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Résumé

Les infirmières canadiennes face à la difficulté de mettre en pratique les valeurs qui leur sont chères

Brenda Beagan et Carolyn Ells

Les chercheuses ont mené des entretiens qualitatifs auprès de 20 infirmières d'une ville canadienne dans le but d'analyser leur expérience morale au travail. Elles ont demandé à celles-ci d'indiquer ce qu'elles valorisaient dans leur vie professionnelle et de préciser en quoi leur travail leur permettait de mettre leurs propres valeurs en pratique. Les répondantes sont quasi unanimes à évoquer leur adhésion à des valeurs comme l'aide, la sollicitude, le besoin d'être utile à la société, la relation axée sur le patient, la défense des droits, l'intégrité professionnelle, les soins holistiques et la volonté de transmettre des connaissances qui permettront aux patients de se prendre en main. Elles relèvent les difficultés et les frustrations qu'elles éprouvent lorsqu'elles tentent de mettre ces valeurs en pratique. Les obstacles de nature systémique comprennent notamment les hiérarchies professionnelles, la structure organisationnelle, les problèmes que connaît le système de santé et les dynamiques de pouvoir. Les faire tomber n'est pas une tâche qui appartient aux seules infirmières. Elle nécessitera un éventail de stratégies complexes : changements systémiques; restructuration des relations de pouvoir; et création d'une culture fondée sur l'éthique et propice au respect des valeurs essentielles à la prestation de soins infirmiers de qualité.

Mots clés : éthique, soins infirmiers; vie professionnelle

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Values That Matter, Barriers That Interfere: The Struggle of Canadian Nurses to Enact Their Values

Brenda Beagan and Carolyn Ells

Qualitative interviews were conducted with 20 nurses in a Canadian city to explore the moral experience of nurses in their working lives. The participants were asked what they valued in their profession and how well their work lives enabled them act on their values. Almost uniformly, they expressed commitment to the values of helping others, caring, making a difference, patient-centredness, advocacy, professional integrity, holistic care, and sharing knowledge for patient empowerment. They identified several challenges and frustrations experienced in attempting to enact these values. System-level challenges included professional hierarchies, organizational structures, issues in the health-care system, and power dynamics. Removing these barriers cannot be left to nurses alone. It requires complex, wide-ranging strategies: system change, power restructuring, and the creation of ethical climates and cultures that support values that are essential to good patient care.

Keywords: ethics, nursing; decision-making, ethical; moral distress; burnout, professional

Attention to ethical practice in health care has been dominated by medical ethics, which has meant a tendency to focus on highly charged medical situations — what Varcoe and colleagues (2004) call "big 'E' ethical issues" (p. 317). The ethical situations that arise in nurses' everyday practice are often dismissed, and they are not identified as ethical concerns by researchers, theorists, or nurses themselves (Cohen & Erickson, 2006; Smith & Godfrey, 2002).

Distinctions made by Andrew Jameton (1984) regarding challenges in nurses' ethical experiences are still apt. Nurses can experience uncertainty about the ethical aspects of a situation, experience conflict between relevant ethical values or responsibilities, and experience ethical distress when something prevents them from acting ethically. According to the Canadian Nurses Association (CNA) (2003), ethical distress occurs when "a decision is made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action" (p. 3). Such barriers can be individual, interpersonal, or institutional (Cohen & Erickson, 2006; Hamric, 2000; Torjuul & Sorlie, 2006).

After studying hospital nurses for more than 10 years, Chambliss (1996) concludes that ethical concerns in nursing are primarily systemic and structural, transcending the moral practices or commitments of the individual nurse. A persistent problem is interprofessional conflict as nurses try to do what they believe should be done in the face of counter-directives by others (cf. Storch, Rodney, Pauly, Brown, & Starzmoski, 2002). In a study with critical care nurses, Gutierrez (2005) found that nurses who were excluded from patient care decision-making perceived their work as devalued. Lacking a sense of autonomy, they felt powerless and constrained in ethical decision-making. Chambliss points out that ethical distress is not individual: "Remove a nurse with an ethical problem from the hospital, replace her, and her replacement will encounter the same problem" (p. 91). Confirming consistency across studies, Redman and Fry (2000), in their systematic analysis of nurses' ethical conflicts, conclude that most of these arise from institutional constraints against rather than uncertainty about the right course of action.

In Canada, Varcoe and colleagues (2004) studied the ethical experiences and needs of nurses on the west coast. They conclude that ethical practice in nursing is utterly contextual. Participants struggled to enact their personal and professional values — to do "good" — in the face of conflicting values and institutional constraints. They described being caught between physicians and patients; caught by the medical emphasis on technology and cure, at the expense of care; and caught by the need to document and account for their work, discounting those aspects of care that were not quantifiable. In the context of the dominant ideologies of scarcity and the need for efficiency, the nurses learned to ration their time and their care, which left them wondering if they were doing the right thing. Many participants were troubled by the belief that they were not practising ethically: "As one said, 'It's everything I can do, but it isn't enough.' This inability to 'do good' and 'do enough'…gave rise to profound moral distress" (p. 320).

Unresolved ethical distress is, clearly, linked to burnout (Severinsson, 2003; Sundin-Huard & Fahy, 1999), as well as to nurses' leaving their posts or leaving the profession (Corley, 1995, 2002). When nurses undergo intensive professional training, they not only acquire skills unique to their profession and specialized knowledge, but also assimilate the attitudes, values, and beliefs of their profession (Thompson, Melia, & Boyd, 2000). This process of professional socialization continues throughout one's career, sometimes reinforcing values and attitudes, sometimes transforming them in the context of practice (Cohen & Erickson, 2006; Lindh, Severinsson, & Berg, 2007). Juthberg, Eriksson, Norberg, and Sundin (2007) suggest that nurses unwittingly "deaden" their consciences,

compromising their values in order to get along in interprofessional environments. The *Code of Ethics* for nurses in Canada identifies core values as follows: provision of safe, competent, and ethical care; promotion of health and well-being; respect for choice and autonomy; advocacy for respectful and dignified treatment of all persons; observance of confidentiality; upholding of justice; observance of accountability; and advocacy for quality practice environments (CNA, 2002, p. 8). If Canadian nurses do in fact hold these values and are prevented from enacting them in daily practice, then ethical distress is a likely outcome.

In contrast to previous studies that have asked nurses about their experiences related to ethical concerns, the current study did not predetermine the ethicality of experiences, nor did it predetermine categories of ethical uncertainty, conflict, or distress. Rather, we asked nurses about their values, and about how those values were or were not supported in their daily practice. Because of our broad focus on values, nurses had room to discuss issues they might not have identified as ethical, particularly as "big 'E' ethical" (Varcoe et al., 2004). This approach enabled us to unearth everyday ethical tensions, which are more subtle than ethical dilemmas (Cohen & Erickson, 2006). We took ethical tensions to include not only ethical distress (where barriers prevent one from doing the right thing) but also those routine feelings of simply being torn between conflicting values (Cohen & Erickson, 2006) or competing value sets (e.g., whether to be a "good nurse" or a "good co-worker") or uncertainty about ethical aspects of a situation. These feelings create a tension — a mental strain — that implicates one's values and the culpability of one's conduct and character. What one nurse defines as an ethical issue another might not. We wanted to explore the intersections among values, practices, and ethics, regardless of whether or not an individual nurse saw the issue as ethical in nature.

This article reports on a qualitative study with 20 nurses in Halifax, Nova Scotia, Canada, addressing four questions: *How do nurses view the core values of their profession? To what extent do they find themselves able to enact those values in practice? What barriers to acting on those values do nurses identify? What ethical tensions arise when there are barriers to acting on core values?*

Methods

Following university research ethics approval, we recruited nurse participants through posters, announcements in newsletters and circulars, snowball sampling, and recruitment letters sent to nurses in the Halifax metropolitan area. Those who were interested in participating contacted the research team. Several more nurses expressed interest than we were able to interview. In selecting participants, we strove for diversity in race, gender, age, and years of nursing experience. Volunteers took part in a

one-on-one semi-structured qualitative interview following a guide that was developed from the literature as well as from discussions among the research team. The interviews drew upon the ethnographic tradition (DePoy & Gitlin, 2005). They were intended to elicit rich descriptions of participants' perceptions and experiences so that their accounts could be analyzed in relation to those of other participants as well as in relation to discourses on ethical practice and nursing values. In the interviews, participants were asked about the values they believed to be inherent to the profession when they entered it, how those perceptions may have changed over time, and their experiences with trying to act on those values in their day-to-day work.

In total, 20 nurses were interviewed by a trained research assistant who was not a nurse. The demographics of the participants are listed in Table 1. Each nurse met with the interviewer at a time and location

Table 1 ***Demographics***

	#
Sex	
Male	2
Female	18
Ethnicity	
Caucasian	14
Racialized minority	6
Practice setting	
Community	6
Hospital	14
Years in practice	
< 5	3
5–9	2
10–14	1
15–19	2
20+	12
Age	
25–35	3
36–45	6
46–55	5
56–65	3
Not provided	3

convenient for the nurse. Consent was obtained. Interviews lasted approximately 1 hour and were audiotaped with permission. The tapes were transcribed verbatim and the transcripts were coded inductively using AtlasTi qualitative data analysis software.

In accordance with standard qualitative practice, themes were generated through in-depth examination of the transcripts. In an inductive and iterative process, data were read in depth and labels (codes) were applied to words, phrases, and concepts used time after time by participants. Text segments were compared within and across transcripts to refine coding. Codes were compared, clustered, and sorted until sufficiently distinct and comprehensive themes were generated and defined (Boyatzis, 1998; Luborsky, 1994). Further analysis followed common techniques in qualitative research, including memoing and thematic interpretation (Coffey & Atkinson, 1996). The findings reported here are drawn particularly from responses to questions about professional values, but the transcripts were also searched for instances in which participants spoke implicitly about values that guided their practice or about situations in which they were or were not able to act in accordance with their values.

One research assistant coded all of the data for internal consistency. She was trained in the use of the software and developed and used a codebook. Codes were refined through weekly meetings of the primary researcher and other research assistants. Participants received a descriptive feedback report based on all the interviews and confirmed the findings of the research team.

Findings

Values That Matter

Nurses expressed their values when speaking about their motivations for practising nursing, the reasons why they had initially chosen the profession, and the reasons why they had remained in the profession despite some challenges, as well as what they thought makes a "good nurse." They were fairly consistent in the values they expressed and often conveyed a deep commitment to those values. The key values identified were helping others, caring and compassion, making a difference, patient-centredness, advocacy, professional integrity, holistic care, and sharing knowledge for patient empowerment.

The value of ***helping others*** was raised frequently during the interviews. The nurses spoke about their desire to "help," about the importance of being in a "helping profession," and about nursing in order to "help others." Many identified the desire to help others as their primary reason for choosing nursing as a career and for finding it "fulfilling and satisfying." Helping was viewed as distinct from caring and empowering.

It was seen as *doing for* the patient and as central to the provision of assistance.

Caring and compassion, also described as empathy, were tied closely to the value of helping others. Yet some participants drew a clear distinction between these two values, noting that helping others can take place without compassion. Compassion can be understood as an emotional connection to the suffering of others. Caring or compassionate action involves understanding the other, then choosing to act in his or her best interests. Some participants referred to a selflessness in caring that nurses expect of themselves and each other:

> *A good nurse is able to be compassionate and holds someone's hand or hugs them without having to be [told]. It should come naturally. You should be intuitive enough to know what the person needs at that moment in time.*

One participant said that nurses should be willing not only to care but to care specifically for strangers.

Most participants explained that their choice of nursing as a career was closely linked to ***making a difference,*** a value held dear. One nurse spoke broadly of "wanting to make a difference and making it a better world." Others spoke of going the extra mile. For instance:

> *A good nurse should have the understanding that that person is at a very vulnerable place in their life and you have the ability to — in some way, shape, or form — touch that person's life, and whether they remember you or don't remember you they'll probably remember that it wasn't as bad as they had feared it would be.*

The words used to describe ***patient-centredness*** differed, but the description always included the right of patients to have a say in their own care. Some nurses described an evolution in patient-centred care: a gradual shift away from doing *for* the patient towards a team approach — doing *with* the patient — so as to provide the best care possible. The core of this value seemed to be respect for the individuality and knowledge of the patient: "We're giving back part of the care to the patients — what does *this* patient want? — whereas before everybody got the same thing." Participants noted that nursing care should accommodate the distinctiveness and individual needs of each patient.

Patient ***advocacy*** was a strongly held value. It was identified as "one of the primary responsibilities of a nurse" and as an integral part of a nurse's standard of care. Its importance stems from nurses' intimate knowledge of their patients: "You certainly have the ability to advocate on their behalf, because you're the one who knows them the best — you're with them all the time." This value lies in a deep-seated belief that nurses

ought to use their knowledge of a patient to act in his or her best interests. One participant described a situation in which a nurse's failure to advocate — to insist on a second opinion — led to a patient's death. The participant considered this an inexcusable abandonment of the patient. Another participant said that nurses can play a role as health advocates on a larger scale, at the level of the health-care system; she described this as an "exciting opportunity," one she clearly thought nurses ought to embrace.

Participants valued ***integrity*** in both personal and professional terms, describing it as doing what you are "supposed to do," "stand[ing] up for what you believe," "doing the right thing," and not going "over the line." What had drawn one participant into the nursing profession was the integrity of his preceptors, who were "meticulous about their charting or their care [to] make sure it's done as per protocol" because "they wanted to be the best nurses possible." Some participants linked integrity to a strong commitment to accountability:

> *It's the code of conduct for nurses. They have a responsibility to maintain standards. Accountability is one of them. If you did something wrong, own up to it… If you've made a medication error…you'll have to suffer the consequences but at least you know in your mind that you've done the right thing.*

A willingness to provide ***holistic care*** was frequently named as an essential value in nursing practice. Participants described holism as a relationship with the whole patient:

> *I could easily just carry out the orders that the doctor has written, [but] I have a choice within my practice to try to explore and further that relationship with the patient, explore what else I can do to help the person… You don't look at just what's in front of you. You always look at the whole picture. That's holistic care.*

Participants ascribed considerable importance to their profession-specific knowledge, naming their expertise yet also insisting on the importance of ***sharing knowledge for patient empowerment***: "Knowledge is power, and you empower people by giving the knowledge to them." One nurse elaborated:

> *I value knowledge because I like knowing as much as I can about what I'm doing and being able to impart that to the people that I am taking care of, so that they can further themselves or take advantage of it [my knowledge] or take responsibility for themselves.*

The value here is the manner in which knowledge is wielded — shared with patients rather than used by nurses to reinforce their own authority.

Challenges and Frustrations

In describing the values that mattered most in their everyday work, the nurses revealed numerous challenges and frustrations. This section focuses on the emotional impact of the nurses' experiences, while the next identifies *why* some of these challenges arose. The inability to make a difference, or sustain patient-centredness, and conflicts between the values of patients and those of colleagues were repeatedly cited as emotional frustrations and challenges. For some nurses, the emotional toll of their inability to enact deeply held values was burnout and detachment, which in turn compromised their ability to enact other values such as caring, compassion, and helping. Many of the participants became profoundly disillusioned when they found that they were unable to do what they had entered nursing to do.

Inability to make a difference. Participants faced significant obstacles to enacting their desire to make a difference in patients' lives, or to alter the course of their patients' care when they knew the care being provided was not what the patient wanted. Several participants came to realize that making a difference was never as easy as it seemed:

> *You go in really wanting to change everything and then you can't even move forward an inch sometimes. I think maybe in my heart, not in the front of my brain, I thought everything would be wonderful. But it's not like that. It's hard work.*

Values in conflict. Several nurses spoke about the difficulty of enacting patient-centred care when their values came into conflict with those of the patient. This challenges the notion of empowering patients by sharing expert knowledge:

> *Sometimes there's a dichotomy between what I know is best for you or what medically is best for you and what you choose to do. I'm a firm believer in giving somebody education to make the choices, but sometimes it's hard to [reconcile] their not doing the right thing. "Why can't you take your medication?" I think that's one of the biggest ethical challenges.*

Some participants spoke of nurses unintentionally and perhaps unwittingly imposing their own values, especially in the case of a nurse believing strongly that a particular course of action is in the patient's best interests. When this is not what the patient wants, the value of patient-centred care is compromised.

Challenges to professional integrity arose because of differences in values or practices among colleagues. When they worked with people who had different perceptions of what constitutes professional behaviour,

or of what constitutes an acceptable standard for fulfilling one's duties, nurses were torn between collegiality and professional integrity:

> *If you don't adhere to the standards of practice, then you shouldn't be in nursing. If you start down the slippery slope, it never stops. If you make that decision not to do proper patient care…if you do it once, you're willing to do it again. I don't feel that people get to a level in their professional life where they're pulled up and reported to the College for a one-off incident. It's a pattern.*

One participant said that nurses about to begin a new job should be advised "to look at the vision and the philosophy of the nurses that you'll be working with so that you know that it's congruent with your own beliefs before you actually start the job." Her warning suggests that incongruent ethical stances may be a source of considerable day-to-day tension.

Unenacted values take an emotional toll. While acknowledging that the reality of their workplaces was often different from what they had expected, participants were quick to state that their values had not changed. One participant said, "My values didn't change, but sure enough there is frustration." Some nurses cited the emotional toll taken by routinely having difficulty enacting one's professional values. Many participants spoke of a drain of energy, which some described as burnout. The constant giving in a profession that tends to give very little in return led some participants to move to a less demanding practice setting or from full-time to part-time work. Such changes allowed them to work in environments where they could provide care in ways that did not leave them drained of energy and detached from their work: "You give and you give and you give all day. We have to replenish that energy. That's human nature."

Emotional detachment from the constant giving of themselves seemed inevitable to the nurses, vital to the preservation of their own health and well-being. The participants felt that, in order to function in their work (and in their lives), they had to detach themselves emotionally and mentally from their work, the politics of their profession, and their patients. One participant stated that pediatric nurses cannot become involved with their patients beyond a superficial level, adding that to become detached one has to be more professional and less sympathetic. A coronary care nurse made a similar claim, adding that attending bereavement services for patients is a signal that the nurse has become too attached. While none of the participants was specifically asked to articulate *why* it was so important not to become "too attached" to patients, there was a suggestion that one must maintain emotional control in order "to cope" or to do one's job competently:

I try to remain as detached as I can to get my work done, but I still want [my patient] to feel that…I'm really there for her and I'm feeling it as much as I can, helping her out. You know, I don't want to dissolve into a slobbering mess. That's not going to help anybody either.

Ironically, while participants expressed the view that burnout and detachment can have negative consequences for patients, these responses also compromise caring, helping, and compassion — the very nursing values that many participants cherished. Detachment, while protective, becomes a barrier to experiencing compassion, a deeply held value. One participant commented that nurses who are more detached in their approach are rarely thanked by patients and are rarely acknowledged as helping or as making a difference.

Not surprisingly, several nurses reported "relentless" and profound disillusionment upon finding themselves routinely unable to enact their core values: "I found my values were being challenged all the time because I wasn't able to give what I thought I wanted to give, and that was a daily frustration." One nurse expressed this frustration particularly well:

I want to care for my patients more than just in the way of giving out medications, washing them up for the day, or filling these tests out. It's just relentless, and that is where I am caught. What I want to do for my patient is always second, and I can't seem to get my head around not being able to do that all the time. I've contemplated a lot about switching professions, just for the mere fact of not being able to carry out the things that I want to do for my patients.

Barriers That Interfere

Participants identified a number of challenges to their ability to enact nursing values in their everyday work. Key barriers identified were hierarchies within health care, workplace structures and policies, and the priorities of the health-care system.

Interprofessional hierarchies within the health-care system were a frequently identified source of frustration and ethical tension, though for the most part those nurses who worked within a team found their colleagues and other health professionals to be very supportive. The workplace conflicts most often discussed were those with physicians, due to the subordinate status of nurses in the health-care hierarchy:

I do butt heads with the physicians… As a nurse you can advocate, but if they really feel that [the patient] needs that medication, they're the ones with the higher credentials…so they're the ones that are going to make the decisions.

One participant commented that the nurse "follows doctors' orders… initiates treatment…and that's your job." For some participants, unquestioning compliance directly contradicted their core values of patient-centredness, helping, and professional integrity:

> *I knew that I wouldn't have the ability to make all the decisions that I wanted to make. I wouldn't have the control. It's not an independent profession, no matter what the academics might say. I knew I wouldn't have the autonomy. I just didn't know, when I graduated, how much that would mean to me. What I see as important for my patient and what their doctor sees as important can be two very divergent things. And it can be frustrating, because I don't have the power to diagnose, I don't have the power to prescribe.*

At the time of the interview this participant was in the process of leaving the profession. Several other participants had seriously contemplated leaving as well. In contrast, some of the nurses expressed relief that the responsibility for medical care did not fall to them; they were, as one put it, "freed" by the scope of their practice — the physicians "are the ones ultimately responsible."

Apart from the lack of autonomy, some participants argued that physicians are simply ignorant about the work that nurses do, the extent of nursing education, and the scope of nursing practice: "We work with some physicians who have no appreciation of nursing, don't know that nurses have their own code of conduct, their own standards of practice… That's very infuriating." Furthermore, the participants reported that some physicians do not provide an opportunity for nurses to be heard and do not tolerate being questioned by nurses:

> *Some physicians will not accept [questioning]. They don't like their authority to be challenged… I know a couple in particular who would not listen to any patients, and even for me to talk to them it wouldn't make any difference.*

This lack of acknowledgement was draining for some participants, who felt they had no place in patient care: "I'm just nobody."

One of the underlying tensions between nurses and physicians apparently stemmed from a difference in professional values. Participants spoke of nurses as focused on care and of physicians as focused on cure, sometimes at the expense of the patient's overall well-being. Related to this difference in focus, some participants identified an epistemological conflict between nurses and physicians, grounded in the valuing of very different kinds of knowledge. Some participants spoke of nurses' ways of knowing being dismissed and evidence-based practice being favoured over "gut feelings," "instinct," and nurses' experiential knowledge. Thus holistic

care requiring the experiential knowledge of nurses, gained through ongoing contact with patients, is compromised in a medically dominated system. The conflict between professions in terms of values was a struggle for the nurses; the interprofessional hierarchy constituted a barrier to their acting in accordance with their values.

Intraprofessional hierarchies and organizational structures. Intraprofessional hierarchies and the organization of the workplace caused tension for the nurses. Several participants described tensions surrounding differences in professional training. Diploma-trained nurses described feeling "diminished," held back, and pressured by management to obtain a degree. One nurse stated:

> *You would get these people who because they have their master's or their bachelor's…would have this holier-than-thou attitude…who maybe had only been there 2 or 3 years. What happened to [the value of] experience?*

Other reasons given for tensions related to workplace structure included an apparent disjuncture between frontline staff and management. A common complaint was that managers were sheltered from the realities of frontline work and failed to seek frontline input into decision-making. Some managers had little clinical experience, or no background in the speciality, and therefore were unfamiliar with the issues confronted by the nurses under their supervision and were distanced from the realities of trying to enact nursing values.

Workplace policies and practices were another source of ethical tension. Participants spoke of nurses sometimes needing to or choosing to circumvent the rules, which created areas of tension. Some cited the presence of "unwritten rules." Lack of clarity about parameters caused one participant to move to an area of nursing where everything was "black and white," with no room for guesswork. For such participants, routine policies and practices got in the way of enacting values, leaving nurses torn between obeying the rules and acting with integrity.

For some participants, in contrast, adhering to policies afforded a measure of protection, guarding them against personal responsibility and liability:

> *It's sort of like a standard set of care you have to follow. It's quite regiment[ed]. If you don't follow it precisely and everything is okay, that's fine. But if you ever didn't follow it precisely and something went wrong, huge, huge litigation… The policies are very restrictive in some ways, but in other ways they're to protect the patients and…to protect us, so even though they're a bit regiment[ed], they're there for a reason.*

These participants appeared to resolve any ethical tensions between practice and values by deferring to the rules.

Failings of the health-care system. The health-care system was often cited as a constant source of frustration and tension because of reduced staffing and lack of funding for quality care. Some participants suggested that, while all health-care workers feel the pressure of constraints on the system, because of nurses' direct contact with patients 24 hours a day, they feel the lack of time and resources as a distinctively *ethical* tension: They are unable to provide the kind of care that compelled them to go into nursing in the first place. One nurse described the situation in a graphic way that also reveals some personal distancing from the diminished care provided:

> *In the hospital years ago we used to [give] a lot more personal care to people… They stay[ed] longer, so you [had] to give them their bedside care, physical care. But now…if they [the nurses] give you a bowl of water you're lucky!*

Most participants felt that they simply did not have the time to provide emotional support to patients. This was an increasing source of tension for them. One nurse explained that there was no time "to hold somebody's hand when they're crying and that sort of thing," which frustrated her ability to enact the value of holistic, patient-centred care. Decreased staffing was seen as a direct cause of increased workload and time constraints:

> *In terms of cuts…it's across the board. Every place I've worked, you see it in nursing. It makes it harder because oftentimes you don't have the resources to always do the right thing to the extent you want to do it. My frustrations come from just so much more I want to do and I can't do it.*

Many participants felt they were unable to provide the best possible care when exhausted from working overtime. Clearly, they believed that their professional integrity was compromised.

One nurse suggested that cutbacks to cleaning, kitchen, and clerical staff had resulted in those support functions being relegated to nurses while, at the same time, their paperwork had increased. One participant was "irked" by having to account for every activity in order to justify staffing levels: "Are we actually measuring this so we can be staffed? How do you measure emotional support? ...that's ridiculous." Another participant spoke of nursing as having become a "paper profession" rather than a "people profession," with nurses having less and less time to perform the caring tasks they see as central to their profession.

Time pressures and stretching oneself too thin served to raise the discomfort level, but it was when these factors led to decreased patient care that distinctly ethical tensions arose. One nurse explained that where once patients were discharged to home-care services, they were now

discharged into the care of neighbours or family members, regardless of their caregiving abilities:

> *You need them to do it. You teach them — how much can they learn in 2 hours…? Somewhere there's somebody suffering, but what can you do? There's no resources, no money — that's what they have to have to get assistance; they're saying there's no money.*

The ethical tensions arose from an inability to express compassion by providing quality care. For some participants, unmet needs seemed limitless and all they could to do was focus on the task at hand. One participant described nurses as "policing" each other so that no one raised patients' expectations by providing care beyond what was deemed feasible:

> *Things were quiet one evening and I was going around rubbing people's backs, while the rest of the staff were totally appalled that I would do something like that, because "these people are going to expect that tomorrow night." And I said, "Well, that's your problem."*

For nurses who had entered the profession to help people, make a difference, or show compassion, the lack of resources to routinely enact these values gave rise to ethical tensions, which could in turn lead to profound disillusionment and detachment.

Summary

The values that mattered most to the participants were clear: helping, caring, making a difference, patient-centredness, advocacy, professional integrity, holistic care, and sharing knowledge for patient empowerment. In attempting to enact these values in their work, the nurses met with frustration and challenges, including the inability to make a difference and conflicting values, leading to emotional detachment, disillusionment, and burnout. The participants identified a number of systemic barriers to their ability to enact their values. These included interprofessional hierarchies; different professional epistemologies, values, and approaches to caring; intraprofessional hierarchies; workplace structures and policies; and the priorities of the health-care system with their accompanying time pressures and reduced quality of care. One participant pointed out that nurses can have difficulty even recognizing the day-to-day ethical challenges:

> *I think my biggest challenge with this [the interview] was trying to rediscover…how I've been ethically challenged throughout my practice. And it's very difficult, but I know in my heart of hearts that I'm ethically challenged 10 times more than I even recognize.*

Discussion

The findings suggest consistency among nurses regarding the core values of their profession, as well as the enduring nature of these values despite barriers to their enactment in the workplace. Further, without prompting about the substance of their values, the nurses described the core values articulated in the CNA's *Code of Ethics for Registered Nurses* (2002). This finding confirms the relevance of the *Code of Ethics* for Canadian nurses. Yet confidence in one's fundamental values and the support of one's professional association for those values are no guarantee that one will be able to enact them in the workplace. Indeed the findings indicate that Canadian nurses face significant constraints in enacting their values, resulting in ethical distress.

Our findings echo those of previous research suggesting that system-level issues impede nurses' everyday work (Chambliss, 1996; Health Canada, 2002; Poncet et al., 2007; Tadd et al., 2006; Varcoe et al., 2004), causing or exacerbating ethical distress (Corley, 2002; Gutierrez, 2005; Hamric, 2000; Millette, 1994; Pask, 2005; Redman & Fry, 2000; Storch et al., 2002; Varcoe et al., 2004). The priorities of the health-care system or of its institutions result in nurses having little say in the care of their patients; understaffing; severe constraints on nurses' time, such that they believe they are fulfilling only a fraction of their ethical mandate; demands that nurses fulfil auxiliary roles despite their inability to fulfil what they see as their primary role; the abandonment of holistic patient care under pressure for early discharge; and limited patient access to diagnostic and treatment interventions. Further, the participants appeared to believe that removal of system-level barriers cannot be left to nurses alone (Chambliss, 1996; Health Canada, 2002; Tadd et al., 2006), as nurses function in a context of multiple players, realities, values, and goals. The ethical environment of Canadian nursing consists of social, political, economic, and institutional forces; regulatory bodies; and multiple health professions with different aims, values, and educational priorities. As health care becomes infused with corporate ideologies, assumptions about scarcity and the need to maximize efficiency form barriers to the enactment of core nursing values (CNA, 2002).

Collaborative, wide-ranging, multifaceted initiatives are needed to generate system change, restructure power, and build ethical climates and cultures that support values that are essential to good care. Such collaboration seems unattainable when nurses' ethical practices are hampered by inter- and intraprofessional differences in power, values, and knowledge and a mutual lack of understanding with respect to professional skills and abilities. Nonetheless, a commission appointed by Health Canada (2002) produced 51 recommendations for improving the working lives of

Canadian nurses; these address workload, leadership, education, violence and abuse, nurses' health, accreditation, human resources, research, and government. A comprehensive set of initiatives based on the recommendations has yet to be accepted and implemented.

In the meantime, there are practical steps that nurses and nursing leaders can take to alleviate ethical distress. They can create organizational environments that foster ethical reflection. Certain types of collaboration with other health professionals (Juthberg et al., 2007) and with nursing colleagues can cause nurses to compromise their values. This can mean "having to deaden one's conscience in order to uphold one's identity as a 'good' health care professional" (Juthberg et al., 2007, p. 339). This deadening can continue as long as everyday activity precludes time to reflect. Reflection results in the need to find justification for one's actions or inactions.

All of this suggests one immediate strategy for enhancing ethical practice even in untenable environments: the creation of opportunities for collegial discussion of nursing values. Such opportunities could take the form of continuing education courses, or could be as simple as a series of brown-bag lunches (Andrews, 2004; Cohen & Erickson, 2006; Lindh et al., 2007; Storch et al., 2002). The point is to provide mutual support for ethical questioning. Among nurses, discussion groups would focus on the kind of reflection that is needed to reverse deadening of conscience. The groups would have to be carefully facilitated, so as not to become mired in discussion that normalizes and therefore reinforces the compromising of ethical values. Facilitation by an outsider, such as a pastoral care specialist or an ethicist, might serve to promote the questioning of taken-for-granted practices. Discussions would need to be guided by critical questions such as What *should* happen in such situations? What would it take to make that happen? The immediate implication for bedside nurses might be to challenge ethical "slippage," supporting one another to find ways to enact one's professional values. This approach could also foster the development of a collective voice at the local level, which is critical since no individual can break down institutional and system-level barriers alone (Buchman & Porock, 2005).

Such ongoing discussion could also serve another, related purpose. Our findings indicate that being hindered from acting on compassion causes ethical distress. At the same time, acting compassionately and altruistically can lead to burnout and detachment, given the magnitude of patient need (cf. Abendroth & Flannery, 2006; Gutierrez, 2005). Safe places where nurses can meet regularly to discuss the ethical values that underpin their work may help to guide those who tend to cross the line into excessive empathy while also validating and affirming the importance of compassion for those who have come to see giving patients a

back rub as violating practice norms. Detachment from caring and compassion denies a core nursing value, a value that motivates many nurses to continue working.

Ideally such discussions of values and ethics would take place among bedside nurses and nurse managers, since different work situations can result in very different values and in ethical conflict (Carney, 2006; Guiterrez, 2005). Similarly, it would be ideal for nurses to converse with other health professionals, especially physicians, to enhance understanding of each other's values and professional ethics as well as the causes of ethical distress in different professions (Torjuul & Sorlie, 2006). We believe, however, that it is too soon to initiate this step. Nurse managers and physicians are among the sources of nurses' ethical distress. Given existing power relations, it is critical that bedside nurses have safe places to talk with each other, to reinforce everyday ethical values in practice. At this point it may be more useful for nurses to converse with other allied health professions who also experience power differentials with physicians and managers.

Educational settings are the ideal site for interprofessional ethics education. Such learning should extend beyond the classroom to clinical rotations. At the same time, ethics education must be pragmatic — it is futile for nurses to learn ethical principles if they see no way to put them into action (Andrews, 2004). A pragmatic ethics education would emphasize contextual realities, including naming the power relations that affect everyday practice, such as nurse-physician relations. It would teach students to consider a range of possible responses when faced with resource limitations that hinder them from acting on their values, to talk with each other about the realities as well as the ideals of practice (Lindh et al., 2007), and to become active in professional organizations that provide a collective voice for change (Buchman & Porock, 2005). In clinical settings, nurse leaders and seasoned nurses need to demonstrate for students a willingness to speak out, to ask critical questions that lead to collective questioning of institutional barriers to ethical practice (Cohen & Erickson, 2006).

Finally, research is needed to assess the effects of interventions, such as those outlined above, for enhancing nurses' ability to act ethically. Nurse leaders and administrators may be able to persuade hospitals and other health-care facilities to fund such research by linking ethical work environments with nurse retention and the potential for improved care. At a time of nursing shortages across the country, many of the participants in this study were contemplating leaving the profession, working fewer hours, or transferring to a less demanding work environment (cf. Health Canada, 2002; Millette, 1994). Cherishing the values and ideals of nursing but unable to provide the kind of care they consider

integral to nursing, some nurses cope by removing themselves from the very workplaces and settings where they aspire to make a difference. Their departure signals a lack of moral will on the part of the health-care system, health professionals, and society.

Limitations

Although the participants represented a variety of work settings and demographics, the study explored the experiences of one sample of nurses in one eastern Canadian city. While a study of this nature seeks depth of description and analysis, rather than generalizability across sites, it would be interesting to explore the ethical experiences of nurses in other settings. It is nonetheless intriguing to note the similarities between our findings and those of two other Canadian studies, one on the east coast (Gaudine & Thorne, 2000) and one on the west coast (Varcoe et al., 2004). Moreover, Gaudine and Beaton (2002) found that nurse managers experienced similar ethical distress, feeling powerless and voiceless, torn between the needs of patients, families, and nurses and the needs of the hospital. There is much in our data to suggest that when nurses are unable to enact their professional values, patient care suffers. At the same time, there are hints that some nurses extend themselves in an attempt to cover the gaps. Future research might explore the relationship between nurses' ethical tensions and quality of patient care. Another limitation is the fact that neither the interviewer nor the primary researchers were nurses. While a nurse interviewer might have been better able to relate to the participants, some nurses might have been unwilling to critique aspects of their work to a fellow nurse. Lastly, the study design allowed for only one interview with each participant. Several of the nurses remarked that the interview had caused them to reflect deeply; a follow-up interview may have elicited valuable insights.

Conclusion

The challenge of working in a nursing environment that does not recognize giving a back rub or holding someone's hand as part of the nursing profession, where personal satisfaction from making a difference or fulfilling one's role is rarely experienced, exacts a toll on nurses. The findings of this study draw attention to these concerns. The detailed reports of the participants, delivered with such emotional urgency and distress, should move us to action. It is urgent that the system-level issues that impede nursing work be addressed. One means of doing so may be to create local environments conducive to the discussion of ethical concerns.

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