sex of sample. Sample younger than the average of US. Nurses	III
Fernandes and Moreira	2012	Identify ICU nurses ethical dilemmas	Qualitative	Portugal	ICU/7 women, 8 men, mean age 34, mean 10 yrs exp., 9 married	15	5 themes of end of life decisions, privacy, patient and family interactions, team work, and health care access, feeling marginalized	Clinical situations, context, and nursing individual factors lead to ethical issues. Recruitment questions	VI
Ferrell et al	2001	Evaluate beliefs on pain manageme nt- ethical dilemmas for members of American Pain Society	Mixed methods	USA	189 nurses, 79% aged 35-54, 85% female, 76% more than 15 yrs nursing exp, 65% more than 7 years in pain, 25% academic setting	1105	Primary dilemmas: 1) management of pain at end of life, 2) impact of managed care on pain treatment, 3) under-treatment of pain, 4) under treatment in elderly, 5) under treatment in children Qualitative findings inappropriate pain management, 2) barriers to care, 3) conflicts, 4) regulatory issues, 5) euthanasia, 6) research issues	not just nurses, but results are separated by discipline, no statistical analysis.	VI

Ganz & Berkovitz	2012	To explore ethical dilemmas, MD, and thoughts on quality with surgical nurses	Quantitative cross sectional	2 Israeli	Surgical nurses, mean age 39.7, 79% staff nurses, 70% married	119	Ethical dilemmas: 1) inappropriate behavior of pt or family toward staff, 2) conflicts b/w pts and families. Power > 0.8, 74% participation	Grouped ethical dilemmas with MD, not the same issue exactly. Some reported dilemmas may have been the duty to report the issue, not the issue itself--nurse violence toward pt for example.	III
Gaudine & Thorne	2012	Correlate ethical conflict, stress, organiza-tional commi-tment, to turnover and absences a year after	Quantitative longitudinal	Canada	Acute care/nurses in 4 hospitals, mean age 39.4, mean exp. 13.3 yrs	410	Absenteeism associated with ethical conflicts, org commitment and stress; some conflict from staffing	Seems more the definition of MD than ethical dilemma	III
Ham	2004	Explore principled thinking in students and RNs	Quantitative desciptive	4 Midwest states	Nursing students and exp. nurses , nurses over 42 with 10 yrs exp., students under 26	232	Higher levels of principled thinking in students, more exp. correlated to lower scores, type of nursing education not related to principled thinking	No discussion of power, use of nursing dilemma tool	III
Harris	2002	Explore dilemmas and issues with withdraw of ECMO in adults	Qualitative grounded	UK	Nurses with experience in withdraw of ECMO	9	Issues were: 1) justification, 2) nurses role in decisions, 3) involvement of others in decisions. Concept of appearance-"rotting"	Did not report demographic of participants. Met saturation. More about issues than exploring dilemmas	VI

Jackson et al	2010	Explore reasons behind blow the whistle and give info on the experience	Qualitative	Australia	Nurses who blew the whistle	11	Blew whistle b/c they couldn't "advocate for pts" -- a dilemma. Caused by incompetent peer, bad department practices, culture of silence	phone and face to face interviews-potential differences in interview quality from different methods	VI
Kinoshita	2007	Explore ICU nurses and problems respecting end of life wishes	Mixed methods	79 Japanese hospitals	93% female, mean age 30, mean exp. 8.6 yrs	1210	Ethical dilemmas from 1) patient wishes not known, 2) persons other than patient making decision, 3) poor info on prognosis to family, 4) conflict with ICU aggressive environment and dying needs, 5) patients expected to recover, and look terrible (characteristics of ICU end of life). Large majority of nurses felt patient wishes for end of life were not respected	mean age and experience less than usual US counterparts	VI
Konishi et al	2002	Explore end of life and dilemmas with artificial nutrition	Mixed methods	Japan	93% in hospitals, 63% leadership roles, 48% 21-30 years exp., 99% female, 94% diploma educated	160	Split into groups of agree to withhold nutrition and disagree. Agree group driven by comfort and natural death, disagree group by the issue of life	Included families-but easy to see nursing views separate--leaders and staff nurses combined findings, however	VI
Langeland and Sorlie	2010	Explore ethical situations in ER	Qualitative	Norway	ER/mean age 40, 6-20yrs exp.	5	3 themes of vulnerability, responsibility and priorities. Used ethical dilemmas and Challenges interchangeably	Very small number of participants	VI

Lutzen et al	2003	Explore moral stress	synthesize 2 qualitative studies	Sweden	2 studies	15/36 nurses	ICU study discussed issues of wanting to act, knowing something should be done: consistent with a dilemma. Moral stress definition matches moral distress/also uses moral sensitivity term consistent with MD definition	included a psychiatric study and an ICU study, outside of inclusion criteria	V
Melia	2001	Explore handling of ethical issues in ICU	Qualitative	Scotland	General ICU, pediatric ICU, cardiology, CCU, teaching hospitals	24 nurses	Caused by futility/withdraw, concern for dignity, appropriateness of care, discontinuity and change of treatment plan per MD, limbo in decisions, already dead—appearance. Argues that nursing ethics is about power struggles	Included nurse managers, large number of nurses included in interviews but inconsistent approach--some in groups of 2, some solo	VI
Pang et al	2003	Compare ethical roles b/w American, Chinese and Japanese	Quantitative cross sectional	US, China, Japan	Chinese 413, 68% 18-30, 99% female, 85% staff nurse/japan 52% 18-30, 96% female, 87% staff, US 61% over 41, 87% female, 88% nurses	1243	Specific issues not important per nationality differed, in importance: US do no harm, Japan and sense of responsibility highest, Chinese more virtue based, Us more principle based, japan care based. Principles what you ought to do and virtue what ought to be--nice	11 point scale is not precise. Americans much older and more men, included leadership roles	III
Pavlish et al	2012	Identify ethical situations and perspectives for oncology nurses	Qualitative ethnography	USA	Oncology nurses, 96% female, 63% Caucasian, 46% catholic,	30	Causes of challenges: contributing to patient suffering, competing tasks--how to prioritize, hope vs honesty, emergent care in the absence of pre-planned end of life discussion. Concepts of speaking up, around, sideways, staying silent and looking away	Included 4 educators, 3 NPs, 1 CNS and 3 administrators--unclear what the message from the bedside staff was	VI

Rejeh et al	2009	Understand ethical issues with pain management in surgical pts	Qualitative	Iran	24 women, 2 men, mean age 33.45, mean exp in surgery 10.6. 4 with master's degree	26	Conflict from organizational limits, closeness to the suffering of pt, nurses "fallibility". Can have shortages in narcs--dilute them, not enough resources to monitor pt closely, dc in pain, ex. Scissors' left in pt--unable to tell them the truth, issues with addiction/not believing pts, desensitization to pain, poor judgment (gave placebo for ex)	16 bedside nurses--also counted sups and nurse manager. Very different culture than nursing in USA.	VI
Shapira-Lishchinsky	2009	Evaluate ethical dilemmas in relation to nurse professional status	Qualitative	Israel	18 organizations, 33 women, age 25-55. 10 -40 yrs exp.	52 nurses	Autonomy vs. safety for pts, (following rules), loyalty vs reporting misconduct, keep secrets vs duty to report, process vs outcome, family needs vs organizational	Included populations (psych) excluded from original search criteria. Difficult to draw parallels with US	VI
Shorideh et al	2012	Explore moral distress in Iran	Qualitative	Iran	28 staff nurses and 3 educators, 67% female, mean age 38, exp. 10 yrs	31	Futility, negligence, disrespecting pt wishes,	Primarily concerned with MD, several causes due to ethical dilemmas	VI
Silen et al	2008	Evaluate stress ad ethical dilemmas in neuroscienc e nursing	Qualitative	Sweden/univer sity hospital,	Mean age 36.7, 71% married or sig other, 89% basic nursing education, median exp. 3 (range 1-41)	21	Causes workplace distress, ethical dilemmas, managing distress and ethical dilemmas, quality of nursing. Subthemes--couldn't do job right, difficult or demanding families, issues with withdraw, helplessness with	One interview only--may have had additional info with a follow-up interview design. Recruitment confidential	VI

							very ill pts, privacy issues--curtain separating		
Silen et al	2008	Compare ethical and stress sit b/w Chinese and Swedish nurses	Quantitative	Sweden and China	China--mean age 28.7, 100% female, nursing exp. 5 yrs/Swedish mean age 38, 93% female, mean exp. 7 yrs	273//136 Chinese, 137 Swedish	Both groups reported heavy workload as the top dilemma, Chinese #2 lack of experience and #3 conflicts with families. In Sweden, #2 regarded life sustaining treatment and #3 conflict with MDs. Chinese more upset at work, but Swedish identified more ethical dilemmas	There were some statistical differences in the two groups in experience and other demographics that could factor into differences in findings	III
Ulrich et al	2010	Evaluate the stress and ethical issues in practice	Quantitative cross sectional	US	4 states, 95% female, 84% white, exp. 19.8 yrs, 18% masters prepared, mean age 45	422	Issues r/t protecting pt rights, informed consent issues, staffing, end of life. Younger nurses more stress and ethical dilemmas	Included non-acute settings, differences across state samples.	III
Wadensten et al	2008	To compare Swedish and Chinese experience with ethical dilemmas and distress in the work environment	qualitative piece of mixed study	Sweden and China	Swedish mean age 37, exp. 7.7 yrs, china mean age 33, exp. 14.1, neuroscience setting	41	Ethical dilemmas for both groups conflicting views with MDS on appropriate treatment, little authority to "fulfill duty and give best care", Swedish more worry over life sustaining treatment and China patient finances dictating quality of care	Can't tell if men were included--some content areas not classified as ethical dilemmas actually are	VI

Prisma Figure 1: Ethical dilemmas Search Methodology