Ethical Dilemmas: The Experiences of Israeli Nurses

Qualitative Health Research
19(11) 1602–1611

DOI: 10.1177/1049732309350730
http://qhr.sagepub.com
SAGE

Orly Shapira-Lishchinsky[1]

Abstract

In this study I explored ethical dilemmas in nursing to gain a better understanding of nurses' work and their professional status. Qualitative data on ethical dilemmas were collected by interviewing 52 nurses in 18 hospitals and health maintenance organizations. The transcribed interviews were analyzed using a stepwise method. Results indicate a large number of dilemmas that can be divided into five main categories: caring vs. following formal codes; fair process vs. fair outcome; organizational standards vs. family agenda; autonomy vs. deference to higher authority, and guarding secrecy vs. duty to report. The study findings might enhance nurses' ability to cope with ethical dilemmas and bring about change in their professional status. In addition, the results might guide nurses and their supervisors toward developing practitioner programs for nurses that deal with ethical aspects. All these might reduce the expected shortage of nurses and improve the ability of the system to provide quality health care.

Keywords

behavior, change; ethics; health care, workplace; nursing; organizations; quality of care

The nursing profession in Israel is currently in a dire state: a shortage of nurses is expected in the near future (Moseley & Paterson, 2008), because too few people consider a nursing career and fewer qualified students are choosing nursing. According to health officials, Israel will have an 18% shortage of nurses by 2020, crippling the system's ability to provide quality health care (Falchuk, 2009). The main reason for the looming shortage of nurses is their professional powerlessness, which creates a surplus of ethical dilemmas. In this study I focused on the ethical confusion arising from powerlessness of nurses within a medical setting of powerful competing interest groups such as physicians, patients, and families.

Ethics is essentially about the relationship between the right and the good. The good is defined in terms of ideals of human well-being. What is right is defined in terms of justice, in the allocation of rewards, and in ensuring that the distribution of rewards does not harm others (Rawls, 1985). An ethical dilemma is a problem involving a choice between two or more alternatives to the competitive assignment of priorities and responsibilities, or to a problem without a satisfactory solution (George & Grypdonck, 2002; Wolf & Zuzelo, 2006). The purpose of this study was to promote a better understanding of the meaning of ethical dilemmas by mapping the tensions between conflicting moral values to which nurses are exposed when they interact with others. The findings might help develop a systemic approach to handling ethical dilemmas that might give nurses the feeling of control, psychological equilibrium, and the ability to provide good patient care.

Background

Ethical Dilemmas in Nursing

Bunting and Webb (1988) define ethical dilemmas as the conflict between "two equally desirable or two equally undesirable choices" (p. 30). An ethical dilemma incorporates a human element that exists when the choice involves differing personal principles, feelings, and personal beliefs about what is good and right in a given situation (Sletteboe, 1997).

Ethical dilemmas are distinct from nonethical dilemmas (Pence, 2004). Nonethical dilemmas are decisional conflicts in which ethics are not involved. In this case, the conflict might be based on the nurse's personal life

[1]Bar-Ilan University, Ramat-Gan, Israel

Corresponding Author:
Orly Shapira-Lishchinsky, Department of Educational Administration, Leadership and Policy, School of Education, Bar-Ilan University, Ramat-Gan 52900, Israel
Email: shapiro4@mail.biu.ac.il

values, decisions would not cause harm to others, and justification would not be required. An example of a nonethical dilemma would be deciding whether or not to continue being a nurse because of low salary or low status. Ethical dilemmas are decisional conflicts in which ethics are taken into consideration. The conflict involves issues such as not causing harm and preventing harm (Kopala & Burkhart, 2005), as decisions affect others and require justification. An example of an ethical dilemma would be deciding between protecting a patient's rights and reporting illegal practices of a health care professional. Thus, an ethical dilemma arises when the decision maker experiences indecision because available choices support conflicting values, or because ethical principles support mutually inconsistent courses of action (Burkhardt & Nathaniel, 2002).

The literature refers to numerous ethical dilemmas in nursing (e.g., Haggstrom, Mbusa, & Wadensten, 2008; McGrath & Holewa, 2006; Wolf & Zuzelo, 2006). Nurses are faced with many ethical dilemmas in practice and make decisions that have ethical implications. When a nurse's free, conscious choice and action directly inflict harm on another person, the choice becomes a matter of ethics (Gert, 1998). Nurses are faced with ethical issues on a daily basis because of inadequate staffing, inappropriate budget allocation, situations in which patients are discussed inappropriately, discriminatory treatment, the withholding of information or the provision of misinformation, and having to manage cultural factors (Berger, Seversen, & Chvatal, 1991; Corley, Elswick, Gorman, & Clor, 2001; Fry & Duffy, 2001; Metcalf & Yankou, 2003; Moore, 2000). According to the studies cited, ethical dilemmas are formulated in terms of tensions not only between values, but also within interpersonal relationships such as nurse–patient, nurse–colleague, and nurse–family. These findings raise interesting questions about the nature of ethical dilemmas in nursing. Investigating these ethical dilemmas can help nurses deal with them better. Learning the ethical dilemma patterns might assist in defining the boundaries of nursing, and by defining these boundaries, nurses might enhance their status.

Nursing in Israel: The Relationship Between Professional Powerlessness and Ethical Dilemmas

The increasing role that nurses play in medical care has developed over the past decade without being recognized by the public. Nurses today administer complex treatments. They are involved in running research studies and head public health programs in addition to providing patient care. Unfortunately, despite all these developments, their professional status has not improved and they are still considered powerless (Falchuk, 2009). The semiprofessional status of nurses, especially in Israel (Greenberger, Reches, & Riba, 2005), impacts their ability to deal with ethical dilemmas. Certain occupations, such as medicine and law, are considered full professions which are defined as (a) providing an important public service; (b) involving a theoretically, as well as practically, grounded expertise; (c) having a distinct ethical dimension that calls for expression in a code of practice; (d) requiring organization and regulation for the purpose of recruitment and discipline; and (e) requiring a high degree of individual autonomy from their practitioners (Carr, 1999, p. 34).

In Israel, nurses do provide an important public service and are organized under a nurses' union (Ehrenfeld, Itzhaki, & Baumann, 2007; Fawcett, Sabone, & DeKeyser Ganz, 2007; Riba, Greenberger, & Reches, 2004). However, although nurses do have practically grounded expertise, they still lack sufficient theory to back it up, and the boundaries of their roles as nurses are not clearly defined (Greenberger et al., 2005). All nurses in Israel are encouraged to obtain an academic degree to secure better jobs (Birenbaum-Carmeli, 2007; Ehrenfeld et al., 2007). They can advance in their field by climbing the managerial ladder, extending their clinical expertise, and/or upgrading their organizational context (Riba et al., 2004). Yet, most still need a doctor's order to perform a simple procedure. Currently, Israel does not have a national nurse practice act; rather, nurses practice under a clause in the Physician Practice Act that allows them to work under medical supervision (Fawcett et al., 2007). The statutory process for approving the delegation of a specific medical function to health professionals other than physicians in Israel is spelled out in Article 59 (1) A of Israel's Physician Ordinance (1976): "A licensed doctor may employ under his supervision nurses, medics and assistants for professional purposes . . . Health Ministry Directors have the authority to empower nurses and assistants to diagnose and treat medical conditions as the directors see fit."

Requests are brought before a special committee chaired by the Head Nurse of Israel and composed of senior nursing and medical personnel. Requests for delegation are presented before the committee in precise detail, after which the Director General of the Health Ministry decides whether to legally endorse or deny the transfer of professional authority. The Nursing Division then determines which of the endorsed functions are appropriate for the generic level of nursing practice and which require specific postgeneric domains of expertise. The sum total of authorized functions provides the basis for formally creating new areas of specialization. In short, attaining a professional standing for nurses is a slow and cumbersome process (Riba et al., 2004).

The increase in the number of nurses who have been pursuing an academic degree for career advancement, the rapid changes in medical technology that have produced new procedures that can be performed safely by nurses and physicians alike, and the rising awareness of the responsibility for the welfare of society all indicate an expansion of the nursing field (Riba, 2000). In a recent study, Brodsky and Van Dijk (2008) found that the growing role of nurses in Israel is perceived by both nurses and physicians to be a positive development which could greatly contribute to the health care system and patient care in Israel. Nevertheless, the nursing role remains unacknowledged and devalued. The medical hegemony continues to render nurses unable to substantially influence the decision-making process (Coombs & Ersser, 2004; Greenberger et al., 2005). Thus, although Israeli nurses do have a code of ethics (Bureau of Ethics, 2004), they are often forced to deal with ethical dilemmas as they find themselves crossing over into the professional territory of physicians without statutory authorization (Riba et al., 2004).

In addition to nurses' problematic status, which makes dealing with ethical dilemmas more difficult, the average salaries of nurses in Israel are among the lowest of all academic professionals in the public sector. In 2004, hospital nurses earned an average of $2,959 (U.S.) a month, whereas the figures were $3,074 for technicians, $3,270 for engineers, and $4,674 for doctors (Wage and Work Agreement Administrator, 2004). This is likely to engender perceptions of unjust rewards, creating a climate that does not foster willingness to confront ethical dilemmas head on. The combination of low salary and lack of power in the decision-making process is rapidly leading to a critical shortage of nurses (Moseley & Paterson, 2008). Nurses favor working in an environment in which they can take ownership of issues that affect their everyday practice. Unfortunately, nurses have not been given this kind of responsibility so far, rendering the profession undervalued and unattractive (Cohen, 2006). It thus stands to reason that empowerment through education will help attract qualified candidates to the profession and reduce future nurse shortages.

Empowering Nurses Through Training: The International Point of View

Previous study findings indicate that the empowerment of nurses is best achieved through programs that focus on active participation in the learning process, which validates their day-to-day experience and increases their confidence (Elwin, 2007; Hawks, 1991; Quant, 2001). The concept of such programs is not new, and models of educational support have varied from hospital-based courses to university- or college-based courses, or a combination of both. Educational strategies in the United States are described by Huggins (2005) as ranging from self-didactic study programs to formal classroom lectures in preparation for clinical placement. Nottingham (2000) mentions similar programs in the United Kingdom, though he suggests that there is little consistency in program design. Roberts, Brannan, and White (2005) mention a Web-based program that provides learning opportunities for nurses in the United States who are unable to access other learning modes. What is clear is that, in step with the United Kingdom and the United States, Israeli nurses should undergo training that includes reflection, critical thinking, and clinical decision making to be considered "advanced practice nurses" (Elwin, 2007; Price, 2007).

There is currently a paucity of studies that have investigated the relationship between ethical dilemmas in nursing and the current status of nurses. Moreover, there is a need for more in-depth research into how nurses in Israel perceive and make sense of ethical dilemmas in their work. Investigating ethical dilemmas and experiences of nurses in Israel might help in defining which of their roles should be expanded for the purpose of strengthening their status. My aim with the present study was to tackle these very issues.

Method

The research goal was to map the ethical tensions and interactions that are involved in managing ethical dilemmas in nursing so that nursing status might be improved. To meet this aim, a qualitative descriptive design was used, based on nurses' accounts of "ethical dilemma" events that occurred during the course of their work in hospitals and health maintenance organizations (HMOs).

Sampling and Participants

Data collection was carried out in 2008. Fifty-two nurses (33 women, 19 men) from various wards in 18 hospitals and HMOs, all in northern and central Israel, were interviewed. This ratio of women to men is representative of the fact that nursing in Israel is a female-dominated field (Israel Central Bureau of Statistics, 2005). The nurses' age range was 25 to 55 years. The nurses came from a variety of clinical backgrounds and had accumulated from 10 to 40 years of clinical experience. Nurses included in the study were employed in hospitals and HMOs varying in size, type (general or academic), and geographical distribution, which resulted in a sample representing a cross-section of practicing nurses in Israeli hospitals and HMOs. The selection of hospitals and HMOs was

pragmatic, based on institutions in which nurses were willing and available to participate.

Data Collection

The data examined in this study were collected during the 2008 academic year. In group information meetings, research assistants informed the nurses that they were collecting data to study the characteristics of ethical dilemmas as experienced by nurses in Israel. Participating nurses were granted full anonymity and confidentiality. They were informed and ensured that when the results of the study were published, they would be given pseudonyms and their statements during the interviews could not be traced back to them. They also received a formal letter describing the goals of the study and the pledge to preserve anonymity and confidentiality according to the Declaration of Helsinki (1996): "The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject" (p. 1448). This assurance was a contributing factor in the willingness of nurses to consent to the study and talk about their ethical dilemmas. Nurses who volunteered for the study signed an informed consent, including a specific consent to tape-recorded interviews. Because the interviews covered sensitive issues, I specifically instructed research assistants as to which questions should be asked, and how. The interviews were carried out by research assistants in unused rooms at the nurses' workplaces. The interviews lasted approximately 45 to 50 minutes each. The tapes were destroyed upon completion of transcription.

During the in-depth interviews, nurses were asked to provide detailed descriptions of ethical dilemmas they had encountered in their daily work. Examples of questions were: Can you share with me one or more ethical dilemmas that have arisen at your workplace? Who was involved in these ethical dilemmas? Can you describe one or more nursing roles that have ethical implications? The nurses were asked to recall ethical dilemmas that might have occurred at any time during their careers and in any employment setting. This technique of data collection was used to obtain the most accurate verbal description of the events (Keatinge, 2002).

Data Analysis

Analysis of the data was conducted by two researchers (myself and a research assistant). Participants were identified by a code number only, and information linking code numbers to individuals was destroyed upon completion of data analysis. The coding process focused on establishing semantic clusters of ethical dilemmas as they emerged from the analysis. The coding of semantic categories was conducted by the researchers both independently and collaboratively to identify and consolidate agreements and disagreements in interpretation (Strauss & Corbin 1998). The interviews were transcribed verbatim, processed as text, and analyzed using a stepwise method (Dahlberg, Dahlberg, & Nystrom, 2008; Gadamer, 2004; Patton, 1990).

First, each interview was read through several times to get a general idea of what had been said and to identify the ethical dilemmas involved. Second, similar experiences of ethical dilemmas were clustered and classified as subcategories. For example, one nurse in a psychiatric ward described her experience as follows:

> Something that happens quite often in our ward is tying down patients. . . .In this case, our dilemma is between giving autonomy to the patient versus providing safe treatment in keeping with the rules, since the patient's violent behavior could impede the treatment process.

Another nurse in a cardiology ward described a similar experience:

> Sometimes, when a patient arrives in the ward . . . it is clear to the nursing staff that he or she will not be able to cope with surgery. Should we share our fear with the patient? . . . But the doctors want to operate nevertheless, and they will present the data in a way that will convince the patient to have the surgery. . . . The decision to perform the surgery or not is in the doctors' hands . . . but what are we to do if we think that it is in the patient's best interest not to undergo surgery?

These two descriptions of ethical dilemmas were classified under the subcategory *patient-centered care vs. keeping the rules*, since both experiences describe a tension between patient-centered care (e.g., patient autonomy to decide on his treatment; sharing treatment options with the patients) and maintaining hospital rules (tying the patient in certain circumstances; the doctor having the mandate to decide whether to operate on the patient or not).

Finally, the content of similar subcategories were combined and clustered into categories. For example, the subcategories *patient-centered care vs. keeping the rules* and *collegial loyalty vs. reporting misbehavior* were merged into one category named *caring for others vs. following formal codes*. Both patient-centered care and collegial loyalty reflect caring for others (patients or colleagues), and both keeping the rules and reporting misbehavior represent following formal codes.

Table 1. Nurses' Ethical Dilemmas: Categories, Subcategories and Interactions

Category	Subcategory	Interactions
Caring for others vs. following formal codes	Collegial loyalty vs. reporting misbehavior	Nurse–colleague Nurse–person in charge Nurse–patient
	Patient-centered care vs. keeping the rules	Nurse–patient Nurse–hospital policy
Fair process vs. fair outcome	Procedural vs. distributive justice	Nurse–patient
	Egalitarian approach vs. discrimination	Nurse–patient Nurse–colleague
Organizational standards vs. family agenda	(None)	Nurse–patient Nurse–family
Autonomy vs. deference to higher authority	(None)	Nurse–person in charge Nurse–patient
Guarding secrecy vs. duty to report	(None)	Nurse–patient Nurse–patient's family

Findings

The ethical dilemmas were divided into five main categories: caring for others vs. following formal codes, fair process vs. fair outcome, organizational standards vs. family agenda, autonomy vs. deference to higher authority, and guarding secrecy vs. duty to report. Some of these categories include subcategories (see Table 1); the different types of verbal interactions that were involved in each incident were specified as well. In the following descriptions, all participants were given pseudonyms.

Caring for Others vs. Following Formal Codes

Almost every workplace has rules and regulations that govern the conduct of its personnel. Rules and regulations are put in place to ensure safety. Allegiances and loyalties among the employees improve the atmosphere at the workplace, and make it a more pleasant and efficient unit (Colnerud, 2006). Sometimes, however, a clash arises between the social aspects of the workplace and the rules that guide it.

Caring for others vs. following formal codes is the first category of ethical dilemmas that were described by the nurses. This category illustrates the tension between caring for either patient or colleague and maintaining proper behavior that is in keeping with the rules and norms of the health organization. Two subcategories fall under this category: collegial loyalty vs. reporting misbehavior and patient-centered care vs. keeping the rules.

Collegial loyalty vs. reporting misbehavior. There are situations in which a nurse perceives a colleague's behavior as contrary to the hospital's formal rules and standards. On the one hand, collegial loyalty keeps nurses from reporting misbehavior. On the other hand, they understand that by keeping quiet, the patients will suffer. Thus, a dilemma arises. Dina, a nurse in a gynecology ward, described her experience:

> We have this very good, dedicated nurse in our ward, but she never wears gloves or a gown, doesn't wash her hands between patients, and it really bothers me . . . because on the one hand, she is endangering herself, by coming into contact with blood and other secretions without the protection of gloves, and she is also not behaving properly toward the patients. She does not adhere to the safety rules regarding bacteria, which could harm the patients, as diseases can be passed from one patient to another. I do not feel comfortable challenging her with this, or reporting her to the supervisor, because she is my colleague . . . but I need to care for the health of my patients.

Dina's dilemma reflects tension between collegial loyalty and knowing that failing to report a colleague's misbehavior is going against hospital rules and standards. In this incident, the interactions involved were interactions between one colleague and another; between nurse and supervisor; and between nurse and patient.

Patient-centered care vs. keeping the rules. The concept of patient-centered care means that patients expect the medical staff to be responsive to their needs and preferences, to provide them with access to their medical information, and to treat them as partners in care decisions (Mead & Bower, 2000). However, when the patient has limited judgment capability, communication is either inadequate or impossible, and thus an ethical dilemma arises. Shira, a female psychiatry ward nurse, described one of her ethical dilemmas:

> I want to talk about ECT, a treatment administered to psychotic patients who are in a state of tumult and detached from reality. Naturally, prior to the treatment, the patient has to sign an agreement form; that is, the family and the patient have to sign. And sometimes I ask myself to what extent the patients, in spite of having received an explanation about the treatment and possible side-effects, understand what they are about to go through. On the one hand, we need to care for them and give them the best possible treatment to avoid their transfer to a closed ward, and therefore their signature is necessary, but on the other hand, it is very difficult to ascertain how much they understand and to what extent they really agree to the treatment.

In this case, Shira presented an ethical dilemma between her desire to involve a patient of limited judgment in his care decisions and her duty to obtain his signed agreement for treatment, despite the fact that he probably did not understand what it meant. In this incident, the interactions involved were between nurse and patient and between nurse and hospital policy.

Fair Process vs. Fair Outcome

Sometimes in health care there might be a tug-of-war between the needs of the individual patient and the needs of the health organization. The best treatment might be unavailable to the individual who needs it because the costs involved would deprive others of medical care because of a limited budget. Rules governing the allocation of resources are put in place to provide optimal care for most patients (Fawcett et al., 2007). As with any set of rules, it might be that the rules say one thing, but the care provider, having the patient's well-being in mind, might see these rules as obstacles to giving proper care (Hsieh, 2008). Fair process vs. fair outcome is the second category of ethical dilemmas that have been described by nurses. This category illustrates the tension between what nurses perceive to be the right treatment or the appropriate attitude toward their patients and what they perceive as just distribution of limited human and time resources which might, in the nurses' view, create an unfair outcome. Two subcategories fall under this category: procedural vs. distributive justice and egalitarian approach vs. discrimination.

Procedural vs. distributive justice. This subcategory indicates the tension that arises when nurses perceive the justice process as lacking in their hospital, creating an unjust outcome. Nira, a nurse in the orthopedics ward, described her ethical dilemma:

> In our ward, we don't wash the patients every day; only Sunday, Tuesday, and Friday. We had a patient who was recovering from surgery, and the family asked me to shower her, although it was Saturday. The family was very critical, and the patient really did look unkempt. She would relieve herself in the bed, or in a diaper or in a bedpan. I decided that I would give her a shower, as she was diabetic, and had a tendency to perspire. My internal feeling was that I wanted to give her everything in my power, within my specific limits, but I received no encouragement for this. I had to make sure that no one was looking so I could take her and wash her so that she would feel more comfortable, and put body lotion on her. Even someone who can't take care of herself wants to smell nice and feel good.

Nira perceived the policy regarding washing patients in her ward to be unjust. She believed that within the justice process it should have been acceptable to wash the patients when necessary, even if this went against the weekly routine. This meant, however, that procedural justice was in conflict with distributive justice, because limited human resources dictated that washing could take place only on specific days. In this incident, the interaction involved was between nurse and patient.

Egalitarian approach vs. discrimination. This subcategory reflects the tension that nurses experience between their belief that all patients should receive equal care and their colleagues' requests for preferential treatment of relatives. Rivka, a nurse working in an HMO, described her experience:

> We're faced with ethical dilemmas day in, day out. For example, it happens sometimes that I'm doing blood tests, and suddenly a member of the staff arrives with some distant relative . . . and asks me to take his blood and be nice to him, and to do so immediately of course, when there is a long line of people waiting. So what am I supposed to do? This person may be a colleague, but I have to treat all patients equally, without discrimination or favoritism.

In this description, Rivka voiced her opinion that all patients are entitled to receive their rightful turn. But this view was threatened when she was asked to treat a colleague's relative first. Although she believed that her approach was the proper approach, she was still uncomfortable saying no to a colleague. In this incident, the interactions involved are those between nurse and patient and nurse and colleague.

Organizational Standards vs. Family Agenda

Organizational standards vs. family agenda is the third category of ethical dilemmas described by the nurses.

This category illustrates the tension between declared health standards that are devised to promote optimum care for the patient, and family perceptions regarding the proper way to act. Yoni, a nurse working in an HMO, described his dilemma:

> During our work in the clinic, there are always cases that have us deliberating and thinking about whether we are acting properly. For example, is it appropriate to refer a mentally disturbed patient to an open hospital ward? The family demands an open ward, so we refer the patient there. It is because of the stigma. They do not want other people to know that they have a family member in a closed ward in a psychiatric hospital. It is easier to hide the problem if the patient is in an open ward. I am not sure that we are doing the right thing for the patient. Such patients are very agitated, and the closed ward helps their recovery process by shortening their recovery time. This is a problem that we have been dealing with for a long time.

In this description, the HMO had declared standards that were devised to protect the health of the patient. The HMO expected the patient's family to act accordingly; that is, to agree to commit the patient to a closed ward in a psychiatric hospital. This policy clashed with the family's wish to protect its reputation by placing the family member in an open hospital ward. The nurse thus faced a dilemma: Is it right to alter the standards to cater to family needs? This incident involved interactions between nurse and patient and between nurse and family members.

Autonomy vs. Deference to Higher Authority

Autonomy vs. professional deference is the fourth category of ethical dilemmas described by the nurses in the study. This category illustrates the tension between nurses' desires to make independent decisions and their loyalty to organizational policy, with which they do not always agree. More specifically, this category expresses tension between nurses' professional autonomy to express what they believe is right and the expectation that nurses should accept the opinions of those in charge, even when they do not agree with those opinions. Gila, a nurse working in an HMO, described a situation that demonstrates this type of dilemma:

> It is not the "done thing" in our clinic to call a mobile intensive care ambulance. . . . Once, I called a doctor to the nurse's office, as a patient was in a very bad way and lacking oxygen . . . the ECG showed bradycardia. I called the general nurse, as well. The doctor said that we should call a regular ambulance, but I said that I thought the patient's condition was very serious. I called a mobile intensive care ambulance, and they did give her treatment that is only available in intensive care, and they took her to the hospital . . . otherwise she would have died. . . . After that, they laughed at me, and it was very humiliating . . . whenever something would happen, the doctor would come by and say, "That is the one who calls the intensive care ambulance and gets stressed out." I was stressed out, the intensive care ambulance arrived in the nick of time and resuscitated her, and she is still alive today.

Gila was expected to be responsible and accountable for optimum patient care, and that is why she called for a mobile intensive care ambulance rather than a regular ambulance. However, she was also expected to accept the doctor's opinion if it contradicted her own. This incident involved interactions between the nurse and the person in charge and between the nurse and the patient.

Guarding Secrecy vs. Duty to Report

An individual who is no longer independent, to the extent that he needs the help of others to complete daily tasks, is at risk of losing his right to privacy. There is a fine line between the need to know certain things about a patient to give him better care and the desire to know, which is based on curiosity (Wolf & Zuzelo, 2006). Guarding secrecy vs. duty to report is the last category of ethical dilemmas described by the participating nurses. This category illustrates the tension between the desire to respect a patient's wishes for privacy regarding personal details, and the nurse's professional duty to report his medical condition. Rachel, a nurse who did follow-up treatments in the community, described her experience:

> All patients have a file at home in which I have to write about their condition, including the patient's mental state . . . their reactions to the treatment, and the viewpoint of the family. It has happened more than once that I have found family members and visitors sitting together and perusing the file. I doubt whether the patient would want his family and visitors to know everything that is written in the file. But he is totally dependent on them, and does not like to say no. On the other hand, you cannot ignore these people. They are the ones caring for him and helping him.

Rachel's ethical dilemma was in the tension between respecting the patient's right to have control over his

personal life and the patient's inability to maintain privacy because he was dependent on his family. This incident involved interactions between the nurse and the patient and between the nurse and the patient's family.

Discussion

My aim with this study was to explore ethical dilemmas in nursing so as to gain a better understanding of nurses' work and their professional status. A taxonomy of the nurses' narratives revealed ethical dilemmas in which nurses' autonomous practice was constrained by their powerlessness. This powerlessness was derived from a lack of tools for dealing with ethical dilemmas, and could be partially attributed to inadequate resources and status issues. The results of this study add to other characteristics in the nursing professions that reflect powerlessness. They include employing specialized nurses in emergency care, surgery, midwifery, and pediatrics without academic recognition or advancement, or overlooking cases in which nurses perform medical procedures without physician approval.

The majority of values presented in this article reflect ethical dilemmas. It is these competing values that might lead to a better understanding of nurses' ethical dilemmas and might create awareness of the need to raise the status of nursing in Israel. This argument is supported by Quinn's (1988) competing values model, which shows that conflicting values might contribute to organizational effectiveness. Colnerud (2006) also argues that a dynamic dialogue between two contradictory positions might be perceived as complementary instead of conflicting, and might contribute to improving a worker's status.

Each ethical dilemma in the study was conceptualized in terms of tension between personal values and contradictory interactions (e.g., with doctors, colleagues, patients, family), and shed light on the complexity of nurses' work. Similar to other studies, the results indicate that caring for the well-being of patients is a critical component in nurses' ethical dilemmas, usually determining their decision making (e.g., Haggstrom et al., 2008; Jones, 2007; McGrath & Holewa, 2006; Wolf & Zuzelo, 2006). Indeed, one of the most common interactions reported was that between nurses and patients. This might be explained by the fact that nurses perceive their ability to understand the client's perspective as an essential component in nursing, as their occupation requires them to spend long hours in contact with patients and their families, whereas doctors have only brief interactions with patients (McGrath & Holewa, 2006). Consequently, physicians are not always aware of the patient and family perspective, whereas nurses are. This fact reinforces the legitimacy of moving the nursing occupation toward attaining professional status by focusing on issues at which nurses excel, such as caring.

At first glance, organizational rules seem limiting when they are described in the context of nurses' ethical dilemmas. However, the findings of this study are in line with the findings of other studies (Brodsky & Van Dijk, 2008, Matt, 2008, Riba et al., 2004) indicating that rules and regulations are very important. These findings indicate that rules and standards protect patients from maltreatment that might result from health care staff being influenced by personal preferences. Standards and rules also provide boundaries and tools for dealing with ethical dilemmas.

Some of the revealed dilemmas related to the specific Israeli context, such as the case in which a nurse described a situation that compromised the quality of health care because of the low ratio of staff to the number of patients. Israel's health care system is characterized by limited resources and rewards (Ehrenfeld et al., 2007), creating a situation in which nurses are more sensitive to issues of justice and the just division of resources among their patients. Also typical of Israeli nurses is the tension between the agenda of the health institute and that of patients and their families. Demographic data indicate that Israel is considered more "familial" than Western and Eastern Europe (Feldman, Shafiq, & Nadam, 2001; Lavee & Katz, 2003). Researchers have suggested a number of explanations for the high level of familiality, such as the intimacy of Israeli society (Fawcett et al., 2007), which amplifies the individual's attachment to his or her family (Halpern, 2001; Sharlin, 1996).

The nurses' narratives are indicative of the wide extent of uncertainty as to how to handle the ethical dilemmas that arise in their work. This uncertainty presents a challenge. It not only emphasizes the importance of reformulating a code of ethics for nurses in Israel, but also suggests that a written code is not enough, as implementation of existing codes is limited and nurses clearly lack tools for dealing with ethical dilemmas. Future research should examine how such codes of ethics can be better applied to actual dilemmas.

Conclusions, Recommendations and Implications

The study findings indicate that ethical dilemmas occur in numerous areas of nursing in Israel, at all levels and in a variety of health care organizations. In most cases, nurses are powerless to deal with these dilemmas because of inadequate resources and low professional status. The study was focused on the explicit interactions that occur during ethical dilemmas, but it should be noted that implicit interactions also exist. Future studies should

examine implicit interactions to further understand nurses' ethical dilemmas, and perhaps contribute to strengthening their status, as well.

From a practical perspective, there are several ways to help nurses in dealing with ethical dilemmas. First, nurses should be empowered: because education is power, nurses and potential nursing students should be encouraged to acquire academic degrees. In addition, opening nurse practitioner programs, as in the United States, would give nurses greater responsibility to deal with complex ethical issues and medical conditions. In these programs, nurses would train in the diagnosis and management of medical events as well as focus on ethical dilemmas that might subsequently arise. Empowering the nursing profession will go a long way toward reducing the expected shortage of nurses and will improve the system's ability to provide quality health care.

Second, a professional nurses council should be established for the purpose of changing the current status of nurses. Such an organization would be more effective in pressing for a nurse practice act, which would provide nurses with a stronger legal basis for practice, including a salary raise and a revised ethics code.

In line with the study results, the following suggestions are proposed regarding a revised and improved code of ethics for nurses in Israel:

1. Nurses should work with colleagues and people outside the profession (e.g., lawyers, organizational consultants, and organizational psychologists) to raise and maintain professional standards of health care.
2. Resources that are under nurses' control should be distributed fairly, based on patients' needs.
3. Nurses should practice within specified limits. When aspects of care are beyond a nurse's capability (i.e., scope of practice), additional information or help should be sought from a supervisor.

Effective dissemination of a revised and improved code of ethics requires that it be included in training programs and curricula, and that it be presented from a practical point of view. It should focus on finding a balance between competing values that might empower nurses to deal more successfully with their ethical dilemmas. It is hoped that by redefining nurses' professional identity, clarifying their responsibilities, and strengthening their status, nurses will be better equipped to solve ethical dilemmas as they arise, and will no longer have to cope with feelings of uncertainty and helplessness when faced with ethical conflicts in the workplace.

Declaration of Conflicting Interests

The author declared no conflicts of interest with respect to the authorship and/or publication of this article.

Funding

The author received no financial support for the research and/or authorship of this article.

References

Berger, M., Seversen, A., & Chvatal, R. (1991). Ethical issues in nursing. *Western Journal of Nursing Research, 13*, 514-521.

Birenbaum-Carmeli, D. (2007). Contextualizing nurse education in Israel: Sociodemography, labor market dynamics and professional training. *Contemporary Nurse, 24*(2), 117-127.

Brodsky, E., & Van Dijk, D. (2008). Advanced and specialist nursing practice: Attitudes of nurses and physicians in Israel. *Journal of Nursing Scholarship*, *40*(2), 187-194.

Bunting, S., & Webb, A. (1988). An ethical model for decision making. *Nurse Practitioner, 13*(12), 30-34.

Bureau of Ethics. (2004). *Code of ethics for nurses in Israel.* Jerusalem, Israel: Israeli Nurse Association. (Hebrew)

Burkhardt, M. A., & Nathaniel, A. K. (2002). *Ethics and issues in contemporary nursing* (2nd ed.). New York: Delmar.

Carr, D. (1999). Professional education and professional ethics. *Journal of Applied Philosophy*, *16*(1), 33-46.

Cohen, D. (2006). The aging nursing workforce: How to retain experienced nurses. *Journal of Healthcare Management, 51*(4), 233-245.

Colnerud, G. (2006). Teacher ethics as a research problem: Syntheses achieved and new issues. *Teachers and Teaching: Theory and Practice*, *12*, 365-385.

Coombs, M., & Ersser, S. (2004). Medical hegemony in decision-making: A barrier to interdisciplinary working in intensive care? *Journal of Advanced Nursing, 46*, 245-252.

Corley, M. C., Elswick, R. K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *Journal of Advanced Nursing, 33*, 250-256.

Dahlberg, K., Dahlberg, H., & Nystrom, M. (2008). *Reflective lifeworld research.* Lund, Sweden: Studentlitteratur.

Declaration of Helsinki. (1996). World Medical Organization. *British Medical Journal, 13*(7070), 1448-1449.

Ehrenfeld, M., Itzhaki, M., & Baumann, S. L. (2007). Nursing in Israel. *Nursing Science Quarterly, 20*(4), 372-375.

Elwin, E. (2007). Returning to nursing practice: A learning journey. *Contemporary Nurse, 24*, 203-211.

Falchuk, N. (2009, May 14). Averting the nursing crisis. *Jerusalem Post*, 16.

Fawcett, J., Sabone, M. B., & DeKeyser Ganz, F. (2007). Nursing, healthcare, and culture: A view of the year 2050 from Botswana and Israel. *Nursing Science Quarterly, 20*(4), 337-341.

Feldman, R., Shafiq, M., & Nadam, R. (2001). Cultural perspective on work and family. *Journal of Family Psychology, 15*(3), 492-509.

Fry, S. T., & Duffy, M. E. (2001). The development and psychometric evaluation of the ethical issues scale. *Image: Journal of Nursing Scholarship, 33*, 273-277.

Gadamer, H. G. (2004). *Truth and method* (J. Weinsheimer & D. Marshall, Trans.). New York: Continuum.

George, J., & Grypdonck, M. (2002). Moral problems experienced by nurses when caring for terminally ill people: A literature review. *Nursing Ethics, 9*, 155-178.

Gert, B. (1998). *Morality.* New York: Oxford.

Greenberger, H., Reches, H., & Riba, S. (2005). Do new graduates of registered nursing programs in Israel perceive themselves as technically competent? *Journal of Continuing Education in Nursing, 36*, 133-140.

Haggstrom, E., Mbusa, E., & Wadensten, E. (2008). Nurses' workplace distress and ethical dilemmas in Tanzanian health care. *Nursing Ethics, 15*(4), 478-491.

Halpern, E. (2001). Family psychology from an Israeli perspective. *American Psychologist, 56*(1), 58-64.

Hawks, J. H. (1991). Empowerment in nurse education: Concept analysis and application to philosophy, learning and instruction. *Journal of Advanced Nursing*, *16*, 609-618.

Hsieh, E. (2008). I am not a robot! Interpreters' views of their roles in health care settings. *Qualitative Health Research, 18*, 1367-1383.

Huggins, M. E. (2005). Registered nurse refresher course as an adjunct in nurse recruitment. *Journal of Continuing Education in Nursing, 35*(5), 213-218.

Israel Central Bureau of Statistics. (2005). *Manpower survey.* Jerusalem, Israel: Author. (Hebrew)

Jones, J. (2007). Do not resuscitate: Reflections on an ethical dilemma. *Nursing Standard*, *21*(46), 35-39.

Keatinge, D. (2002). Versatility and flexibility: Attributes of critical incident technique in nursing research. *Nursing and Health Sciences, 4*, 33-39.

Kopala, B., & Burkhart, L. (2005). Ethical dilemma and moral distress: Proposed new NANDA diagnoses. *International Journal of Nursing Terminologies and Classifications, 16*(1), 3-13.

Lavee, Y., & Katz, R. (2003). The family in Israel: Between tradition and modernity. *Marriage & Family Review*, *35*(2), 193-212.

Matt, S. B. (2008). Nurses with disabilities: Self-reported experiences as hospital employees. *Qualitative Health Research, 18*, 1524-1534.

McGrath, P., & Holewa, H. (2006). Ethical decision making in an acute medical ward: Australian findings on dealing with conflict and tension. *Ethics & Behavior*, *16*(3), 233-252.

Mead, N., & Bower, P. (2000). Patient centredness: A conceptual framework and review of empirical literature. *Social Science & Medicine*, *51*, 1087-1110.

Metcalf, B. L., & Yankou, D. (2003). Using gaming to help nursing students understand ethics. *Journal of Nursing Education, 42*(5), 212-215.

Moore, M. L. (2000). Ethical issues for nurses providing perinatal care in community settings. *Journal of Perinatal and Neonatal Nursing*, *14*(2), 25-35.

Moseley, A., & Paterson, J. (2008). The retention of the older nursing workforce: A literature review exploring factors that influence the retention and turnover of older nurses. *Contemporary Nurse, 30,* 46-56.

Nottingham, E. (2000). Creating the right environment for return-to-practice candidates. *Nursing Standards, 14*(32), 44-45.

Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Pence, G. E. (2004). *Classic cases in medical ethics* (4th ed.). Boston: McGraw-Hill.

Physician Ordinance. (1976). *Chapter 6, Article 59 (1) A,* Statutes of the State of Israel: Israel.

Price, K. (2007). Nurses in general practice settings: Roles and responsibilities. *Contemporary Nurse,* 26, 7-14.

Quant, T. (2001). Education for nurses returning to practice. *Nursing Standards, 15*(17), 39-41.

Quinn, R. E. (1988). *Beyond rational management*. San Francisco: Jossey Bass.

Rawls, J. (1985). Justice as fairness: Political not metaphysical. *Philosophy & Public Affairs, 14*(3), 223-251.

Riba, S. (2000). *The impact of various professional interactions between physicians and nurses upon attitudinal change towards reshaping the scope of nurses' authority and responsibility.* Unpublished doctoral dissertation, Ben Gurion University of the Negev.

Riba, S., Greenberger, C., & Reches, H. (2004). State involvement in professional nursing development in Israel: Promotive or restrictive. *Online Journal of Issues in Nursing, 9*(3), 1-12.

Roberts, V. W., Brannan, J. D., & White, A. (2005). Outcome based research: Evaluating the effectiveness of an online nurse refresher course. *Journal of Continuing Education in Nursing, 36*(5), 200-205.

Sharlin, S. A. (1996). Long-term successful marriages in Israel. *Contemporary Family Therapy*, *18*(2), 225-242.

Sletteboe, A. (1997). Dilemma: A concept analysis. *Journal of Advanced Nursing, 26*(4), 449-454.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Wage and Work Agreement Administrator. (2004). *Report on wage expenses in the civil service*. Jerusalem, Israel: Ministry of Finance. (Hebrew)

Wolf, Z. R., & Zuzelo, P. R. (2006). "Never again" stories of nurses: Dilemmas in nursing practice. *Qualitative Health Research, 16*, 1191-1206.

Bio

Orly Shapira-Lishchinsky, PhD, is a faculty member in the Department of Educational Administration, Leadership and Policy, School of Education, at Bar-Ilan University in Ramat-Gan, Israel.