

**RESEARCH**

Bioethical conflicts experienced by nurses in a university hospital

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Abstract

The article is the result of research carried out at a university hospital in Rio Grande do Sul, with the objective of identifying and analyzing the bioethical conflicts experienced by nurses and the institutional support mechanisms offered and used by them to address these conflicts. For the data collection, a semi-structured interview was used. All the ethical procedures and recommendations were observed. Data analysis followed Bardin's perspective. Two main categories were defined to support the data: bioethical conflicts experienced in daily life and the support mechanisms available to the professional facing bioethical conflicts. What was evidenced is that nurses are confronted with bioethical conflicts of different natures and do not always have the knowledge, conditions, authorization and support necessary to solve them, which impairs their performance or makes them feel frustrated about their work.

Keywords: Bioethics. Decision-making. Nursing. Health services.

Resumo**Conflitos bioéticos vivenciados por enfermeiros em hospital universitário**

O artigo resulta de pesquisa de campo realizada em um hospital universitário no Rio Grande do Sul com o objetivo de identificar e analisar conflitos bioéticos vivenciados por enfermeiros e os mecanismos institucionais de suporte para lidar com essas situações. Na coleta de dados utilizou-se entrevista semiestruturada, observando todos os procedimentos e recomendações éticas. Os dados foram analisados a partir da perspectiva de Bardin, sendo distribuídos em duas categorias: conflitos bioéticos vivenciados no cotidiano laboral e mecanismos de suporte ao profissional para enfrentá-los. Ficou evidente que enfermeiros deparam com esses dilemas e nem sempre possuem conhecimento, condições, autorização e amparo necessários para solucioná-los, o que prejudica seu desempenho ou gera sentimento de frustração no trabalho.

Palavras-chave: Bioética. Tomada de decisões. Enfermagem. Serviços de saúde.

Resumen**Conflictos bioéticos vivenciados por enfermeros en hospital universitario**

El artículo resulta de una investigación de campo, realizada en un hospital universitario en Rio Grande do Sul, con el objetivo de identificar y analizar los conflictos bioéticos vivenciados por enfermeros y los mecanismos institucionales de apoyo para lidiar con estas situaciones. En la recolección de datos se utilizó la entrevista semiestructurada, observando todos los procedimientos y recomendaciones éticas. Los datos se analizaron a partir de la perspectiva de Bardin, distribuyéndose en dos categorías: conflictos bioéticos vivenciados en la cotidianidad laboral y mecanismos de apoyo al profesional para afrontarlos. Quedó evidenciado que los enfermeros se enfrentan con estos dilemas y no siempre poseen el conocimiento, las condiciones, la autorización y el apoyo necesarios para solucionarlos, lo que perjudica su desempeño o genera sentimientos de frustración en el trabajo.

Palabras clave: Bioética. Toma de decisiones. Enfermería. Servicios de salud.

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Declararam não haver conflito de interesse.

The industrial revolution, which led to the emergence of the capitalist society, promoted scientific and technological development, culminating in profound social transformations¹. In terms of health care, such advances contributed to the improvement of medical instruments, techniques, and means of intervention in human life, in addition to the development of unprecedented therapeutic possibilities. In contrast, the risks inherent to high complexity care also increased.

The evolution of biomedical technology sparked bioethical conflicts among health professionals, patients, and families. The impact of techno-scientific progress stirred up long-established values and norms creating a multidimensional reality². While biotechnoscience has improved the quality of life and the chances of survival, it has also raised concerns, such as to what extent it is acceptable to invest in state-of-the-art tests, technologies, and drugs for patients with poor chances of survival (poor prognosis).

Based on this incongruity, Taylor and collaborators add that, for nurses, the synergy between *being aware of the ethical dimensions of professional practice and having the confidence in "doing the ethically correct thing" just because it is the right thing to do has never been more important than it is today*³. Therefore, ethical conflicts will inevitably emerge as a result of the scientific and technological influence on health professionals, especially nurses, and how they care for their patients⁴. After all, for how long can anyone intervene in life in itself, or somebody else's for that matter?

Ethics then resurfaces as the basis for answering this and many other questions. In order to deepen the ethical approach to questions related to scientific development, a plural and interdisciplinary field has evolved over the last four decades – bioethics, defined by Potter as *a new wisdom that provides the 'knowledge of how to use knowledge' for human survival and to improve the quality of life*⁵. Hence, bioethics arises from human unrest and the challenges related to preserving and improving living conditions⁶.

This study seeks to identify and analyze the bioethical conflicts experienced by nurses working at an university hospital located in the central region of Rio Grande do Sul, including the institutional support mechanisms provided to help them deal with such situations.

The increase of diagnostic and therapeutic possibilities made possible by the advent of

technoscience⁷ and the improvement of quality of life dramatically extended the human lifespan. Even though technology facilitates the work of health care professionals, it can also create a number of obstacles withholding many from the right to access health care when the resources available are limited. Being aware of such difficulties can help professionals and institutions to implement strategies that can reduce the suffering of caregivers and help patients and families to endure decision-making processes.

Method

This article summarizes the findings of a qualitative research conducted between March and June 2016 including 21 nurses representing a university hospital located in the central region of Rio Grande do Sul. Inclusion criteria were as follows: be a nurse, accept to participate in the research and work in adult emergency care, adult intensive care unit (ICU), cardiac intensive care unit (CICU), post anesthesia care unit (PACU), and/or operating room (OR). Nurses who were absent from the workplace on the days of data collection were excluded from the study.

The first step was to contact unit coordinators to introduce them to the research, requesting authorization to conduct interviews on the spot and finding out which nurses would agree to participate. The 20-minute semi-structured interviews took place in the participants' own workspace, individually and privately, according to their interest and availability. They were audio recorded upon consent to ensure the reliability of the material, which was later transcribed according to the order of the interviews.

A structured script was used for data collection including questions to characterize the participants' socio-demographic profile, and open questions about bioethical conflicts experienced within the work environment. The interviews were finalized when repetition and saturation of information were noticed. To ensure anonymity, nurses were identified by the letter E followed by a cardinal number (between 1 and 21).

The study was evaluated and authorized by the Comitê de Ética em Pesquisa com Seres Humanos – CEP (Human Research Ethics Committee) of the Universidade Regional Integrada do Alto Uruguai e das Missões (Regional Integrated University of Upper Uruguay and Missions) – Frederico

Westphalen campus, in compliance with the ethical and methodological precepts established by the Conselho Nacional de Saúde - CNS (National Health Council) Resolution 466/2012⁸. The nurses interviewed were aware of the nature of the research and signed the two copies of an informed consent form (ICF), keeping one of them and handing out the other to the researcher.

The data collected was interpreted based on content analysis procedures described by Bardin⁹, which include three phases: pre-analysis; material exploration and handling of results; inference and interpretation. The first included listening to the recordings, transcribing the interviews, reading the material collected, and organizing the information by using tables. The tables were printed out to make them easier to handle and emphasized by colored highlighters, according to the main idea.

The information highlighted included contextual units that were detailed in the second phase, and later subsidized the creation of categories. The inference and interpretation phase included data analysis according to the literature available on the subject, starting off with the objectives of the study.

Results and discussion

Among the 21 participants, 81% were female and 19% male. The ages ranged between 25 and 29 years old (19%), 30 to 34(43%), 35 to 39(19%), 40 to 44(9.5%), and 45 to 49(9.5%). As for level of education, 5% of respondents had a bachelor's degree, 57% had a postgraduate specialization, and 38% had a master's degree, thus representing a qualified sample.

Regarding length of service, 28% of nurses had between 2 and 6 years of work experience; 43% had between 7 and 11 years; 14% between 12 and 16 years; 5% had between 17 and 21 years; and 10% between 22 and 26 years. Twenty-four percent of respondents worked in the adult ICU, 14% in the IMCU, 29% in the PACU and OR, and 33% worked in the adult emergency care. It is important to highlight that PACUs and ORs are units physically interconnected, so nurses often assisted both. For this reason, they were grouped in the overall analysis.

Two categories stand out in this article: bioethical conflicts experienced within the work environment; and professional support mechanisms

designed to help health care professionals deal with these situations. The first was further divided into four subcategories: 1) infrastructure and resources; 2) difficulties with the team; 3) difficulties with patients and family members; and 4) imminence of death and human terminality issues.

Bioethical conflicts within the work environment

For this category, the study showed that nurses experience several bioethical conflicts at work, which are related to factors such as lack of beds, communication issues among staff and patients, breach of confidentiality, disrespect towards the right to information, negligence, disrespect towards patient autonomy and dysthanasia. These elements were analyzed and divided into four subcategories.

In terms of lack of infrastructure and resources for examinations and other medical procedures, the interviewees provided the following statements:

"There is no infrastructure, no (...) human resources" (E4);

"We need to improvise daily (...) we do not have the resources necessary to provide the right level of customer service and sometimes I think we end up (...) putting people at risk" (E7);

"Working at a hospital that is (...) constantly overloaded, in a unit that can't keep up with the demand (...), not just the unit, the entire hospital. So, I believe that everyone who works here experiences a bioethical dilemma because we end up making choices (...) for what may be someone's life" (E1).

These statements demonstrate the disparity between demand and the capacity available; some units are either overloaded or run beyond their capacity, especially urgent and emergency care units. Failure in primary care leads to many highly complex medical appointments, higher individual costs, and waste of public resources, since what most of those seeking such care really need is a service that is not as complex. In addition, patients are constantly exposed to iatrogenic risks.

Professionals are also exposed to other risks, as these conditions promote the occurrence of occupational accidents, psychological distress, and psychosomatic diseases, which may lead to the abuse of licit and illicit drugs, absenteeism, high

turnover, in addition to labor conflicts that result in judicial and administrative proceedings¹⁰.

Another study also pointed out the lack of adequate health care resources, showing that professionals do not know how to proceed in the case of insufficient number of ICU beds¹¹. Given the difficulty of managing limited resources more equitably, some authors stress the need to define the criteria required to meet the ever-more delicate demand that can determine one's life or death¹².

According to Lunardi, *even though we are unaware of it, we are continually making moral decisions, such as prioritizing what we do*¹³. So, choosing to take care of one patient over another is already a decision, perhaps avoidance to dealing with the suffering of those who are denied care. When a health care professional is faced with moral issues, he/she must decide whether to base his/her actions on personal values and beliefs, or to take the risk of acting upon what others determine or expect, even if it goes against his/her principles¹⁴.

Good infrastructure that includes adequate materials, equipment, and appropriate human resources is paramount for health care professionals. It promotes humanization and good health care, improving the working conditions of nurses. When infrastructure is insufficient, limitations and improvisations can compromise team activities and results¹⁵⁻¹⁷.

Vagheti and collaborators stress the fact that public hospitals are under budget *due to inadequate revenue distribution (...) and poor overall management*¹⁸. In addition, the hiring and purchasing of inputs is bureaucratic and time consuming. This reality leads nursing teams to improvise – a practice historically applied by professionals involved in the art of care. Regarding the lack of human resources, Gonçalves and collaborators highlight the high rate of nurses on leave due to *musculoskeletal, mental, and respiratory diseases, in addition to injuries related to external causes*¹⁹.

The second subcategory focuses on the difficulties experienced by teams, in addition to exposing the negligence of mid-level nursing workers and doctors. According to one of the interviewees, *"sometimes [it is] the medical team that does not want to treat [patients]"* (E16). Another nurse also discussed this problem:

"We have patients here with several clinical conditions. Surgical patients, clinical patients who come here after a certain procedure and (...) they

all undergo surgery followed by anesthesia. The patient is hospitalized in the recovery room (...) because there are no beds available in an inpatient unit; there are no beds available in the ICU and, in most cases, we are unable to find out who the doctor responsible for that patient is. So, the surgery team asks us to talk to the anesthesia care team, and the anesthesia care team asks us to talk to the surgery team. The patient is stuck in the middle of all this, and so are we, the nurses, suffering because we just want the patient to be cared for" (E17).

Such declarations prove that the medical team is usually negligent and does not commit to the integrity of medical care, dealing only with the fragments of an indivisible whole. The problem becomes even greater when it comes to inadequate communication among doctors, patients, and family members. Regardless of the patient's condition and level of education, it is unacceptable that health care professionals demonstrate disregard towards anyone by withholding information or not providing the patient with clear explanation about his/her medical condition²⁰.

The nursing staff has also demonstrated negligence by failing to comply with medical prescriptions, causing harm to patients and disrespecting their right to obtain information about the care provided, in addition to preventing them from gaining access to risk-free health care²¹: *"Many of those who are new do not follow the procedures, or do not administer medications; there are many antibiotics left over, and we realize that nothing is done at all. We do not know who does it and who does not, but (...) we realize that there are many antibiotics left over, so we know patients are left without the right treatment"* (E16).

Another study²² showed that negligence is the main cause of technical or procedural failures. These occurrences are not properly reported to the health care team, nor even to patients, whose right to error-free information and treatment is completely neglected²³. Nurses must comply with the Code of Ethics for Registered Nurses²¹ to promote, protect and rehabilitate people's health, ensuring their respect for ethical and legal precepts.

Negligence may be due to laziness, unpreparedness, or even lack of interest resulting from tiredness, work overload, and poor working conditions imposed upon many doctors working in public hospitals and health care units²⁰. It is necessary to identify the source of ethical violations first in order to devise the strategies required to address them²⁴.

In the third subcategory – difficulties with patients and family members, the interviewees mentioned deadlocks when patients ask the health care team to not let relatives visit them; or when the team does not authorize the disclosure of diagnosis or any other information; or when, even with life at risk, patients refuse to receive treatment due to their religious convictions.

The nurses interviewed declared that patients, sometimes, *“do not wish to see a family member, or they might have a problem (...), and that a family member is trying to impose something (...) [and there are cases] when other family members do not want another family member to see the patient”* (E2). Nurses are aware of how important it is for patients to have relatives and friends visiting them daily, but their presence may not necessarily be something positive. In order to comply with the principles of autonomy and non-maleficence, it is necessary to respect the will of those hospitalized, whether conscious or not, as long as they have already expressed their wish¹¹.

Situations involving professional secrecy were also mentioned: *“HIV patients arriving with their partners... When will the doctor tell the partner? (...) Has the patient ever told his/her partner that he/she is HIV positive?”* (E15). Nurses, as compared to the other members of the health care team, are the ones who spend the longest time with patients and their relatives, which only strengthens the bond between them.

However, not all questions can be satisfactorily answered by nurses. In the ICU, for example, the intensive care physician is the one responsible for communicating about critically ill patients²⁵. Thus, when the diagnosis has not yet been disclosed to the family, the nursing staff must deal with a delicate situation, as it cannot grant the patient and his/her relatives the right to information, which can lead to moral distress and a feeling of helplessness.

The participants also recalled a case involving a Jehovah's Witness patient: *“We had a patient who was sedated and had not declared that he was a Jehovah's Witness; the family had come for many days and talked to the doctors several times, but nobody said (...) anything about it. And a blood transfusion was requested due to his clinical condition. The transfusion was scheduled during visiting hours. The family had just arrived and saw what was about to happen. So, the transfusion was interrupted”* (E15).

For those who practice this religion, non-acceptance of blood transfusion is more than a belief; it is a health issue, due to the risk of disease transmission²⁶. The bioethical conflict arises in emergency situations, when the patient can actually die, and the doctor finds him/herself stuck between two constitutional principles of equal relevance in the Brazilian legal system: the right to life and religious freedom²⁷.

Although the physician is responsible for the treatment and for respecting the patient's autonomy, the law, and the medical code of ethics, the nursing team also takes the risk of complying or not with what has been decided. Its performance must also comply with the Medical Code of Ethics²¹. The team must observe the right of their patients (and that of legal representatives) to make decisions about their health, being prohibited to provide assistance without consent, except in emergency situations

In the case of Jehovah's Witnesses, non-consensual blood transfusion may lead to emotional and moral harm. Therefore, it is important to remember that despite the refusal of this medical procedure, nurses must establish an open dialogue channel to discuss other options and alternative methods for blood preservation techniques so that patients can autonomously choose the treatment of their choice.

The lack of knowledge of alternative methods may lead health care professionals to disregard the decisions made previously by the patient. However, there is a network of physicians qualified to care for Jehovah's Witnesses who can be contacted if the doctor assigned prefers not to treat the patient²⁸.

Finally, the fourth subcategory involves issues related to the end of life; there were several declarations about dysthanasia, as follows:

“How far can we interfere without causing any harm when trying to keep a person alive who doesn't (...) really have any hope? In this case, investing in something that will only prolong suffering will not really benefit anyone...” (E9);

“Sometimes there is nothing we can do... the disease has already progressed; everything has been done and (...) so, extraordinary maneuvers take place, which I am not really sure if the patient would like them... maneuvers that represent no turning back. So, we end up accepting the situation because it's not really up to us to decide” (E5).

These statements reveal the difficulties nurses have when dealing with the eminence of death. Health care professionals often witness death within the hospital environment, and because they are trained to maintain life, they express feelings of guilt if they witness the death of a patient, believing that it represents lack of competence. The study conducted by Oneti, Barreto and Martins²⁹ shows that nurses become distressed in highly complex environments because they see death as a result of the poor quality of the health care provided, in addition to the uncertainty about the best options available for terminal patients.

Regarding the training of health professionals on how to deal with the end of life, some authors explain that *there is practically nothing included in the academic curriculum yet as far as caring for terminally ill patients*³⁰. Susaki, Silva and Possari corroborate this statement, emphasizing the fact that *the undergraduate nursing curriculum (...) has not subsidized qualitatively the basis required for the formation of knowledge focused on palliative care and training [on] how to deal with death and end-of-life situations*³¹.

The authors also found that although all participants have a theoretical basis on the care of patients outside the therapeutic possibilities, they still do not associate scientific content with their own professional practice. Other research indicates that factors such as length of service, religious belief, health care professional-patient bond, age, and diagnosis/prognosis of the patient also interfere in this process^{32,33}.

The interviewees were also concerned about not prolonging the life of incurable patients, only delaying their death and causing more suffering through extraordinary therapeutic resources, without which they could not subsist². However, the decision to discontinue treatment rests upon the physician, leaving little room for the nursing staff to engage in any further discussion³⁴.

Organ donation was another issue mentioned by the participants. The lack of training on how to take care of the body after the biological death was highlighted. As one participant pointed out: *"There was a young patient that passed away, who could very well donate his organs. We stay on top of it, because organ donation is very important. And it seems that if we had done a little more, the patient could have donated an organ"* (E11).

For organ donations, the individual must have expressed a willingness to donate one or more parts of his/her body after death. In addition, the nurse in charge must be sensitive when approaching the

family of the deceased during this delicate time. The statements gathered show that the issue is equally difficult for the nurse who takes care of the person who still has the physiological functions preserved. As Lima points out, *the corpse is not looked after, but the usable organs housed within the corpse still live and must remain alive inside a recipient*³⁵.

The statement given by E11 shows the concern with the lack of commitment shown by the health care teams to ensure that the donation takes place in a timely manner, perhaps because they are not aware of the institutional protocols for collecting organs and tissues. Hence the importance of investing in continuing professional education, considering that the lack of knowledge about the process and the lack of identification of potential donors are still obstacles that hinder the completion of the procedure³⁶.

Support mechanisms available for bioethical conflicts

The nurses were asked about the support provided by the institution they work for on how to deal with bioethical dilemmas. The hospital where the research was conducted has a Bioethics Committee (CB); however, only 28% of respondents mentioned it as a resource for addressing issues, such as the following: *"It seems to me that there is a group of professionals here at the hospital who discusses a lot about bioethical dilemmas. But since I started working here, it has never (...) been formally passed on to me that [it] exists and that I can count on it"* (E14).

The other 72% of participants stated that, in these situations, they can count on the support of the health team, the immediate leadership representatives, the occupational health service, and the social and psychology services, being the latter the one mentioned more often. Of 72%, 19% said they never needed help with these matters; 53% turned to the institution's psychosocial support and management for assistance.

The CB is composed of professionals from several areas who work in an interdisciplinary manner to teach, research, provide consulting, and recommend standards for ethical matters³⁷. According to the data presented, the decreased number of nurses looking up for the Committee's assistance may be due to the centralization of decision-making restricted to physicians only and the lack of a truly interdisciplinary approach. In addition, nurses can count on other support network groups within the workplace, which may explain the lower participation of the CB in therapeutic decisions that involve ethical issues.

This fact may also be justified by the lack of knowledge the nurses possess about the CB in general. As indicated by Loch and Gauer, *it is necessary to promote the visibility of the Bioethics Committee within the institution so that applicants have quick and easy access to the management, streamlining the consultation process*³⁸. It is also worth noting that the CB must not be seen by the hospital community as a disciplinary body. This role is incumbent upon professional boards. The CB must be a present, dynamic, welcoming instance able to assist professionals on any ethical issue experienced in clinical practice that requires additional consideration³⁸.

Final considerations

The study demonstrated that the nurses who participated in the research come across several bioethical conflicts involving cases of dysthanasia, organ donation, equitable distribution of resources, blood donation and Jehovah's Witnesses, among others. These delicate issues must be addressed collectively after reflection based on science and in-depth bioethical knowledge.

It is important to promote and strengthen communication and the exchange of experiences among health team members by setting up spaces

conducive to the open discussion of issues that cause distress among professionals, patients, and families. Similarly, health institutions must encourage continuing education to expend the collective knowledge on the subject.

Usually, it is not up to the nursing staff to make bioethical decisions, but to the medical staff. However, this does not reduce the responsibility of nurses, as they act according to the procedures established, experiencing first-hand the impact of their choices, both regarding their ideas, feelings, and convictions, as well as to patients and their relatives. In addition, decisions made by the staff have ethical and legal implications and can cause harm to patients, the institution, and perhaps even health care professionals.

Understanding the topic and knowing the most common situations are the stimuli for health care professionals to further their studies and find better solutions when addressing these dilemmas. It is also important to strengthen the role of CBs in supporting decisions by encouraging health care professionals to act as educators within health institutions. Far from exhausting the subject, it is expected that the results of this research inspire others to broaden the knowledge on the subject.

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Participation of the authors

Fernanda Bortolin Maciel collected, analyzed, interpreted the data, and wrote the article. Arnaldo Nogaro guided the study, which included his collaborative writing and critical review. Ms. Maciel and Mr. Nogaro are the authors of the study.


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Annex

Interview script

1. 1. Description of the interviewee.
 - a. Age:
 - b. Marital status:
 - c. Children:
 - d. Do you practice any religion?
 - e. Year of completion of undergraduate program:
 - f. Postgraduate () Specialization? Which one?
() Master's degree
() Doctorate degree
() Post-doctoral
 - g. Unit:
() ICU
() IMCU
() Emergency
() Surgical ward
() Anesthetic Recovery Room
2. How long have you been a nurse?
3. Have ever taken any bioethics-related course?
4. Do you remember which contents or topics were covered?
5. In your opinion, what is a bioethical dilemma?
6. In your opinion, is there a difference between ethical dilemma and bioethical dilemma?
 - a. What's the difference?
7. Do you come across bioethical dilemmas very often?
 - a. Which ones?
 - b. Which are the most frequent?
8. Do you feel safe when dealing with bioethical dilemmas?
 - a. If not, which difficulties do you encounter?
9. Does the institution you work for provide you with any support to help you solve relevant bioethical issues?
 - b. What kind?
10. Do you feel the need to gain more knowledge to solve bioethical issues?
 - a. If so, what would this knowledge be?
11. In your opinion, is the bioethical knowledge you've gained in school enough to help you professionally?