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Employed to Go Against One's Values: Nurse Managers' Accounts of Ethical Conflict With Their Organizations

Alice P. Gaudine and Marilyn R. Beaton

Cette étude qualitative descriptive se penche sur la question des conflits déontologiques en milieu de travail, tels que vécus par des infirmières gestionnaires. Quinze de ces professionnelles œuvrant dans sept hôpitaux d'une province de l'Est du Canada ont été interviewées dans le cadre d'entrevues semi-structurées. Les données recueillies sur les conflits déontologiques ont permis de dégager quatre thèmes : l'impossibilité de participer aux décisions, les désaccords quant aux priorités budgétaires, les droits des individus par opposition aux besoins de l'organisation, et les pratiques injustes exercées par la haute direction et / ou l'institution. Les auteures identifient les facteurs qui atténuent ou exacerbent les conflits déontologiques et présentent les dénouements du point de vue des infirmières gestionnaires. Elles discutent aussi des conséquences pour les infirmières, les hôpitaux et la recherche à venir.

This qualitative descriptive study examined ethical conflict in the workplace as experienced by nurse managers. Using semi-structured interviews, 15 nurse managers employed by 7 hospitals in 1 province in eastern Canada were interviewed. Four themes of ethical conflict were identified in the data: voicelessness, "where to spend the money," the rights of the individual versus the needs of the organization, and unjust practices on the part of senior administration and/or the organization. The authors identify factors that mitigated or worsened the ethical conflict, as well as the outcomes for the nurse managers. They also discuss the implications for nurses, hospitals, and future research.

An individual's personal values, often held passionately, are an integral part of one's self-concept (Rokeach, 1973; Uustal, 1978). They provide the framework for one's view of the world and one's place in it, and for distinguishing right from wrong (Rokeach, 1968).

Personal values may conflict with the values of professional associations and employing organizations. For example, while the nursing profession socializes nurses to provide the care that is best for each patient (Jameton, 1984), nurses may not be able to fulfil this obligation

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Alice P. Gaudine, RN, MScA, PhD, is Associate Professor and Associate Director, Graduate Programs and Research, School of Nursing, Memorial University of Newfoundland, St. John's, Canada. Marilyn R. Beaton, RN, MN, MBA, is Associate Professor, School of Nursing, Memorial University of Newfoundland.

when employed by organizations charged with the distribution of scarce resources.

When an individual's personal values clash with those of the employing organization, the result is ethical conflict. Rest (1994) notes that professionals are especially at risk for ethical conflict because of their dual role, as a member of both an organization and a profession. Ethical conflict can affect individuals, organizations, professions, and society at large. Rodney and Starzomski (1993) suggest that ethical conflict experienced by nurses can lower morale and increase burnout and turnover, while Gaudine and Thorne (2000) suggest that it can affect commitment to the organization or profession and increase absenteeism and turnover.

Studies that have looked at ethical conflict as experienced by nurses have focused on the conflicts that stem from clinical decision-making (e.g., Butz, Redman, & Fry, 1998; Redman, 1996; Redman, Hill, & Fry, 1997, 1998; Rodney, 1998; von Post, 1996; Wagner & Ronen, 1996). Very little is known about ethical conflict between nurses and their employing organization or their professional association. However, a recent study (Gaudine & Thorne, 2000) described the ethical conflicts of 12 direct-care hospital nurses with their employing organizations and professional associations. It found three themes of nurses' ethical conflict with their employing organization: compromised safety and/or quality of patient care due to heavy workloads, lack of value for human resources on the part of management, and ineffective or inappropriate actions on the part of the organization. The authors note that most of the value differential between nurses and organizations represented ongoing situations, wherein nurses perceived they had little power to resolve the conflict. In addition, the study identified three ways in which professional associations represented ethical conflict for nurses: lack of visibility, distance from the realities of direct-care nursing, and lack of support for nurses.

While Gaudine and Thorne (2000) describe the ethical conflicts between direct-care hospital nurses and their organizations, the issue of ethical conflict between hospital nurse managers and their organizations has not been explored. Nurse managers are socialized as nurses but speak on behalf of their organization. Recent cost-cutting measures in health care have led many hospitals to make difficult budget-allocation decisions, placing hospital nurse managers at particular risk for ethical conflict with their employing organizations. Knowledge about such experiences is essential if we are to work towards the resolution of

ethical conflicts and towards the mitigation of negative outcomes for nurse managers, their organizations, and the nursing profession.

The current study adds to our knowledge by describing nurse managers' ethical conflicts and value differences with their employing organization and their nursing associations. Its main objectives are: to provide rich descriptions, themes, and patterns of ethical conflict between nurse managers and hospitals; to describe factors that mitigate or worsen this ethical conflict; to identify outcomes associated with this ethical conflict; and to describe ethical conflict between hospital nurse managers and their nursing associations.

Methodology

Design

This was a qualitative, descriptive study based on the belief that events and feelings are best described by the person who has experienced them. In addition, the study used a grounded theory approach (Glaser & Strauss, 1967) to data collection, in that analysis was ongoing throughout data collection as recommended by Merriam (1988) and emerging themes helped to guide subsequent interviews.

Sample

A convenience sample of 15 nurse managers in an eastern Canadian province was recruited with the help of two senior nurse administrators and two nursing professors. The nurse managers were asked if they were willing to be interviewed on the topic of ethical conflict with organizations. (In addition to the 15 nurse managers in the sample, two other nurses were approached: one did not wish to be interviewed and one agreed to be interviewed but later became too busy to schedule a meeting with a researcher.)

Three of the 15 participants were employed at two different centres that had recently been merged under one hospital administration. The remaining 12 worked for six different organizations. Three participants were the senior nurse administrator in their hospital (henceforth referred to as "senior nurse managers"). The other 12 were responsible for two or more departments, including intensive care, emergency, obstetrics, pediatrics, rehabilitation, long-term care, peri-operative and operative nursing, and medical and surgical nursing. All but one of the participants were female. One participant was between the ages of 30 and 39, 12 were between 40 and 49, and two were between 50 and 59.

Two participants had 5 years or less of management experience, two had between 6 and 10 years, seven had between 11 and 20 years, and four had between 21 and 30 years. Ten participants had a diploma, three had a bachelor's degree, and two had a master's degree. Four of the participants with a diploma were enrolled in bachelor's studies, and two of these also had a diploma in departmental management. One other participant with a diploma also had a diploma in departmental management. One of the participants with a bachelor's degree was enrolled in master's studies.

Two nurse researchers, the authors of this paper, each conducted approximately half of the interviews. The meetings with potential participants began with the nurse researcher describing the purpose of the study and the role of the participant. Due to the sensitive and confidential nature of the interview data, potential participants were informed that the data would be collected from a number of different organizations throughout the province in an effort to preserve anonymity. The potential participants were informed that the interviews would be audiotaped and transcribed by a secretary and that they would be mailed a copy of the transcript along with a summary of their interview, to allow them an opportunity to identify material that should be disguised or removed and to verify accuracy. All of the nurse managers who listened to this detailed description of the study agreed to participate. They signed the consent form and provided demographic information.

The interviews lasted approximately 60 to 90 minutes and took place in a private room at the participant's workplace. The study used a semi-structured interview methodology. The participants were asked if they had any ethical conflict with their organization or with their provincial or national professional associations. An ethical conflict was defined as a situation wherein the nurse manager's values differed from those of the organization and the nurse manager experienced conflict as a result. All of the participants were readily able to describe at least one current situation of ethical conflict and to identify their own values and those of the organization. For each ethical conflict identified, the participant was asked to describe factors that eased the ethical conflict, factors that worsened the ethical conflict, and personal outcomes resulting from the ethical conflict. These questions were included in the semi-structured interview guide in an effort to elicit a full description of each nurse manager's experiences of ethical conflict.

After each of the first six interviews, the two researchers met to review the transcript in depth, in order to make a preliminary identifi-

cation of codings and to identify any potentially important areas for exploration in subsequent interviews. They also reviewed their interviewing techniques with respect to facilitating participants' comfort in sharing sensitive material and with respect to avoiding bias in the experiences participants chose to share. After each of the remaining nine interviews, the researchers held brief meetings to share any areas for exploration in subsequent interviews.

Analysis

The interviews were transcribed verbatim. In order to verify the data, each nurse manager was mailed a transcript as well as a summary of his or her interview. Several weeks later the researchers phoned the nurse managers, all of whom were in agreement with the summary.

In first-level coding, the transcripts were reviewed for material related to the five areas covered in the semi-structured interview guide: ethical conflict with the employing organization, ethical conflict with the professional association, factors that mitigated or resolved ethical conflict, factors that worsened ethical conflict, and outcomes for the nurse manager. In second-level coding of ethical conflict situations, themes or categories were identified from the first-level coding. Finally, the data were explored for patterns of ethical conflict.

This study used step-wise replication (Guba & Lincoln, 1985), in which the researchers separately analyze the data, then cross-check each other's categories, themes, and interpretations. The transcripts were first analyzed separately by each of the two nurse researchers. The researchers became immersed in the data by reading and rereading the transcripts. Separately they developed codings for each of the five areas. The two researchers compared their codings and sought agreement on themes and patterns. Differences in the two analyses were minimal and were readily resolved through discussion.

Results

Four themes of ethical conflict between nurse managers and their organizations were identified: voicelessness, "where to spend the money," the rights of the individual versus the needs of the organization, and unjust practices on the part of senior administration and/or the organization (see Table 1). The theme of voicelessness was identified in every interview, suggesting conflict with the participants' value of collaboration. Many of the participants felt that their organization wanted them to be invisible and made an effort to recruit nurse managers who would

Table 1 *Nurse Managers' Ethical Conflicts With Hospitals*

Voicelessness

- nurse managers hired because they are perceived to "toe the party line"
- nurse managers not present during decision-making on issues that affect nursing
- nurse manager positions radically decreased, resulting in minimal nursing input
- nursing not valued
- nursing not understood
- no effort made to understand nursing

"Where to spend the money"

- spending on acute care instead of long-term care; failure to invest in staff development; focus on short-term issues instead of quality of nurses' work life
- sacrificing of quality (e.g., substandard patient care; patient/family rights secondary to balanced budget)
- crisis management instead of long-term budgetary planning

Rights of the individual versus needs of the organization

- policies that support the hospital's legal needs as opposed to patients' and nurses' needs as perceived by nurse manager
- nurse manager forced to make decisions that serve the needs of the organization but have negative implications for nurses

Unjust practices on the part of senior administration and/or the organization

- unfair policies for the promotion and termination of nurse managers
- unfair workloads for direct-care nurses and nurse managers
- failure to act even when senior administration is aware of a problem
- centralized versus decentralized decision-making
- non-nurses given priority over nurses for first-line supervisory positions
- punitive absenteeism policy
- punitive medication-error policy
- underpaying of nurse managers
- hospital's stated values (e.g., integrity; consultation) not upheld by administration and board
- lack of interest and lack of information on the part of board of directors

"toe the party line." The majority of the participants felt that they were not always included in decisions that involved nursing, and that neither they nor nursing were understood by administrators. Further, several participants believed that administrators did not want to understand nurses and did not intend to act on nurses' needs. A major outcome of this theme was that the nurses felt devalued and powerless.

The following excerpts illustrate the voicelessness theme and the sense of powerlessness experienced by the nurse managers:

> *There doesn't seem to be knowledge with regards to why we need nursing, why we need to have a good float pool, why we need to have permanent staff versus casual staff, that kind of thing. And there never seems to be a will, either, for them to understand it. The bottom line is always the dollar and the cents and I keep going back saying, "Well, you know, this is a business, but it's a health-care business, and when you forget that you have forgotten why we're here." And of course everybody looks at me like I'm from another planet... In senior administration, yes, I really don't think that they want to get it.*

> *I was a senior manager but was not included in the decision-making because they knew that I would not support that decision... When I became aware of [a particular decision], that is when I started asking questions. I was told at that time, in words that I can remember, "I don't want to hear any more about it. This is the way it is going to be."*

This senior nurse manager was actually disregarded through a lack of dialogue, and she felt she had to speak out about this decision. She and the nurse managers who reported to her made presentations to senior administrators:

> *Right after that I found myself in significant difficulty and [my assistant] and myself were both terminated from our positions. Now, I was terminated and not given any reason. In the letter they said that it was due to restructuring.*

This senior nurse manager reported that consequently the remaining nurse managers seldom shared information with hospital administrators or board members.

The second theme of ethical conflict, "where to spend the money," was identified in all of the interviews. This theme reflects differences in mission: for the nurse managers, meeting the needs of each patient, family, and staff member; for the hospital, staying on budget and maintaining services. All participants were distressed when they saw unmet patient or family needs and difficulty in recruiting and retaining nurses. This distress was aggravated when their attempts to have senior administration understand a situation proved unsuccessful.

A senior nurse manager responsible for acute and long-term care in a hospital said:

> *If it's an acute-care issue, okay, we have to call an ambulance to bring someone to [referral hospital], or we have to call extra staff because we have a motor vehicle accident. Well, it seems like people can understand the acute side, but heaven forbid that long-term care should have a reason to need extra staff.*

The three nurse managers who had responsibility for both acute and chronic care shared the view that hospitals valued acute care more than chronic care.

The theme of "where to spend the money" is also illustrated by the fact that a number of participants noted the frequency of budget cuts in staff development. The nurse manager of a specialty unit explained:

> *In order for me to keep critical care and all the changes in [specialty unit] front and centre, I do need an instructor. Then again, they only have a limited [amount of money] to give out and that is not high on the priority list.*

Similar to "where to spend the money," the theme "the rights of the individual versus the needs of the organization" reflects the nurse managers' valuing of individual rights through their concern for the needs of each patient, family, and staff member. A common outcome in this theme was the participant feeling caught between the needs of the organization and the rights of patients, families, and/or nurses.

One participant described a situation in which a nurse with a suspected substance addiction was transferred to a specialty unit and the nurse manager was not told of the suspected addiction:

> *I think the value of the organization was autonomy for this individual. I mean, nothing had been proven although there had been an awful, awful lot of suspect behaviour... However, I think it put me in jeopardy, and it put my patient care in jeopardy. Unfortunately, we had incidents...where drugs were stolen.*

This nurse manager also spoke of the conflict between hospital policies and the rights of an aboriginal woman who had assumed responsibility for her sister's child:

> *We had an example where the child came in for [surgical procedure], not a big deal, certainly correctable... We treated the child metabolically with IV and got him...ready for surgery and the surgeon came in to get consent from the parents. That is when the mother said she did not give birth to the child, [the biological mother] gave the child to her because she only had one [child] and [the biological mother] had five. [The biological*

> *mother] was up in [location] on the hunt, so the surgery was delayed for almost a full day... But [the biological mother] had given this child to this other woman. This is their culture and they accept it and to [the biological mother] these other people were the parents... I don't think we have come far enough in appreciating culture; these people are in our own province.*

In referring to the hospital's need for beds, one participant said:

> *Our beds are blocked today because of the patients that we have waiting for beds in long-term care. I don't know if I can say that administration does not appreciate the right of the patient — we have to keep them until they go somewhere. But there is a stipulation in medical discharge so that they pay here in the hospital the same as they would in a long-term facility. Sometimes that would be assumed to be the deterrent for the family to keep them here. But if they do take them home, are they going to take care of them as well as they need to.*

The theme "unjust practices on the part of senior administration and/or the organization" was identified in several of the interviews. The usual outcome was the nurse manager resigning or wanting to resign and feeling frustrated, angry, or concerned for the well-being of the nursing staff.

One nurse manager described a progressive disciplinary policy for medication errors that had been developed by human-resources and nursing consultants:

> *Now, I know people have to be held accountable for their practice and everything else, but we are into a process that a nurse makes one medication error and you have to tell them, "Look, consider this your verbal reprimand." The next one, they get a letter of reprimand, which is on file for 18 months, and if they make another one in the same year they are suspended. I have concerns with that. I do have concerns with safe medications...but I have an ethical dilemma with this whole disciplinary process. It sounds so punitive, and it is punitive.*

One senior nurse manager described the board of directors of a hospital as "not terribly effective":

> *They did not attempt to find out about quality of care, about advocating for patients, and so on. I felt that there were a few board members that would get involved and ask questions and research, but I found for the most part that the board was there for tokens and did not really have the interest of the organization at heart.*

Table 2 summarizes the wide range of factors that worsened the nurse managers' ethical conflicts with hospitals. These factors include having to deal with fallout from actions the nurse manager did not agree with, being constrained in resolving the ethical conflict, situa-

Table 2 *Factors That Worsen Nurse Managers' Ethical Conflicts With Hospitals*

Fallout from decisions the nurse manager did not agree with
- poor or unsafe patient care
- poor treatment of friends/relatives
- increased number of patient complaints about poor nursing care
- downsized nursing management that results in increased costs elsewhere

Inability to resolve ethical conflict
- inability to speak out or to act
- unwillingness of staff nurses to speak out, often due to fear
- inability to make the needs of nursing understood
- knowing that senior management is aware of a problem but will do nothing
- knowing that documenting required changes has been a waste of time

Situational factors
- fear that situation will escalate if nurse manager speaks out
- poor communication with senior administration, either because of organization's size or because the administration does not value nursing management
- persons who refuse to negotiate
- opinions of physicians more valued than those of nurses
- uninformed boards of directors
- salary inequities among nurse managers
- new nurses for whom nursing is just a job
- difficulty in recruiting and retaining nurses
- nurses who complain instead of taking constructive action
- unfair comparisons to other hospitals regarding staffing levels
- knowing that other hospitals have better resources or have eliminated their deficits
- knowing that other hospitals go beyond the contract
- seeing money spent on physician retention
- silence on the part of professional associations and other directors of nursing on an issue they are aware of
- knowing that nurse manager's situation is not unique and that nursing in Canada is in trouble
- smear campaign against a nurse manager

Factors relating to the nurse manager
- inability to identify what is right and what is wrong
- remembering when nursing used to be valued
- needing to have a mentor
- feeling trapped because of number of years in nursing management
- not knowing if one is doing the right thing
- feeling responsibility to improve the situation
- inability to inform staff nurses of one's efforts to resolve issues of concern to nurses

tional factors, and characteristics of the nurse manager. Table 3 summarizes the factors that mitigated nurse managers' ethical conflicts with hospitals. These revolved around support, problem-solving, and refocusing. Table 4 summarizes the outcomes of ethical conflicts for nurse managers personally. These include a wide range of negative feelings, a desire to leave nursing management, and learning to remain silent about one's ethical conflicts with the organization.

Several participants said they wished their professional associations would be more vocal about ethical issues faced by nurse managers, explaining that sometimes a situation could be improved by a few timely questions addressed to a hospital. Several mentioned the moral support they got from knowing that their professional association shared their values and would stand behind their actions. The majority of participants said they had no ethical conflicts with their professional associations and believed their actions were "in tune and on track."

Table 3 *Factors That Mitigate Nurse Managers' Ethical Conflicts With Hospitals*

Support

- support from other nurse managers, hospital administrators, physicians, hospital ethics committee, staff nurses, family, public
- internal strength gained from knowing that one is morally right
- internal strength gained from knowing that one is following the Canadian Nurses Association's *Code of Ethics*

Problem-solving and growth

- problem-solving with other nurse managers, hospital administrators, physicians, hospital ethics committee, staff nurses
- learning to separate personal values from professional responsibilities
- developing and presenting a proposal to senior administrators

Refocusing

- hoping that the next generation of (better-educated) nurses will improve nursing
- focusing on one's own goals and on what one can do
- focusing on the high quality of care that nurses do provide
- dwelling on the positive when senior administration begins to address a problem

Table 4 *Outcomes of Nurse Managers' Ethical Conflicts With Hospitals*

Negative feelings

- frustration, anger, fear, stress, burnout, loneliness, demoralization, powerlessness and/or lack of fulfilment
- concern for well-being of nursing staff
- poor self-image as manager when over-budget
- unsupported and unvalued
- fear for patient safety
- torn between viewpoints of staff nurses and those of senior administration

Turnover, resulting in a changed profession

Learning to remain silent

Discussion

The themes of ethical conflict were associated with distinct outcomes: "voicelessness" was associated with feeling devalued and powerless; "where to spend the money" with distress at seeing unmet patient, family, or staff needs; "the rights of the individual versus the needs of the organization" with feeling caught in the middle; and "unjust practices on the part of senior administration and/or the organization" with resigning or wanting to resign, feeling angry, and being concerned for staff well-being. However, all four themes of ethical conflict were associated with distress and frustration. We have tried to capture the participants' experiences in the themes identified in the data and in the selection of excerpts from the transcripts. Nevertheless, it is difficult to convey the extent of the frustration, stress, pain, and powerlessness expressed in the interviews. The nurse managers shared the concern of their staff nurses when quality care could not be delivered, and they perceived themselves as the person responsible for improving patient care and for alleviating staff concerns.

The distress expressed by the nurse managers may reflect what Jameton (1984) refers to as moral distress. Jameton defines three types of ethical conflict: moral dilemmas, moral distress, and moral uncertainty. A moral dilemma occurs when the person sees more than one right thing to do, moral distress when the person knows the right thing to do but is constrained in doing so, and moral uncertainty when the

person is uncertain about which moral principles apply. The ethical conflicts between the nurse managers and hospitals were primarily ones of moral distress: the nurse manager knew what should be done but was unable to make it happen. The ethical conflict between the nurse managers and their organization represents ongoing, unresolved situations, with the potential for long-term stress and feelings of powerlessness.

While distress and frustration were common outcomes of ethical conflict among the participants, "wanting to resign" is a particularly troublesome outcome for the future stability and recruitment of the nurse manager work force. Some of the participants were thinking of leaving nursing, and some stated that they remained in their current position only because they had few employment options. Several participants stated that they could not encourage any of their staff members to go into nursing management.

The nurse managers described their own values as providing quality care, or doing what is best for each client, family, or staff member, and the fair treatment of nurses and nurse managers in the workplace. These values reflect the ethical principles of beneficence and non-maleficence — or the moral imperatives to do good to others and to not cause harm to others (Beauchamp & Childress, 1994) — and justice. The nurse managers described their hospitals' values, in contrast, as balancing their budgets and protecting their legal position.

The majority of nurse managers did not experience ethical conflict with their professional associations, and a number spoke of feeling supported by their associations, either through the simple sharing of values or through the association speaking out on an issue. In contrast, the majority of staff nurses interviewed by Gaudine and Thorne (2000) felt that their professional association was insufficiently vocal and visible. It is possible that nurse managers, because of their administrative tasks, have more access to information about the activities of the association than direct-care nurses and are more comfortable contacting the association when an issue arises.

The ethical conflicts described by the participants have serious implications for nurses, hospitals, and all those responsible for the provision of health services.

The theme of "voicelessness" has disturbing implications for nurse managers and direct-care or clinical nurses. It is demeaning for nurse managers to feel that they are not supposed to speak out and that decisions are being made around them. Further, being voiceless goes

against their values of collaboration and inclusion. Direct-care nurses working in hospitals where the contribution of nursing leaders is devalued are apt to feel that their own contribution is devalued as well. In addition, these nurses may believe they lack the opportunity for meaningful advancement within their organization. Current and potential nursing students may have second thoughts about entering a profession in which they will not have a real voice in decision-making.

The theme of "voicelessness" also has disturbing implications for hospital administrators and boards interested in attracting and retaining excellent nurses. The development of quality nursing services in any hospital requires nurse leaders who are visionary and assertive. In order to recruit and retain such persons, administrators and boards will have to ensure that nurses' voices are valued. Nurse leaders ought to be included in senior administrative and board decision-making, and staff nurses should be represented as well. A few of the participants said that in cases where a senior nurse manager sat on the board of directors, he or she was there only to answer questions and was under pressure not to disagree with the chief executive officer of the hospital. The public should be made aware of such situations, because the stakes in health care are too high to allow the stifling of nurses' concerns.

Policy-makers will have to ensure that organizational structures facilitate communication among nurse managers, senior hospital administrators, and board members. For example, the inclusion of direct-care nurses on the board of directors as well as on all hospital committees may serve to increase communication. Since it is relatively easy for an organization to take sanctions against non-unionized employees, unionized nurses may be more apt to provide information that goes against the views of senior administrators.

The participants were distressed to see nurses as the object of unjust administrative or human-resource practices. If nurse managers are to ensure quality nursing care, they will need to be in positions of authority concerning hiring, staffing, staff development, and human resources.

Nurse managers need help in their quest to provide a nursing voice at senior organizational levels. Several participants spoke of feeling isolated because their attempts to influence decision-making at the hospital could not be discussed with the direct-care nurses: unaware of the extent of the barriers facing the nurse managers, the direct-care nurses often harshly judged them for failing to produce results.

It is doubtful that direct-care nurses are aware of the extent of nurse managers' feelings of distress and powerlessness, or their need for support from their staff. A few participants noted that affective support from their staff was critical in mitigating the negative effects of ethical conflict. Nurse managers also need other types of support from direct-care nurses. The findings suggest that nurse managers feel alone and overburdened in their search for solutions. Budget cuts have forced hospitals to make changes that go against nursing values. The participants felt they shouldered the burden of attempting to influence hospital decision-making. It is time this burden was shifted to direct-care nurses. We need to develop councils or associations of direct-care nurses that will speak for nurses at senior administrative and board levels. Such associations should be separate from nursing unions, in order to prevent senior administrators from discrediting their voice to board members on the grounds that they represent union self-interests.

Nursing leadership and management courses should cover ethical issues faced by nurse managers and the ways in which associations of direct-care nurses can influence decision-making. Nursing students need to learn that direct-care nurses may be in the best position to influence hospital nursing. Inservice educators, nursing managers, and professional associations ought to educate direct-care nurses about effecting change and influencing policy. Nurse managers need to learn how to share their burden and their role as nurses' voice within the hospital. They should support the efforts of direct-care nurses to form their own association.

A few of the participants said they wished their professional associations were more vocal about issues facing nurse managers. While a professional association may not have the legal mandate to intervene, posing questions to the chief hospital administrator and the board may in itself serve as an impetus to change. In light of nurse managers' feelings of voicelessness, professional associations need to consider how they might intervene at the organizational level.

One senior nursing administrator stated that she and her assistant had their positions terminated, supposedly due to organizational restructuring, shortly after speaking out against a decision taken by their organization. She noted that surviving nurse managers were hesitant to voice their concerns following this "restructuring." For nurses such as these, legislation against "whistle blowing" is meaningless. They have learned that an organization can distance the dismissal decision from the nurse manager's actions by claiming to be restructuring.

Further, a few participants witnessed the damaging effects of a senior administrator's smear campaign against a nurse manager. Boards of directors and professional associations need to be vigilant when a hospital's nurse manager turnover rate is higher than the norm for the region. They could do exit interviews of nurse managers when turnover rates are particularly high. Professional associations and senior nurse administrators of other hospitals should support nurse managers who have had their positions terminated or who are the victims of smear campaigns.

The findings of this study have implications for nursing research. Studies of nursing work life have focused on direct-care nurses. The present findings demonstrate that nurse managers are sometimes employed to go against their own values. Feelings of voicelessness, lack of budgetary control, having to sacrifice individual rights for organizational needs, and inability to change unjust administrative or human-resource practices result in nurse managers going against their own values and risking self-alienation. There is a need for more research on ethical decision-making in nursing management as well as on quality of work life among nurse managers.

Studies of nursing work life have typically focused on constructs such as job satisfaction, stress, and burnout and the prediction of absenteeism, organizational commitment, and turnover. It is possible that ethical conflict, as a construct related to values and self-concept, has a strong influence on the retention of nurses either by causing job dissatisfaction, stress, and burnout or by directly affecting turnover and commitment to the organization. Thus, research on nursing work life that includes ethical conflict as a variable could add to our knowledge about the factors that influence the retention of both nurse managers and direct-care nurses.

The present study is limited in that it describes the experiences of 15 nurse managers working in a hospital setting in one Canadian province. Future research could examine ethical conflict as experienced by nurse managers working in other settings and in other provinces. Quantitative research on the prevalence and intensity of ethical conflict among nurse managers would strengthen the findings of this study.

If they are to provide quality nursing care, hospitals will have to recruit and retain nurse leaders who have the vision, talent, and skills to develop nursing. For this to occur, nurse managers and hospitals need to understand each other's values and perspectives. Future research could evaluate the effectiveness of workshops that bring together nurse managers, direct-care nurses, administrators, and board

members in order for them to share their perspectives. These workshops could be combined with organizational reforms such as decision-making processes that are more visible and structured in a way that allows all parties a voice and ensures that their opinions are respected.

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