University of Alberta

Conflicts of Conscience in Neonatal Intensive Care Units: Perspectives of Neonatal Nurses in Alberta

by

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Dedicated to my family and friends who have cheered me on throughout this journey. And to the most encouraging and patient husband I could ask for, Francis.

Abstract

The aim of this study was to explore the individual experiences of conflict of conscience for neonatal nurses in Alberta. Interpretive description, a qualitative method, was selected for its value to help situate the findings in a meaningful clinical context. The findings of five interviews with neonatal nurses working in NICUs throughout Alberta illuminated three common themes: the unforgettable conflict with pain and suffering, finding the nurse's voice, and the unique proximity of nurses. When the nurses witnessed undermanaged pain and perceived unnecessary suffering they experienced both emotional and physical distress. The nurses felt *guilty, sad, hopeless,* and *powerless* when they were unable to follow their conscience. Informal ways to follow their conscience were employed before declaring a conscientious objection was considered. This study highlights the vital importance of respecting a conflict of conscience for neonatal nurses and exposes the complexities of conscientious objection in the NICU.

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Chapter 1

Introduction

The stress felt by nurses who care for critically ill or dying neonates can be intense. Life sustaining technology has both saved infants who would have otherwise died and has also prolonged the suffering of those infants who have complex anomalies or severe complications from birth. Thus many nurses find themselves in a state of distress particularly when caring for dying babies (Kain, 2007). The neonatal nurse is expected to implement actions which include providing or withdrawing treatments, however have a recognized right to disagree or agree with these ordered decisions (National Association of Neonatal Nurses, 2006). The words "numbness", "failure", and "detachment" have been used to describe nurses' feelings when delivering care they believe to be unethical to neonates and infants in the Neonatal Intensive Care (NICU) (Hefferman & Heilig, 1999, pp.175-176). These feelings have been termed "moral distress" and are often stimulated or augmented by institutional and team conflicts (Austin, Kelecevic, Goble, & Meckechuk, 2009; Jameton, 1993; Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005).The Canadian Nurses Association (CNA) uses "ethical" and "moral" interchangeably and define ethical/moral distress occuring "when one is unable to act on one's ethical choices, when constraints interfere with acting in the way one believes to be right" (2003, p.2).

Research suggests unresolved moral distress can lead to bodily distress, (Austin et al., 2005), to burnout (Sudin-Huard & Fahy, 1999; Cameron, 1986) and/or to leaving ones position/discipline (Wilkinson, 1988). The cost of replacing a specialized neonatal nurse is high, not only in economic investment, but also in terms of staff morale and the workplace environment. Hefferman and Heilig (1999) argue the voices of concern of neonatal nurses

regarding futility and harmful interventions have been significantly muted. Literature exploring moral distress in neonatology suggests moral distress experienced by nurses in NICU may be different and even magnified than some other nursing specialties related to the curative environment of the NICU and the complexity of caring for the non-communicative neonate (Kain, 2007; Cavaliere, Daly, Dowling, & Montgomery, 2010).

Much of nurses' moral distress is thought to come from the feeling of being constrained as a moral agent (Oberle & Raffin Bouchal, 2009). When assigned care is at odds with the nurse's personal or moral beliefs the need to declare a conflict of conscience may occur (Ford, Fraser, & Marck, 2010; CNA, 2008). The 2008 Centennial edition of the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses recently included the new section called, "Ethical considerations in addressing expectations that are in conflict with one's conscience" (CNA, 2008, pp.43-46). This section offers guiding steps for RNs who consider the need to declare a conflict in conscience. In the 2008 Code of Ethics the CNA defines Conscientious Objection (CO) as, "a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs" (CNA, 2008, p. 23; College of Registered Nurses of British Columbia, 2007). Despite this new section published dialogue surrounding the potentials and restrictions of CO for nurses as moral agents has remained minimal. Additionally what has remained unclear in the nursing literature, are details of how nurses, such as those in the NICU, experience a conflict of conscience.

As a Registered Nurse (RN) working in the NICU I had felt powerless at times when I was unable to make a change which I believed was right, and often felt unclear about how my moral beliefs impacted my actions as a nurse. After reading the revised 2008 Code of Ethics for

Registered Nurses and the new guidelines for CO I was interested in learning more about the power and implications of such guidelines related to my own conscience or core moral beliefs. Throughout my graduate studies I reviewed the nursing literature about conflicts of conscience and CO in nursing. In 2010, this work was published as *Conscientious Objection: A Call to Nursing Leadership.* It highlighted the lack of clarity around the concept of CO in addition to identifying significant barriers for nurses (Ford et al., 2010). Both theoretical and concrete barriers for nurses to enact or declare a conflict with their conscience were found. Lack of clarity of when a nurse could declare a CO, potential ramifications of not recognizing and acting on a conflict of conscience, direct conflict with duty to care guidelines, and the unpredictability of when a conflict of conscience can arise, as described in Ford et al. (2010), contribute to the need to further understand what happens when an RN experiences a conflict of conscience.

In efforts to understand the decision behind the new addition of CO into the latest Canadian Code of Ethics for Registered Nurses, with support of my supervisor, I connected with Canadian Nurse Ethicist, Janet Storch over the telephone. Dr. Storch has been a leader in the evolution of the Canadian Code of Ethics and has been involved in several of its revisions, including the most recent. In our telephone conversation with Dr. Janet Storch (personal communication, March 9, 2011) she explained that the new addition of the guidelines came after much discussion regarding the ethical issues that arose during the 2003 outbreak of SARS in Canada. Philosopher and Clinical Ethicist Dr. George Webster recommended the Code address CO. He recognized and emphasized the need for *Canadian* content of conflicts of conscience and CO in the growing complexity of the health care field. Even though the philosophical underpinnings of CO are highly theoretical, the Canadian Nurses Association felt recent pandemics such as SARS raised concrete questions in regards to nurses' moral obligations to

families and the duty to return to work and provide care. In the past, as Dr. Storch described, the Code of Ethics has referenced the concept of CO using the language of "Duty to Care". This occurred, however primarily in reference to abortions. As the concept of CO in nursing is still evolving there remains uncertainty on the specific clinical implications of the guidelines and concepts presented in the Canadian Code of Ethics. It was agreed that it may not be easy to declare a conflict of conscience prior to employment as it may then cause employers to question the abilities of the nurse to perform in that specific setting. Dr. Storch supported the need for asking the research question, "What are the individual experiences of conflicts of conscience like for neonatal nurses within Alberta?" as a means to further understand the experiences of conflicts of conscience for nurses in an arena such as the NICU.

After learning more about the background to include conflicts of conscience and CO in the Code of Ethics, I felt even more motivated to explore the experience of conflicts of conscience for nurses in the NICU. Kain (2007) insists the attitudes of neonatal nurses regarding care in the NICUs are complex and raises ongoing ethical issues. I believe I have personally witnessed neonatal nurses engage in a refusal of an assignment to protect their conscience; however the term CO was not actually used. The paucity of nursing literature exploring conflicts of conscience coupled with the complexities of CO for nurses prompted this research.

Purpose of the study

The purpose of this study is to explore the individual experiences of conflicts of conscience for neonatal nurses in Alberta and perhaps illuminate potential uses of CO to follow their conscience. Keeping in mind that the inclusion of CO in the Code of Ethics was very recent, the term "conscientious objection" may not be common language used in practice. Thus the research will be focused on exploring the experience of conflicts of conscience as a whole for

these nurses, not just CO. By examining conflicts of conscience for neonatal nurses, such as those working in Alberta, one may contribute to the development of ways to deal with such conflicts that protect the conscience of the nurse and the interests of the neonate and family. Academically, the findings from this research may enhance the usefulness and limitations of the current guidelines in the CNA Code of Ethics. The use of interpretive description may illuminate insights into the clinical application of these findings in the NICU.

Significance of study

The constant dismissing of one's conscience has been suggested to lead to desensitization to the warning function of the conscience (Morton & Kirkwood, 2009). If the nurse was to act with less conscience in future ethical situations, it can be hypothesized advocacy against suffering or futile treatments may not occur and ethical dialogue could be further muted (Ford et al., 2010). Studies describing the ramifications of the nurse dismissing or perceiving the inability to follow their conscience may expose the vulnerabilities of the nurse within the context of the neonatal unit. Also, research exploring the experiences of conflicts of conscience may highlight helpful strategies or environments which support the conscience of the nurse.

Recently Ford et al. (2010) called to nurse leaders to further clarify the concept of CO and help develop "morally supportive environments that provide room to exercise CO" in Canada (p. 47). When one performs a procedure they are opposed to moral distress can result (Tiedje, 2000), which creates a poor outcome for a nurse who feels they are experiencing a conflict of conscience and they are not able to object. In the NICU, life and death decisions are routinely made which may affect quality of life for the infant and the families caring for them. With everyday exposure to complex decision making and outcomes of advanced technology,

neonatal nurses are not isolated from the complexities within conflicts of conscience or immune to the effects of moral distress.

Chapter 2

Review of the Literature: What Do We Know?

A literature review was undertaken to develop an exploratory framework to direct this research in investigating what is known about conflicts of conscience for neonatal nurses in Canada. The two questions which provided guidance for the literature review were as follows: "**What are the individual experiences of conflicts of conscience like for neonatal nurses?** And, **"How is conscientious objection used in times of conflicts of conscience in NICU?"**

Considerable effort was made to locate relevant articles to the research questions within time and resource constraints. One search engine and three online databases were accessed to collect articles and literature pertaining to the research question using access from the University of Alberta Library. Highly cited articles and studies referenced in the extracted literature, but not produced from the initial literature search, were found directly using the University of Alberta library. The search engine "Google" within the World Wide Web was used to gather preliminary knowledge on current terms used to describe CO specifically as well as identify any national position statements pertaining to CO for nurses in Canada and internationally. Google was used because it is one of the largest and familiar search engines. The three key online databases were CINAHL, Medline, and Philosophers index. Keywords as singular or combination thereof used in the literature search included: "conflicts of conscience", "conscientious objection", and "conscience". These key terms were then combined with "nurse, nurses, NURS*", and "NICU, newborn, nursery, neonates, neonatal". By narrowing the key search terms to "NURS*", primarily opinion, editorial, and argument papers were produced. After narrowing the search terms again to "NICU, neonatal", this yielded minimal results within the chosen search engines.

This literature search produced a large quantity of literature about the conscience, conflicts of conscience, and conscientious objection through the lenses of various disciplines. Limits to the search were determined by the research question as it pertains to neonatal nurses. Limits were also developed when I felt I had a basic understanding of the foundational elements of certain corresponding concepts such as the complexity of the conscience and the fundamental criticisms of CO in health care. This basic understanding was needed to situate the experiences of neonatal nurses not only in the context of nursing, but also within the complexities of health care and institutions. The content of this literature review thus does not represent a full review of each key term, rather it serves to situate the research inquiry in a larger meaningful context of ethical discourse in health care. The review concludes with the most relevant studies and literature to the clinical question of the experiences of conflicts of conscience in neonatal nursing.

The Conscience

Much of the philosophical debate in the literature regarding conscientious objection argues what constitutes a *genuine* objection and seeks to define the conscience. Of critical importance to these arguments of the conscience, is understanding that the conscience is not infallible (Benjamin, 1995; Salmasy, 2008). Thus, investigations into the limits of the conscience are valid. Due to the scope and purpose of this proposed study, defining the conscience or establishing criteria for a genuine CO is not the primary focus. Understanding the basis for these concepts, however, serves to create a foundation for the seriousness of both ignoring and acting on one's conscience as a nurse. It situates both personal consequences as well as informal and formal ramifications.

Freedom of conscience is recognized in both the Declaration of Human Rights in 1948 (article 18) and the Canadian Charter of Rights and Freedoms in 1982 (United Nations, 2010; Department of Justice, 1982). The CNA holds a position statement for RNs and human rights urging governments and employers to protect and support the rights of the nurse while they are assisting those who require care (CNA, 2004). It is debated in the literature whether these rights trump legal and professional obligations while in professional, civil, or social servant roles. Further complicating laws and guidelines, is the lack of universal definition of the "conscience" and on what grounds conscientious objection can be declared.

Minds from philosophy, psychology, theology, and the social sciences have marveled over what defines the human conscience. Opposing ideas of the definition of conscience between religious and secular perspectives are possible triggers of controversy in medicine (Lawrence & Curlin, 2007). However, it seems the definition of the conscience does not always include a religious foundation for some authors. The CNA recognizes a conflict of conscience as an incongruence of care with one's "moral or religious beliefs" (CNA, 2008, p.23). Therefore the CNA loosely defines the conscience as one's moral or religious beliefs.

After examining the various definitions of the conscience in the literature, Morton and Kirkwood (2009) confirmed a general consensus of the definition of the conscience as possessing an alerting or informing function in times of conflict in values. They proposed the following definition:

> Conscience is the mental process that strives to maintain an individual's authenticity and integrity by alerting the individual to potential violations by persistent badgering or harassing of the person until the violations (both general and specific) are remedied or the person becomes desensitized to the warnings (Morton & Kirkwood, 2009, p. 352, para 2).

The role, or actions, of the conscience in nursing has been articulated in various ways such as alerting, guiding, or possibly burdensome (Morton & Kirkwood, 2009; Gustafsson, Erikson, Strandberg, & Norberg, 2010; Jensen & Lidell, 2009). In the Encyclopedia of Bioethics (revised edition) Benjamin (1995) explains three main conceptions of the conscience, that is: a) possessing an inner sense of right and wrong, b) an internalization of societal norms, and c) a reflection of integrity within the self. The concept of integrity has been used throughout the medical, nursing, and philosophical literature within arguments defining the importance of following one's conscience. Nurses are expected to act with integrity (CNA, 2008), however there are proposed challenges to achieving this expectation within the literature.

In 2011 *Nursing Philosophy*, an academic nursing journal based in the United Kingdom, dedicated and entire issue to the complex conversation of integrity in nursing. Pattison and Edgar (2011) argue one must acknowledge the vast diversity of implications and meanings of the concept of integrity specifically in relation to organizational norms and CO. Throughout the issue, integrity is critically described and debated in varying contexts of health care. Sanders, Pattison, and Hurwitz (2011) capture the devastating impact of shame and humiliation in a personal narrative of one nurse in the Emergency Department whose actions, she felt, were in defiance of her integrity. In the article by Edgar and Pattison (2011), they propose integrity is not just innate to a person, but rather can be developed in the form of capacity for reflection among conflict of values, roles, and ethics. The views of integrity in this article are particularly important in CO and conflicts of conscience because the authors highlight flaws among varying definitions of integrity which impact the actions of individuals specifically in organizations such as nurses.

Within the moral distress literature, authors have discussed the devastating repercussions to one's being and integrity when nurses' act against what they feel is right. The CNA explains when commitments and values are compromised the nurse's identity and integrity as a moral agent is affected and moral distress results (CNA, 2008). Integrity in this sense implies consistency between ones beliefs and actions in the moral sense, in addition to identifying a consequence of not acting with this integrity. To add to the depth of the definition of integrity Hardingham argues,

> A person with integrity is a whole person in some sense, and when we refer to our moral integrity, either as a person or as a professional, we think about a wholeness in the relationship between our actions and our values and beliefs, in other words, about a certain conception of our self as being a consistent whole (2004, p. 129, para 3).

The differentiation between personal, moral, and professional integrity is not seamless in the nursing literature. However, the CNA differentiates between a patient's integrity versus the integrity of the nurse. The patient's integrity encompasses wholeness, and the nurse's integrity includes consistency of actions to moral norms (CNA, 2008). There is no expansion on what constitutes "moral norms", however the meaning of this has critical implications in respect to CO and conflicts of conscience. The conscience and integrity both remain debatable in the literature with no clear consensus of one definition. Therefore, for the purpose of this thesis the definition of integrity and the conscience will be taken from the CNA Code of Ethics.

Conscientious Objection and Conflicts of Conscience

Preliminary searches using the key words "conscientious objection" were linked to military and religious views. Conscientious objectors are perhaps most easily recognized in the context of war and the concept has since carried over to health care providers in the form of

abortion laws and guidelines from national professional bodies. The term "conscientious objector" often refers to the refusal to participate in war or military service because of deeply held beliefs or religious groundings (Mennonite Central Committee, 2011).. Robinson (2009) argues there still remains "selective CO" in the military, or the refusal of orders to which the military person finds conflict, or deems unjust. He believes this selective CO does not deserve "dishonourable" discharge when it is indeed honour that is trying to be maintained through intact integrity (Robinson, 2009, pp.34-35). Similar to Robinson's argument, health care professionals are also asked to practice with integrity. Whether the conscientious objector is in the military, or medicine, the main argument to respect an objection is based on the preservation of integrity and the importance of promoting integrity within the professional role.

Within the health care literature, the key terms "Conflicts of Conscience" and "Conscientious Objection" were predominantly described in medical journals with specific focus on physicians and pharmacists. Fundamental players in the debate surrounding CO in health care and the definition of the conscience include the disciplines of medicine, philosophy, and theology. Main themes involving the morning after pill or "plan B", abortion, and the obligation to refer infused the debates of CO and conflicts of conscience for physicians and pharmacists. Orr (2010) argues the shift from paternalism to an "autonomy-focused setting" has sparked the renewed questioning of rights to CO for physicians (p. 50). This argument highlights the recent customer service model in which the patient is in more of the authoritative role. Savulescu (2006) asserts there has to be different roles for values in one's public and private life arguing against accommodation of CO in medicine. From the perspective of medicine he argues, "The door to "value driven medicine" is a door to a Pandora's box of idiosyncratic, bigoted,

discriminatory medicine. Public servants must act in the public interest not their own" (Savulescu, 2006, p. 297).

In 2008, Lynch published "Conflicts of Conscience in Health Care: An Institutional Compromise". She clearly emphasizes the importance of allowing CO in medicine to preserve integrity and promote ethical physicians through respect of their conscience. Lynch concludes if institutions are to allow room for the conscience of a physician, as well as ensure patients have access to medical care, medical licensing boards should engage in physician and patient matching. As McLeod (2010) concurs, Lynch's suggestions for institutional compromise are very intriguing but not without criticism. However, as Lynch (2008) notes in the preface of her book, the scope of her argument ends with physicians because of the differences of professional obligations among health care workers.

Conscientious Objection and Conflicts of Conscience in Nursing

Objecting to an aspect of care or procedure because of a conflict of conscience is not a new concept in health care as noted above; however a unified language to describe the concept has not been consistent for Canadian nurses or internationally. The ideas and concepts of both CO and conflicts of conscience can be found in previous Codes and position statements under "Duty of Care" (College of Registered Nurses of British Columbia, 2007) or in the *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care* approved in 1998 by the Canadian Healthcare Association, Canadian Medical Association (CMA), Canadian Nurses Association, and the Catholic Health Association of Canada Preventing or Resolving Ethical conflicts (CMA, 2011). Perhaps the most significant document specifically using the terms "conscientious objection" and "conflict with one's conscience" was published in the 2008 Centennial edition of the CNA Code of Ethics for

Registered Nurses in the section "Ethical Considerations in Addressing Expectations that are in Conflict with One's Conscience" (see pages 43-46).

Canadian nurses association code of ethics.

The 2008 Centennial edition of the Canadian Code of Ethics for Registered Nurses recently included conflicts of conscience into the national vocabulary for nurses in Canada. The CNA define Conscientious Objection (CO) as, "a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs" (CNA, 2008, p. 23; College of Registered Nurses of British Columbia, 2007). The code also includes guiding steps for nurses who feel they need to declare a conflict in conscience in circumstances of anticipated and spontaneous events (see CNA, 2008, pp. 43-46). The inclusion of this additional section in the revised Code can be a very important resource for Canadian nurses; however the definitions in these guidelines are much more ambiguous than those from international nursing organizations.

International statements and references.

Australian nursing bodies included CO guidelines for nurses in their Code of Ethics in 1993 (Australian Nursing Federation, 2006), and in policy statements supporting CO during a conflict of conscience (Australian Nursing Federation, 2011). The published position statement on *Conscientious Objection* from the Royal College of Nursing Australia (RCNA) in 1998 strictly clarifies the moral obligations of the nurse and the employer within the framework of obligations towards the patient in non-emergency situations (RCNA, 1998). The United Kingdom is even more stringent in the use of CO, only allowing the enactment of CO in select aspects of the abortion process as per The Abortion Act 1967 and within the parameters of The Human Fertilization and Embryology Act in 1990 (Nursing and Midwifery Council, 2010).

The United States has several organizations which recognize CO in health care; many of the rules and guidelines vary by state and profession. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Nurses Association (ANA) provide reference to CO for health care professionals and nurses respectively. The ANA Code of Ethics provides a clear obligation for the nurse to respect and preserve his/her own integrity and "wholeness of character" providing the option of CO to the nurse based on moral grounds (ANA, 2001, section 5.3).

Much of the debate in the literature is American. The much publicized *Protection of Conscience Act* under President Bush and then the Obama administration seemed to have sparked renewed debate of the topic among health professionals. The current state of this proposed conscience clause is not clear. Several articles in the medical and philosophical disciplines published rebuttals of such a policy which includes rejections of blanket protection to claiming a CO. The primary arguments include both patient autonomy and functionality of the health system as a whole (see Card, 2009).

Views of conflicts of conscience in nursing: Room for conscientious objection?

For nurses, it seems additional guidelines and standards within the nursing profession must be met beyond those of individual rights and freedoms. Jenson and Lidell (2009) feel it is essential that nurses are alerted to the congruence of professional codes and guidelines with the provision of care and the role of conscience. The provisions of "Duty to Care" (CNA, 2008) must be met while in the nursing relationship. This obligation is the main element argued in the nursing literature. The contradictory positions described in the Code of Ethics encouraging nurses to practice with integrity while they also have a duty to provide care to the patient, make it difficult for the nurse to discern which obligation should take precedence while delivering

nursing care. Olsen (2007) believes the unique relationship of the nurse and patient sets the stage for what is acceptable within that relationship. He continues to argue nurses who object to treatment sanctioned by society are essentially claiming society is acting immorally (Olsen, 2007, p.278). Olsen maintains nurses are to preserve the "collective values of society" by protecting patient rights (Olsen cited in Jacobson, 2005, p.27).

It has been questioned whether nurses should have the right to refuse to provide care due to conflict of conscience while in the professional role (Waller-Wise, 2005) or if this should be defined instead as a privilege (Mahle, 2009). The formal and informal penalties of perceived patient abandonment are a barrier for nurses who feel they are experiencing a conflict in conscience. Nursing as a public service, or sharing responsibility with society (International Council of Nurses, 2006), carries significant obligations to the relationships nurses create with patients, families, and communities. It is the art of reassignment to accommodate the nurse without the appearance of patient abandonment that is the critical task for the nurse (Waller-Wise, 2005).

Balancing the rights, or privilege, of the nurse and the rights of the patient seems highly influenced by contextual elements within the workplace. Catlin et al. (2008) attempted to uncover barriers to the use of CO in neonatal nursing in efforts to establish CO as a potential response to moral distress. Similarly Morton and Kirkwood (2009) created a working definition of the conscience in order to establish a supportive argument highlighting penalties of dismissing the conscience in health care. Multiple sources endorse the protection of conscience when it can be accommodated (Salmasy, 2008; Benjamin, 1995; Morton & Kirkwood, 2009; Committee of Bioethics, 2009; CNA, 2008). Despite the written endorsement of protecting the conscience, practical application of the concept of CO during a conflict of conscience requires an

understanding of the moral habitat in the practice environment, current system restrictions, and formal and informal penalties to the nurse claiming a conflict of conscience. Researchers have tried to uncover some of these barriers for nurses and help clarify the role of the conscience in nursing.

Research Exploring Conflicts of Conscience in Nursing

Little research about a "conflict of conscience" or the term "conscientious objection" and nursing was identified within this literature search. Four studies involving nurses were found which were relevant to the research inquiry; none of which contained Canadian research data. Two Swedish studies and two American studies were reviewed. The influence of conscience within the professional role as a nurse was examined in one Swedish study through a phenomenological approach. Jenson and Lidell (2009) interviewed fifteen nurses from rehabilitation, intensive care and surgical units in Sweden. Nurses in their study perceived the conscience as an influential aspect of their professional duties, and that listening to their conscience needed to be taken seriously. The researchers identified three descriptive categories: conscience as a "driving force, restricting factor, and as a source of sensitivity" (Jenson & Lidell, 2009, p.34). This study highlights the relevance of the conscience, however does not explore the nursing implications of conflicts of conscience.

Also conducted in Sweden, the findings of the pilot study by Gustafsson et al. (2010) yielded a much more descriptive outlook on the influences of the conscience, particularly as it related to burnout. The authors pondered the relationship of workplace factors and the overriding influence of conscience in those who experienced burnout. Five questionnaires were completed by 40 nurses comprising of one group who showed no signs of burnout and a second group on sick-leave related to burnout. The 16-item Perception of Conscience Questionnaire (PCQ) was

utilized to better understand the origin, nature, and function of the conscience. The burnout group reported their conscience as more of a burden and perceived their conscience would fade away if they did not listen to it; the non-burnout group reported the conscience as an unavoidable guide and asset which helped them provide ideal care (Gustafsson et al., 2010). The burnout group also scored higher in their perceived ability to sense patient's needs (Gustafsson et al., 2010). This study's findings are parallel to Tiedje's statement of leaving the profession due to moral distress; "Nurses unable to cope with moral distress who leave nursing may be the nurses most sensitive to moral issues and the most advocating for patients" (2000, p. 42). The study results of Gustafsson et al. (2010) support the need to identify conscience as an asset and not a burden.

American researchers Solomon et al. (2005) studied new and ongoing controversies in pediatric end-of-life care with 780 clinicians at four children's hospitals and three general hospitals with PICUs in the United States. Concerns of conscience described as, "At times, I have acted against my conscience in providing treatment to children in my care" were reported highest among house officers and nurses compared to attending physicians (Solomon et al., 2005, p.874). The results of the study raised concerns for the researchers about the lack of knowledge of published guidelines involving burdensome treatments, in addition to lack of understanding of ethics literature. Similarly in the Canadian study by Janvier, Nadeau, Deschenes, Couture, and Barrington (2007) neonatal nurses who had limited knowledge of resuscitative outcomes in premature neonates and it's correlation to Cerebral Palsy experienced the most ethical conflict. These results substantiate warnings of Vaiani (2009) to the dangers of moral certitude and acting on perceived outcomes.

Perhaps the most significant study to my thesis research inquiry is a pilot study conducted in 2008 in the United States. Catlin et al. (2008) suggest a very direct purpose of CO within neonatal nursing. The authors propose that CO may be used when the care the nurse has been assigned causes suffering or harm (Catlin et al., 2008). In their pilot study, a survey was devised to test the concept of CO as a potential response to moral distress when the nurse perceived their assigned care caused suffering or harm. A convenience sample of 66 pediatric critical care nurses and neonatal critical care nurses was accessed. Despite the initial positive interest in the concept of CO in neonatal care, barriers such as physicians' orders of futile care, administrative policies, influence from parents, and legal consequences were identified in the study (Catlin et al., 2008). The participants were interested in learning more about the concept and using CO "as a method of being able to live within their own moral frameworks" (Catlin et al., 2008, p. 106).

This study increased my curiosity of how neonatal nurses in Canada perceive CO as a potential method to prevent moral distress in the NICU. Qualitative studies that contain rich descriptive data about the experiences of CO and conflicts of conscience in the NICU are lacking. The benefits of an in-depth examination of conflicts of conscience and the potentials of CO for neonatal nurses may provide strategies to overt moral distress and may contribute to the ethical discourse of conflicts of conscience for nurses in Canada.

Definition of Terms

Before continuing, it would be sensible to define the key terms used in this proposed study.

Conscientious Objection and a Conflict of Conscience

In the 2008 Code of Ethics the CNA define CO as, "a situation in which a nurse requests permission from his or her employer to refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs" (CNA, 2008, p. 23; College of

Registered Nurses of British Columbia, 2007). From this definition, *acting against one's conscience* will imply that one is acting against their "moral or religious beliefs" (CNA, 2008, p. 23).

The Conscience

Based on the definition of a conflict of one's conscience by the CNA in the 2008 Code of Ethics, the conscience will be defined as one's moral or religious beliefs.

Moral Agency

As defined by Oberle and Raffin Bouchal (2009, p.21), moral agency is the ability to act on one's moral beliefs.

Moral / Ethical Distress

The CNA uses "ethical" and "moral" interchangeabley and affirms that ethical/moral distress occurs "when one is unable to act on one's ethical choices, when constraints interfere with acting in the way one believes to be right" (2003, p.2).

Intregrity

As found in the definition of integrity within the CNA Code of Ethics for Registered Nurses, "Showing integrity means consistently following accepted moral norms. Implicit in intergity is soundess, trustworthiness and consistency of convictions actions, and emotions" (Burkhart & Nathaniel, 2002 cited in CNA, 2008, p.26).

Research Question

After reviewing the literature, an abundance of ethical debates about the theoretical use of CO in clinical practice were identified. The experience of what is happening in clinical practice prior to a CO however, is less known. From this, the research question for this thesis was

developed. Therefore the following research question will be used: **"What are the individual experiences of conflicts of conscience like for neonatal nurses within Alberta?"**

Chapter 3

Methodology and Method

In this chapter, the design of the research is presented. The purpose of this study is to explore the experience of conflicts of conscience for neonatal nurses in Alberta, therefore a qualitative design is best suited for this aim. Within the details of the research method the researcher is described and the participants and data collection activities detailed. Ethical considerations, limitations of the study, and plans for knowledge translation are presented.

Research Method

To answer the research question, a descriptive, qualitative method was used called interpretive description (ID). This method is particularly appropriate when the aim is to gain greater understanding of a clinical phenomenon. It allows themes and patterns arising within subjective perceptions to be identified and explored (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). It allows a description with explanatory power to be generated, one which can inform clinical practice. There is also an explicit effort to link individual and common aspects of the experience under study to broader structures, in this instance, the context of the neonatal environment and the practice of nursing.

Themes and patterns within the experience of conflicts of conscience are not yet well understood in the broader context of nursing. The research question can be best addressed through inductive reasoning, consistent with a qualitative approach. It would then make sense to choose ID to guide both the data construction and data analysis in findings with such clinical application and significance.

Philosophical Grounding for this Study

This research was conducted with understandings of the philosophical underpinnings used in ID identified by Sally Thorne (2008: see also Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). That is, with the world view of multiple constructed realities influenced by subjective experience and experiential knowledge (Thorne, 2008). Through ID one absolute reality will not be presented but multiple socially constructed realities which will contribute to the understanding of the phenomenon being examined. As each participant presents their perceptions of the conflict experienced, common elements are sought, however the "inherent value of all expressed perceptions is recognized" (Thorne, 2008, p.75).

The Researcher

Those who are credibly located within the discipline and scholarship of the profession may best generate legitmate empirical knowledge (Thorne, 2008). It is also through this relationship that the researcher can fully understand the context of the findings. As a RN who has worked in an NICU in Alberta for several years, I believe I have experienced variations of conflicts of conscience and moral distress at the bedside, and among the health care team. I believe I have witnessed colleagues refusing assignments because the plan of care for that baby conflicted with what they felt was right. When asking my colleagues about conflicts of conscience and CO in the NICU, the terms seemed to be unfamiliar to them and nurses seemed uncertain of its existence in nursing policies or within the Canadian Code of Ethics. Despite their lack of recognition of these concepts, forms of moral action as a result of a conflict of conscience were happening, perhaps just not in a well defined way. This further prompted my curiosity of how conflicts of conscience were experienced. I do feel the act of CO or declaring a conflict with

one's conscience has the potential to protect a nurse's integrity, which is felt to be compromised when the nurse acts against their conscience.

The researcher, using ID as a method, has a constructive role in data collection and analysis. It was imperative then to identify personal assumptions. I engaged in continual reflection regarding any ideas, perspectives, and assumptions within the data construction process. This documentation may serve as evidence of logic to the research findings.

Personal assumptions relevant to the study:

1. Subjective experiences of conflicts of conscience possess inherent importance within the nursing profession.

2. Nurses have a dual obligation both to the moral self in maintaining fitness to practice, and to their patients as a duty to provide care.

3. Conflicts of conscience in neonatal nurses are inherently different from those of physicians due to the intimate nature of the nursing role.

4. Both conflicts of conscience and CO exist within the NICU; however a common language to describe these experiences has been lacking in nursing discourse.

5. Core moral beliefs or the conscience do not require a religious basis.

I engaged in critical reflection regarding these assumptions throughout the progress of this study. Under Dr. Austin's supervision, I used my clinical knowledge of neonatal nursing and skills as a novice researcher to examine the experience of conflicts of conscience for neonatal nurses in the NICU. I recognized the influence my previous experience may present in addition to potential distress to myself during the interviews. To address any potential distress I had access the Employee Assistance Program provided by Alberta Health Services in addition to the support of my committee members, one of whom is a mental health professional.

Study Participants

Sample size.

A purposive sample of four to seven neonatal nurses practicing in Alberta who met inclusion criteria was the goal. As there are no absolute requirements for sample size in ID, the maximum number of participants was limited by time, resources, and scope of this graduate thesis. As conflicts of conscience in neonatal nursing is not a well described phenomenon in the current literature, I believe four participants have the potential to produce findings that could both add to existing understandings and produce new knowledge in this clinical field. Thorne (2008) states "there will always be more to study" (p.98). I agree. This thesis project is just the beginning of an inquiry into the understanding of the experiences of conflicts of conscience for neonatal nurses in Alberta.

Inclusion criteria.

The inclusion criteria required participants to have a self-identified experience with a conflict of their conscience (or conflict with their deeply held moral/religious beliefs) while working in the NICU or neonatal care unit in Alberta. Within the past five years potential participants required a minimum of one year experience in a NICU or neonatal care unit such as an "Intermediate Care Unit" (ICN) for neonates, or a "Special Care Nursery" (SCN) within Alberta. Nurses who had left the NICU within a year, who heard about the study, were also eligible to participate. Participants needed to be willing to be interviewed over the phone or in person by the researcher (myself) and be comfortable articulating their experiences.

Recruitment.

As the scope of this study was limited by time and resources, the sample was collected from one province within Canada. The province of Alberta contains a myrid of ICN , SCN, and

NICU's within Alberta Health Services. The provincial professional interest organization called Alberta Neonatal Nurses Association (ANNA) extends invitation to all nurses working with neonates in Alberta and is viewed as a reputable forum for advancing education and engaging in research . Several neonatal centers in Alberta have a representative from ANNA who coordinates teleconferences or distributes new information from the organization. ANNA was used as a platform to make contact with potential study participants within Alberta. ANNA was not asked to endorse this study, rather only provide a platform to advertise participation in research for neonatal nurses.

I utilized the ANNA contact email list to distribute my advertisement poster (see Appendix A). The ANNA email contact list included both ANNA members and nurses working in Alberta who indicated a special interest in "neonatal nursing" during annual registration with our professional college. To maintain confidentiality of it's members, the research information was provided to the ANNA president to distribute electronically. Interested participants were asked to help recruit other potential participants to the study by word of mouth. The email recruitment strategy was employed in July 2011.

Due to an insufficient number or participants, a second recruitment strategy was employed utilizing the ANNA facebook page. The ANNA facebook page boasts 162 current members. The president of ANNA created a "document" containing the same recruitment information as that in the intial recruitment email. The document was posted in September 2011 and removed from the site early December 2011 when a sufficient sample size of five participants was met.

Initial contact was confidential and occurred via personal email by the individual nurses interested in the study. The study information page (see Appendix B) was then sent to each

interested individual. Once the study information was read, the participants were asked to contact myself to review eligibility criteria and obtain consent for participation prior to booking the interview. Any questions they has about the study were answered prior to obtaining consent.

The neonatal nurses.

Five neonatal nurses who lived in three different cities within Alberta participated in this study. Each participant was given a pseudonym which I assigned to them. The pseudonyms of the five participants were: Heather, Paula, Sam, Lexi, and Jodi. Demographicaly the nurses had a wide range of ages and years of experience. Ages ranged from 27-53 years old. Years of experience as a NICU nurse ranged from 2 ½ - 32 years, and years as a RN ranged from 7-32 years. Only one of the five nurses was currently working in a NICU; the remainder worked in either an ICN or SCN. All but one experience shared in the interviews took place when they had worked in a NICU. Each of the participants were female, and their religious beliefs included two who described themselves as Christian, one who was Agnostic, and two who were Atheist.

Data Collection

The primary source of data collection were interviews with neonatal nurses who felt they had experienced a conflict of conscience while working in a NICU in Alberta. The five neonatal nurses were interviewed from July 2011 to December 2011. All of the interviews were conducted over the phone at a mutually agreeable time and date. Interviews took approximately 30-60 minutes and were guided by a semi-structured interview format which utilized open-ended questions (see Appendix C). Every effort was made to encourage rich descriptions of the conflict of conscience experienced by each participant. Phrases like “Can you tell me more about that?” or “How did this conflict make you feel?” were utilized in each interview. Written informed consent (see Appendix D) was obtained prior to each interview and reviewed once more at the

time of the interview. All interviews were audio-recorded and transcribed verbatim. Each participant was encouraged to contact me after the interviews if they had questions or if they felt they wanted to add more detail to their interviews; none contacted me.

Reflexivity of the interview data was illuminated by the use of personal interview notes (field notes) to help create context. Additionaly personal entries were made in a reflective journal before and after each interview and during significant points of the research process to track my reflections on the analysis or new questions generated from the research data. Situating oneself into the researcher role requires insight into potential influences and careful identification of insights into the phenomenon being studied (Thorne, 2008), thus creating importance of continual reflection. Although as Thorne (2008) also notes, these documented reflections are not "data per se" (p.109), they become a critical element in informing ones inductive analytic process.

Data Analysis

Interpretive description (ID) asks, "What is happening here?" and "What am I learning about this?" (Thorne et al., 1997, p. 174). An interpretive description capable of informing clinical understanding evolves through informed questioning, critical examination, and thoughtful reflection (Thorne et al., 1997). In ID the data collection and analysis of the data inform one another iteratively (Thorne et al., 1997, p.11).

In the analysis themes and patterns are generated from the participant's subjective perceptions. Constant comparative analysis is suited to theorize relations of ID data (Thorne, 2008). In constant comparative analysis, data analysis begins with the first interview and involves repeated analysis of data sources which include: the interview, contextual information included in the field notes, and reflection of the researcher's internal perceptions in the form of a

reflective journal. The reflective journal and interview notes were consulted throughout the analysis process as a means to better understand personal assumptions, but also situate the researcher (myself) within the context and experience of neonatal nurses. These forms of documentation also add rigour to the process as they become elements in which to track my analytic decisions and add transparency to my logic and the process of inductive data analysis.

As I read and re-read individual transcripts, I sought to identify phrases, sentences, and paragraphs which directly related to conflicts of conscience and the participant's response to them. During this I asked, "What is happening here?" rather than limiting analysis to line by line coding, which can minimize the contextual nature of the data (Thorne, 2008). I looked for patterns and connections leading to potential themes in each transcript. Inter-relatedness of each participant's experiences such as similarities, variations, and linkages were considered. As the analysis across transcripts occurred, overall themes were identified. The end results were findings which presented neonatal nurses' rich descriptions of their experiences with conflicts of conscience in the NICU.

Ethical Considerations

Informed Consent

The study proposal for this graduate thesis was approved following ethics review by the Health Research Ethics Board (HREB) at the University of Alberta. As the participants were interviewed as members of the discipline of nursing, who work in neonatal intensive care setting in Alberta, administrative approval from specific units was not pursued. To ensure the elements set forth by the Tri-Council Policy Statement for research involving humans were met, a series of steps were followed in this study. Participants were provided the research information sheet to review at their leisure prior to engaging in conversation over the phone. After a review of the

information sheet, an opportunity to ask questions, and potential risks and benefits of participation discussed. Written consent to participate in the study was obtained from each participant.

Risks and Benefits

A potential benefit of study participation was identified as the freedom to explore experiences of conflicts of conscience in an anonymous and confidential arena. It is recognized that some nurses may not feel comfortable talking about these issues at their current worksite. As well, it was as an opportunity for nurses to contribute to the understanding of this aspect of nursing ethics. However, it is recognized that discussion of conflicts of conscience may be distressing for some participants. My supervisor, who has a mental health background, was available to assist in debriefing sessions if any were requested. If an alternative counseling option was requested local resources would have been explored on a case by case basis. To date no participant has requested a debriefing, counseling, or called back with questions about the interview or study after participation.

Confidentiality

Confidentiality and anonymity (protection of identifying factors) of the participants was maintained according to Research Ethics involving Human Subjects guidelines. Names and identifying factors were removed from the transcripts and will not appear in any publication of the data. Pseudonyms were randomly selected. The provincial sample allowed for recruitment of nurses from several NICU environments which aids in securing participant anonymity. Transcripts were only made available to my supervisor and I for data analysis. Two transcribers were hired to convert the audio data into written transcripts. Both signed a confidentiality

agreement. All data collection materials will be protected in a locked cabinet for a period of seven years.

In the province of Alberta, the law requires the reporting of any harmful or illegal activities revealed by the participant. As well, if the nurse participant declares to the researchers that s/he is "not fit to practice", the researchers are required to report this to the College and Association of Registered Nurses of Alberta. To screen for this during the interview, participants were each asked how they felt after talking about their conflicts. There were no concerns or incidents related to the above clauses.

Limitations

It is recognized there are two main limitations of this study. First is my novice level as a beginning researcher. As a graduate student, however, I have the support of a veteran nurse researcher who is my supervisor to aid in this endeavour. The other members of my supervisory committee are also experienced researchers, one a nurse philosopher, the other a NICU intensivist. I have also recognized this research as a work in progress and the beginning steps to my academic and personal interest in conflicts of conscience for both neonatal nurses and nurses as a profession. Second, the inherent nature of data collection via personal interviews presents the risk of relying on participants who, may vary greatly in their ability to recall and articulate their experiences (Thorne et al., 1997). Qualitative interviews, particularly ID, require an expert level of awareness and reflection from the research participants. Acknowledging that ethical reflection and moral growth is a continual process, this study relies on participants to be able to clearly articulate the journey through their conflict of conscience and then identify how they felt about it. This also depends on a reflective awareness of their conscience (or core moral beliefs) and an understanding of the concept of moral objections. Although "the ability to articulate the

experience with a conflict of conscience" was requested in the recruitment strategy this cannot guarantee an ideal research participant. In this case it is up to the researcher to decipher "eccentricities from commonalities" within the analysis (Thorne et al., 1997, p.174).

Knowledge Translation

The findings of this study will hopefully contribute to the understanding of conflicts of conscience and CO for nurses, particularly in NICU environments. Findings may also illuminate the supports and barriers involved for nurses and the NICU team when CO or moral action is enacted or requested. Research findings will be disseminated through my graduate thesis, a minimum of one published article, and one research conference presentation. Ideally this research will also contribute to the national dialogue regarding conlicts of conscience.

Chapter 4

Findings

The findings presented here were derived from five interviews completed with neonatal nurses in Alberta. Participants were asked to describe their experiences with a conflict of conscience in the NICU. Commonalities within the nurses' experiences illuminated three overarching themes: 1) *the unforgettable conflict with pain and suffering, 2) finding the nurse's voice, and 3) the unique proximity of nurses*. These themes did not exist in isolation, but rather encompassed the nurses' experiences as a whole. Each baby had a different story, as did the nurses who experienced a conflict of conscience. Within these unique stories, commonalties in the nurses' experiences were found.

The Unforgettable Conflict with Pain and Suffering

Nurses interviewed described a conflict of conscience when they felt their assigned care, required duties, or nursing actions were incongruent with their conscience or core moral beliefs. Even when more than one conflict had occurred during their neonatal nursing career, the nurses clearly articulated one particular incident which resulted in an unforgettable conflict. For some the distress they had experienced stayed with them years after the conflict.

The most common of these experiences were related to a baby's undermanaged pain and unnecessary suffering. A conflict of conscience was created when a nurse was unable to provide what she believed to be the best care for the baby, care in which pain was properly managed and suffering reduced. Undermanaged pain, specifically during invasive medical procedures, produced a deep conflict of conscience for the nurses.

Procedural Pain

> *I'd say my first major conflict was the insertion of a chest tube with no pain control on the baby's part… the doctor didn't believe they felt pain. I did ask him several times (for an order of analgesic), and I stated that I thought that baby was uncomfortable and experiencing pain, but he just brushed me off...*[1]

For Lexi[2], her unforgettable experience occurred almost 20 years ago in the NICU. She was still able to vividly remember how she felt during her conflict, and quickly described her responses to the violation of her conscience. The baby's unrecognized pain by the physician during the procedure, made Lexi advocate for better pain control; however she was unsuccessful in doing so.

After repetitive unsuccessful attempts to help intervene in the baby's pain, she experienced a deep sense of personal failure to protect her patient as she believed she should. This sense of failure generated both physical symptoms and emotional responses within her:

> *(I felt) really sick to my stomach, actually. I felt guilty. The major thing was guilt; that I was actually part of that situation. I felt extremely sad for the baby. I know that chest tubes are painful, so ... that was really upsetting. I didn't really like the doctor much, I was actually quite mad at him. So, kind of all those negative feelings you would feel. No control over what you're doing....*

Lexi's feeling of failure extended beyond the bedside and was felt when she saw the baby's family. She described a sense of violation of her surrogate responsibility with the parents to protect their baby as a nurse:

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[1] Exact quotations from the transcripts will be represented in italics. Quotes will remain verbatim with only removal of nuances such as "um" for ease of reading.
[2] Pseudonyms were given to each participant.

> *I felt I let that baby down. The whole family, actually, in terms of trying to get the best care that is possible for their baby…I felt bad when I saw the parents the next time. You're trying to explain that it went well, but you know it really wasn't as good as it could've been for the baby....*

Even though the technical aspects of the procedure went well, Lexi knew the success of the procedure encompassed more for the baby. The baby's experience of pain must also be considered. The undermanaged and unrecognized pain of the baby seemed to discount any technical success from Lexi's perspective; she felt guilty about not making the physician recognize this.

Just as Lexi experienced an intense physical response when she witnessed the baby's undermanaged pain, Jodi also experienced a physical response to unrecognized pain. At times, the nurse's participation during a conflict of conscience evoked an unforeseen physical response within her. During a chest tube insertion, Jodi described her physical inability to watch the resident struggle to insert another foreign tube in an already compromised baby:

> *Watching her putting it (a number 20 chest tube)… into an already pre-existing chest tube hole, just watching her putting it in and jabbing it in, I actually had to physically walk away.*

Jodi could not endure watching the painful "*jabbing*" of the tube into the baby. In the midst of the conflict Jodie felt "*uneasy*". The intensity of her response continued to increase as she experienced more:

> *It made me feel horrible for the baby… watching it was, it was just a horrible experience to watch… I didn't feel I could just speak up and tell the resident that she was being invasive…She actually punctured the lung.*

Feeling powerless to change what was happening in front of her, Jodi felt forced to walk away from witnessing the baby's procedure. The vulnerability of the baby was too much. Fortunately, she was not the only nurse at bedside, allowing Jodi to distance herself from her conflict and her overwhelming response to it. Lexi and Jodi described feeling "*sad"* and "*uneasy",* when they were unable to manage their baby patients' pain during medical procedures. A sense of powerlessness was experienced when they were unable to change what was happening before them and manage the baby's unnecessary pain.

A particular painful medical procedure that caused a conflict of conscience for Heather did not directly occur in front of her. The procedure of circumcision did not occur directly on the unit; however Heather felt directing the parents towards the procedure was just as horrible. Heather was vividly able to imagine the suffering of a baby boy during a circumcision. She described her professional obligation to provide referral information about circumcision:

> *When parents are requesting it (circumcision) done I have to give them the information, because it not illegal yet unfortunately… it is deemed not medically necessary. But I still have to… (Circumcision) is definitely one of the things that will be criminalized in the future.*

Heather felt arranging information for the procedure was like a motion supporting circumcision, or even participating in it, thus creating a conflict of conscience for her. Her emotional and physical response to the thought of the long lasting effects on the baby during the procedure was strong:

> *I absolutely ache for the baby boys… I hate it… It hurts my insides to have to think about them getting mutilated…*

Heather conceived the act of circumcision as "*mutilation",* a mutilation she was unable to prevent. The mere thought of the baby boys having a circumcision intensely disturbed her.

The nurses' intimately responded when witnessing undermanaged or unnecessary pain in the baby during invasive procedures. Both emotional and physical reactions emerged in response to their inability to follow their conscience and provide the best care for the little baby in their care. When the nurses were ordered to complete painful procedures or performed tasks which were perceived as painful, particularly at end-of-life, nurses articulated a personal sense of suffering.

End-of –Life

An inability to alleviate perceived suffering at the baby's end-of-life was another common cause of conflict for the nurses:

> *I think it is better for a baby to die a comfortable, humane death… It is the fact these kids are suffering*.

Paula indicated she had experienced several conflicts of conscience over the years relating to perceived unnecessary suffering at times of prolonged death in the NICU. However, she described an unforgettable experience of a baby born at 23-weeks gestation, who initially was doing well, then developed sepsis and subsequent multi-organ failure leading to death. The baby's continual decomposition was unbearable:

> *It was torture for her, and her parents stopped visiting. Every new attending on, so every two weeks, they would approach the parents on a regular basis and they (the parents) would say the same thing, "Nope, nope, she will be fine. We know there are miracles". But, they stopped visiting…this went on and on for almost two months. So everybody that looked after her … oh they just cried… and it was awful, because, you*

> *know renal failure, she puffed up like a balloon. Nobody wanted to look after her, after a while.*

This perceived "*torture"* of the baby to keep her alive caused Paula to suffer. She could remember her own embodied feeling of suffering when providing nursing care to the baby:

> *(I felt) like I was going to Hell for torturing this baby. You just dreaded coming to work and people could only look after her for maybe one or two shifts and they would have to get their assignment switched… so that she didn't have the same nurse all the time. Her primary (nurse) stopped looking after her because people just couldn't face up to doing her care… We were causing her pain. We felt this was unnecessary.*

Completing care which seemed more tortuous than caring made Paula feel she deserved to be doomed to Hell for her actions. It was not the imminent death of this baby that made Paula morally conflicted; it was the idea that Paula was, in part, responsible for the baby's suffering. It was not comfort and compassion that she could offer only further pain. Paula watched as the baby's parents, and then her primary nurse removed themselves, leaving the baby to face the pain without them. Paula forced herself to come to work, to give the baby her prescribed care. But felt she was part of something very wrong.

Unnecessary suffering was identified even in the absence of specific painful procedures. Suffering was intolerable when there was no one there to provide comfort. Sam described coming to work one day and was told of the nursing care plan for a 28 week[3] neonate on the unit. Sam described the way her conflict of conscience developed as she learnt more about the baby's story:

[3] 28 weeks refers to the gestation period in which the baby was delivered. Term gestation is considered to be 38-40 weeks.

> *The decision had been made before I had arrived on shift to just do nothing for the baby, to not provide any extensive resuscitation; which was distressing… The baby was, you know, pink and alive for a long time after birth… but was basically just put in a back room by itself to perish… he was just in a crib in a back room with the door closed. There was no nurse assigned... no nothing.*

Sam was not assigned to the baby; no nurse had been assigned to him. The lack of comfort care, which she felt contributed to suffering at the baby's end of life, horrified Sam. She remembered the mother of the baby was not there to help protect or comfort the dying baby. This left Sam and the other nurses on shift to respond to the baby's suffering and death:

> *I think a lot of people felt uncomfortable about it because we thought we should at least be providing some sort of comfort care… or something for this baby who wasn't very wanted.*

Realizing the baby was alone, without parent, and without an assigned nurse, the baby seemed abandoned in the midst a room of people. Unable to properly provide comfort to the dying baby, she felt "*powerless...to change anything".* For Sam, it was more than just an everyday event in the NICU; it became embedded in her memory. Sam explained the inability to provide the needed comfort to the dying baby was, "*a really horrible thing to have to live through*". During the interview, residual emotions from her experience with a conflict of her conscience rose up again. Sam wept for the baby she remembered; the baby had died over 20 years ago.

Finding the Nurse's Voice

The various institutional and unit specific environments that shaped the nurses' experiences of a conflict of their conscience had at least one thing in common: the nurses did not believe they had the necessary power to change their patient's care. Nurses described feeling

"*powerless*", "*hopeless*" and "*guilty*" when they were unable provide what they perceived to be the best care for their assigned baby and follow their conscience:

> *So it's kind of that dilemma of, I know what I should do; I'm trying but I'm not really getting anywhere. I feel a little bit hopeless about getting the result that I want.*

A common sense of restriction as a nurse to declare, or discuss their conflict of conscience was clearly articulated amongst the nurses. Both external and internal barriers prevented them from acting on what was they thought was right by their conscience.

Novice Nurse

For all but one nurse, the most memorable conflict of conscience occurred early in her career. At the beginning stages of their neonatal nursing career, they often questioned their professional confidence as a novice nurse during a conflict of conscience. Lexi described her distinct memory of the way her beginning understanding of her nursing role and novice awareness of what was happening to the baby influenced her responses during her conflict of conscience. During her experience of a conflict of conscience with a chest tube insertion without the use of analgesic, she found herself questioning her role in advocacy and what her conscience was telling her:

> *I think it's that whole doctor–nurse ... that whole paradigm of authority. I said my piece. I don't want this guy yelling at me in the middle of a unit, which to me was really powerful as a young nurse. I think now I would confront any doctor and be very comfortable being yelled at if I felt that what was the right thing to do. But, back then I didn't. I was nervous that maybe I wasn't asking at the appropriate time, or that he was right, that the baby really wasn't feeling pain ... just unsure of my own knowledge base, a little bit, and my own role in advocacy at that point in my career...*

As a novice nurse, Lexi was inhibited by her own lack of clinical confidence. After an unsuccessful attempt to gain analgesic for the baby she turned to questioning herself, not the physician. She was unsure how far to push for what she believed would be the best care for the baby in fear of making the physician angry and yelling at her.

Jodi, also a novice nurse at the time of her conflict of conscience, felt inhibited talking to the physician and questioned the extent of her role to protect her patient:

> *I didn't feel like that I could talk to the resident about it. I didn't feel like I could talk to the person that was actually doing the experience. I didn't think it was my place, but yet I did feel it was my place…Being fairly new in nursing, in neonatal nursing, I find that sometimes it's not so easy.*

A secondary conflict was described when, as a novice nurse, she felt uncertain about her ability and obligation to advocate for the baby. Her novice understanding of the core obligation to advocate for the baby became lost in her fear to address the resident.

Even when the role of the advocacy was clear, Sam also felt despite having an opportunity to speak up, she would not have the power to make a change:

> *Even if I had spoken to someone about it…I didn't think that much would come from me trying to speak to someone about it.*

Sam felt she did not even possess enough power to protect her patient. A feeling of failure before even trying emerged from her statement.

Over time the nurses identified a progressive ability to better articulate and act on their conscience at times of conflict. For Heather, her clarity in times of her own moral conflict evolved with experience:

> *I have only been nursing seven years so as you do it more you become more of an adult. I was a fresh from high school when I went in so I was young and naïve and you just do what you are told. I think nursing is like that so you can just be manipulated and you just do whatever you are told to do. But, as I get older I get a little bit more comfortable in saying, "I don't think so"… There are some things that I do that I wish I didn't.*

Unfortunately for Heather, clarity alone did not eliminate the conflicts from happening.

Experience and time acted as a source of guidance and helped the nurses gain confidence in their nursing actions at times of a conflict of conscience. Lexi felt she grew into the confidence she required to pursue her conscience:

> *Now that I think I am older and have many years of experience I think I would be fairly comfortable with stating any objection that I might have, and more comfortable also taking that decision to higher levels within the organization if need be.*

With time and experience navigating around the institutional system Lexi found she was more equipped to speak up about her beliefs and know where to turn on the unit to follow-up. After her unforgettable experience with a conflict of conscience Lexi recognized her personal limitations leading to personal failure. She felt that first feeling of failure as a neonatal nurse was a catalyst for change in her nursing career:

> *It kind of sets your tone, you know, that that will never happen to me again. If I feel that way again, I think I'd pursue it harder. I think I have developed that skill over time. I did flight nursing and charge roles, and stuff like that, and really I don't think I ever let myself down, where I went home from work thinking that I'd failed a family like that again.*

The nurses described an inability to use their voice at times of a conflict of conscience which was embedded deep within themselves as a young nurse. Even with the skill, desire, or ability, to see the conflict more clearly, or react with more confidence at times of moral conflict, the nurses also described another set of barriers separate from themselves.

Expected Silence

The nurses sensed certain professional expectations prevented them from using their developed voices at times of conflict. Heather recognized that a professional obligation to stay silent competed against her desire to voice her conflict of conscience with circumcision:

> *I would like to try and explore that (the decision to circumcise their baby boy) with the parents and try to change their mind from making that decision but it is probably not the professional thing to do...If I hear somebody else talking about it I want to leap up and go and say "No!"But I just kind of pause and say, "Nope I can't do that". I have to remind myself that it is not my place unfortunately.*

On one particular occasion, Heather spoke out in front of the baby's mother verbalizing her disagreement with circumcision:

> *She was asking how she could go about getting a circumcision and I was like, "You know we don't really deal, with that in here because it is not a medically supported thing and I don't support it", and I thought, "Oh I shouldn't have said that!"*

She concluded she had been a, "*bad nurse…for saying my opinion"* and not being an *"unbiased information giver"*. She realized she was restricted to a form of silence at the bedside as a nurse when she felt a conflict of conscience. Realizing the restrictions embedded within her role as a nurse she concluded:

> *I can't really do much beside hold myself back.*

She concluded the best nursing action was to be silent at bedside, particularly in front of the family. The only way to do this was by "holding herself back", and to place a barrier between her beliefs and what she had to do.

Questioning the origin of her own views on professionalism during circumstances of ethical conflict, Jodi concluded individual morals were to come second. She recalls:

> *I guess how I have just been trained through all the years is it's not always your morals that needs to come first.*

The idea that individual, personal morals should be contained made it even harder for the nurses to voice their conflict. Jodi explains:

> *I think when you're in a new environment where you don't really know the people or people don't really know you I think it's harder to speak up. I think it's because people… that are nursing for so long, I find, they're kind of just taught just kind of go with what needs to be done.*

She described a level of comfort needed before straying from an accepted norm of following orders without questioning.

Heather also identified restrictions to discuss her conflicts of conscience embedded within the culture of nursing itself, much as Jodi described. She explained in nursing:

> Y*ou just do what you are told. I think nursing is like that so you can just be manipulated and just do whatever you are told.*

Not accepting this voiceless depiction of the nurse, Heather felt she was better suited to critically review practices and advocate for her patients rather than stay silent:

> *Some people just don't question practices and, you know, "it is just the nursing way". They just do it, because that is what we do and that is the policy or they are just not*

updated to current research as much. So, they just kind of look at me and think, well, "Why do you care? What is the big deal?" Or, "It is just none of your business."... Actually as a patient advocate it absolutely is our business.

Despite this articulated responsibility of the nurse to question practices or procedures, voicing a conflict with practice was, at times, associated with negative nursing attributes. Nurses called themselves, "*vocal*" when they spoke out against a practice or on their conscience. The idea that she would be seen as an outsider in some way by stating a conflict with a practice, made Heather hesitate before raising matters of her conscience. She stated she did not want to be perceived as the "*opinionated, outspoken, annoying one*" to her peers when she disagreed with a practice or nursing routine. Disagreement with a practice or treatment posed many unique dilemmas for the nurses. Recognizing the inherent restrictions against voicing her conflict of conscience involving the baby's suffering at end-of-life, Sam concluded:

I mean my personal ethics are always important but I think that this sort of incident makes me, as a nurse, think more about ethics in my profession.

To Sam, her experience of a conflict of conscience not only highlighted her own personal beliefs, but also exposed the reality of her life as a nurse. She recognized the responsibilities of nurses do not always come with the necessary power to make a change, often leaving a nurse destined for moral conflict.

In their experiences the nurses repeatedly expressed a sense of powerlessness as nurses. At the same time, they also felt a critical responsibility to protect the patient. Providing a visual description of their powerlessness, Paula described the condition of nurses through her eyes:

Our hands are tied.

Her words depicted the nurse bound to, possibly both obligation and responsibility. After recognizing the restraints within their role as a nurse, they attempted to follow their conscience within their individual environments. This did not always come as an easy task; often forcing the nurse to weigh the risks and benefits both personally and professionally. Complicating this decision the nurses described a unique proximity of the nurse to the perceived pain and suffering of the baby, which could not be ignored.

The Unique Proximity of Nurses

> *I think it is because we are at the bedside. We see the physical and emotional responses in the client as well as with the family. I think we are just more in touch, to be very honest with you, with the client than even medicine. Doctors are great but they are not at the bedside watching or doing the stuff that requires pain… I would not say that doctors are not emotionally involved with their clients, but nursing is forefront to care.*

Lexi believed nurses shared an intimate connection with their patients unlike other professions. It was the way the nurse sensed the patient's needs and responses through touch, sight, and emotion that made the nurse more vulnerable to a conflict of conscience. This concept of the unique proximity of nurses, or closeness, to the patient's needs and responses was captured within the nurses' struggles to work around perceived constraints, while attempting to maintain the best care for the baby. The nurse's direct proximity to the patient care or a procedure influenced both the intensity of the conflict and how she felt she needed to protect herself from violating her conscience.

Heather felt a deep conflict of conscience with circumcision. However, she felt her actions to direct parents towards circumcision did not cause distress once she was off work. When asked if this conflict of conscience affected her home life she responded:

> *Not usually because something like a circ I just have to talk to the parents. I don't have to be there when he gets it. If I actually had to be there… well I wouldn't. That is just something that I just wouldn't do. I think that would spill over to my life. It is a little easier maybe to let go of just the theoretical circ.*

The circumcision was perceived as theoretical if she was only providing information; therefore, not a direct result of her own nursing actions. The idea of theoretically supporting a baby boy's circumcision still created both emotional and physical distress for Heather, however it created much less distress than if she had to play a role in the procedure. If she was asked to be at the bedside to assist with a circumcision, she expressed she would not support actions that would be in direct violation of her conscience. The intensity of this violation, Heather described, would force her to remove herself from the treatment and affect her home life. That would be a moral line she would not be willing to cross.

Recognizing the real and potential emotional and physical distress felt when they acted against their conscience, nurses attempted to function within both the comfort of their conscience and the institutional and professional restrictions of their nursing role. This was not always an easy undertaking, and often needed experience to develop. Lexi described her insight into the process of following her conscience:

> *Well, just the awareness…recognizing that you're stepping over a line of comfort … is probably the first step…after that; it just became a willingness to (say) I'm not happy with this, or I'm not comfortable with this treatment. And go to the charge nurse, and go as far as removing yourself from the assignment, if that's the pursuit. Most often it became a conversation, and it was resolved with kind of a mutual agreement.*

Lexi felt following the conscience was a step-by-step process involving recognition, declaration, and action. Not always was removing one's self the action needed to follow the conscience.

Refusal of assignment

Acting on a conflict of conscience took many forms for the nurses. The varying attempts described by the nurses to follow their conscience shared a common goal; the nurses tried to alter the proximity of themselves to their conflict. Within their experiences, the act of refusing an assignment as a form of CO was not seen as a good first response:

> *I don't feel supported when you get people who refuse assignments, because I really don't think that's fair, especially if everybody's in the same boat.*

Paula felt CO, in the form of refusing an assignment, was "*unsupportive*" if used when *"everyone"* was having moral conflict with the care a baby was receiving. Even when the treatment or situation caused conflict for the nurse, Paula felt the nurse should make a decision which placed the baby's comfort before their own. If a nurse had a conflict with a common practice in neonatal nursing, Paula believed that it added pressure on other staff to accommodate:

> *Palliative care is part of neonatal nursing… I've seen people say, Oh, I just can't stand a dying baby. And I'm like, Uh, you could be in the wrong area, because it's going to happen to you eventually, and you've got to learn to deal with it. This is part of the territory.*

Babies die in NICU. Paula felt a NICU nurse cannot avoid this reality by avoiding the dying patient and his or her family:

> *I saw one nurse…I don't know if she'd ever done death care, she's been a nurse longer than I have. They (the NICU) had a baby, and it had coded and died, and she (the*

> *bedside nurse) literally walked away, she just said, I want my assignment changed, I can't deal with this.*

The perspective of the nurse who had "*walked away",* as a response to change her proximity to her conflict, was uncertain, as Paula did not confront her about it. However, the ripples of the nurse's actions were far reaching on the unit:

> *We weren't expecting this baby to die; he just abruptly coded and died. But she'd looked after him for several days, and (the parents) came in, and of course they were devastated. They said, "Where's so-and-so? She was supposed to have him today"…We just ended up lying to them…we just said, "She had to go home"…. And we had to make sure that they didn't see her…It would've been better for them to have a familiar face. But she (the nurse) couldn't deal with it. We were angry about that.*

Paula perceived the nurse should make a self sacrifice if their absence would be detrimental to the care the baby would receive. However, this was not easy as it sounded. The nurse would then be the one compromising herself, thus creating:

> (*A) moral struggle where you don't want to look after that baby; but you know if you do, you could make it better for him*.

Reassignment

Requesting a reassignment was not viewed the same way as outright refusing an assignment. A reassignment meant an attempt was made to remain at the baby's bedside for a length of time or shift. The nurse has thus tried to take her turn in a sense, or had attempted to place the patient first. In Paula's experience, with the 23-week old baby who was experiencing multi-organ failure, nurses took turns taking care of the baby for only one or two days at a time. They were only able to care for the baby in short intervals:

People just couldn't face up to doing her care because we were causing her pain.

Reassignment allowed the nurses to maintain a certain amount of closeness with the baby during their shift, but also take time away from the distressing nursing care. The change in proximity allowed the nurses to distance themselves from the intense distress they felt by causing the baby pain. If they were at bedside they experienced their own sense of suffering when providing care for the baby. The nurses in Paula's case all felt a conflict of conscience when providing nursing care to the dying baby. A request for a reassignment was employed by Lexi on her unit after she also recognized a conflict of conscience when providing bedside care.

Following maternity leave Lexi returned to the unit as, "*A mother (and) as a nurse with more experience*". Back on the unit she experienced an unfamiliar conflict of conscience involving new resuscitation guidelines for 23-week neonates while she was away:

> *Taking care of those 23-weekers who, for instance, have no skin, they have no terminal lung arterials, and their eyes are fused. It's really quite disturbing to take care of those babies. (The baby) was too premature and I didn't think we should be saving or continuing with that baby in particular.*

For Lexi, she could not bear to be a part of trying to save this extremely premature neonate. To stay at the baby's bedside and provide nursing care would create a conflict of conscience for her. Such care, provided against her conscience, would be compromising the best care for the baby:

> *I did take care of the baby one day, and I talked to the charge nurse, and I just said, "You know, I'm just feeling this is wrong, I'm feeling very angry at our staff, and I'm feeling a little bit angry at the family for wanting to pursue when they're seeing what's lying on that bed". So I said, "I'm probably not the best nurse (for this)", and they were like,*

> *"Okay, that's the right thing to do". And they just gave me a different assignment the next day.*

After her shift Lexi requested a reassignment for the next day. She purposefully only discussed this with the charge nurse and stated her beliefs were conflicted with the care the baby was receiving.

Her request served a dual purpose; she was following her conscience while trying to ensure the baby received the best nursing care. Knowing she was conflicted with the nursing care required for this premature baby, she felt she could not trust herself to provide the best care. She explained to the charge nurse:

> *It's just not going to work if you want me to do good patient care…I think I'm going to get in trouble.... So I just opted out.*

She did not elaborate on what "*good patient care*" or "*get in trouble*" meant. However for Lexi, a reassignment not only protected her, but also protected the baby in some sense. Lexi knew that if she was asked to continue providing nursing care for the baby, that baby's care would be compromised in some way. It was like Lexi truly felt she had to believe in the care she was providing in order for quality nursing care to be achieved. To avoid sacrificing quality nursing care for the baby she requested a reassignment.

Adapting

In attempts to avoid refusing an assignment, or refusing to perform a procedure in order to protect themselves from acting against their conscience, nurses additionally used alternative techniques to follow their conscience at the bedside. In efforts to minimize unnecessary painful procedures, Paula explained her strategies at the bedside:

> *They've ordered lab work and I'll do rounds and say, "I noticed you've ordered morning lab work". And I talk them out of it. But if you refuse to do care, well, you could get into a lot of trouble, but you can talk them out of a lot of things…I'll say, we've ordered all this lab work, is it really necessary? Can we stop this or at least turn it down a little bit? Usually you can get them (physicians) to go along with it, too. But to actually say, I refuse to do this. I don't think I've ever done that.*

When Paula did not agree with an aspect of care she found a way to change the minds of the physicians by requesting a reduction in the frequency of the blood work to help reduce painful interventions. This sort of negotiation helped Paula avoid formally declaring a conflict of conscience. As Lexi had described also, *"a mutual agreement"* was made.

Compromise of some kind in times of a conflict of conscience, was also articulated by other nurses. Instead of refusing to provide information to parents regarding circumcision, Heather provided the recommendations from the American Academy of Pediatrics stating circumcision was medically unnecessary in addition to the medical contact information the parents requested for circumcision. She also planned to call all of the doctors and ask about their techniques and pain practices so she could provide this information as well. Heather stated:

If they are going to do it, I want them to do it in the most comfortable way for the baby.

She felt if she could not stop the procedure from happening, she could protect her patient in other ways, such as by providing full disclosure of the medical necessity of the procedure and pain management practices.

Also compromising, Sam adjusted her nursing care to help follow her conscience without formally objecting. Feeling conflicted by the doctor's orders to not initiate comfort care to the dying baby on her unit, Sam and her colleagues instead, "*took turns holding the baby*" in

attempts to provide comfort and alleviate suffering. It was clear this compromise did not prevent distress from occurring. Sam still felt the compromise of providing comfort care by holding the baby, versus leaving the baby to perish, still violated her conscience. She was still emotional during the interview as she remembered how it was her who was compromised.

If attempts to alter nursing actions, which were incongruent with their conscience, had failed, the nurses found intangible ways to change their proximity to the conflict:

> *I think sometimes one of the outcomes of that is that you develop perhaps a way of keeping some distance between yourself and the situations at work.*

If the nurses were unable to physically distance themselves from the care they disagreed with, they instead developed techniques to mentally or emotional distance themselves from the baby's care. This mental distancing altered their sense of proximity to the patient to maintain a level of functioning as a nurse; perhaps to allow themselves to try and give quality care to the baby by removing their conscience in some sense.

As described by Lexi, a nurse at the bedside acting against her conscience could affect the baby's care. Rooted deeper in the nurses' choices to be reassigned or work around a conflicting care order, was the goal to protect the patient. A repetitive feeling of failure or distress when acting against ones conscience and not protecting the patient was to be avoided:

> *I think it is important to believe in that side of nursing. I think with exposure to repetitive conflicts, repetitive sad feelings in client care…that is part of burnout and…people who quit nursing and go into something else.*

Constantly acting against ones conscience, Lexi felt, was not positive for the nurse or the larger

profession of nursing. Lexi suggested it was also the inability to provide the best care for the patient that would contribute to burnout in addition to constantly acting against ones conscience. She felt respecting the conscience of the nurse promoted a healthy sense of functioning:

> *I think it (the conscience) needs to be respected… to keep a nurse functioning at her best, to keep her in the profession. You need to be able to discuss when we're having some conflict of morality or objection to care.*

Despite the potential negative outcomes of a conflict of conscience, Lexi thought moral conflict at work meant active moral beliefs were present. She felt moral conflict was a reality of working with different people and a multidisciplinary team:

> *Recognising that we have moral conflict, and that we are all individuals and have different beliefs coming in…There is a way to express in a management form, and that ability to remove yourself if it really conflicts your conscience. I guess it has got to come from policy, procedure, from changes in the culture in the unit in terms of accepting people voicing what they are feeling, and finding upper avenues to allow staff to manage those feelings of conflicts I guess. It is not really earth shattering.*

Lexi felt solutions would not only come from recognizing people's beliefs, but also finding ways to respect them while at work. Support for nurses who experienced a conflict of conscience often only occurred through informal discussion.

Following a distressing experience with a conflict of their conscience nurses sought advice, debriefing, or conversation from their nursing colleagues. Colleagues in this case did not include management or the employer. Sam describes what she felt was an unanticipated outcome after sharing such an unforgettable experience of a moral conflict at work:

At work…I guess in some ways you might even say that it strengthens the bond between your colleagues and yourself. You are kind of sharing the experiences and discussing them and so forth. So in some ways, that is perhaps an unanticipated benefit; you strengthen your relationships with your colleagues.

The openness to discuss individual conflicts within the profession, and on individual nursing units, was seen as a change required to respect the conscience of the nurse. A conflict of conscience was not something one nurse was to battle alone; rather the profession of nursing was called to take action:

As a profession we have to identify that it is part of what we do every day.

In health care there can be many differing values and beliefs among team members. The nurses articulated an intimate connection with the patient, which may place them in a unique position on the team.

In this study each nurse articulated one unforgettable experience. Within these unforgettable experiences they failed to protect the baby from unnecessary pain or suffering. Nurses felt the impact of their nursing actions affected more than just themselves. As Paula stated:

Your care will impact that baby for the rest of his[4] life…

Participants illuminated the understanding of this responsibility to their patient when they described a personal sense of failure when they were unable to ensure their infant patients received the best care possible. For some their distress at such failure was still present after two decades.

Thematic analysis within the experiences of conflicts of conscience as described by five nurse participants included three core commonalities. In this chapter these themes of *the*

[4] The gender "his" represents either male or female in this context.

unforgettable conflict with pain and suffering, *finding the nurse's voice*, and *the unique proximity of nurses* were identified and described. In the final chapter these themes will be interpreted within a larger context.

Chapter 5

Discussion

The exploration of the experiences of conflicts of conscience with neonatal nurses in Alberta is a way to learn more about the scenarios or procedures which may cause such conflicts in the NICU. Currently this lack of understanding has been a gap within the literature. Only recently the Canadian Code of Ethics for Registered Nurses included "Ethical considerations in addressing expectations that are in conflict with one's conscience" (CNA, 2008). To date, primarily theoretical views and broad definitions of conflicts of one's conscience are present in the Canadian nursing literature. This may create ambiguity when considering moral action during a conflict of conscience in environments which have a broad scope of moral conflict on a day-to-day basis, such as the NICU. As a NICU nurse, I was confused with the practical implications of the guidelines in the Canadian Code of Ethics in the clinical setting, particularly related to conflict during morally ambiguous scenarios, such as end-of-life or potential suffering. This confusion lead to the research question, "What are the individual experiences of conflicts of conscience like for neonatal nurses within Alberta?" In this Chapter the research findings of this study are discussed within the broader context of the nursing literature. Following this discussion, implications for clinical practice and suggestions for further research are presented.

The guidelines in the 2008 CNA Code of Ethics address the nurse's moral duty to their family, particularly in circumstances of a pandemic. The conflicts of conscience of the neonatal nurses in this study however, did not occur during crisis times like a pandemic; their moral conflicts occurred during the everyday situations they faced in nursing. This potential for everyday exposure to situations which produced a conflict of conscience creates unique challenges for nurses. The nurses in this study described being forced between their moral

responsibility to protect their patient and the completing duties which may contradict providing comfort. Three common themes were illuminated from the interviews in this study, *the unforgettable conflict with pain and suffering*, *finding the nurse's voice*, and *the unique proximity of nurses*.

The Unforgettable Conflict with Pain and Suffering: Causing Pain and Suffering

An unforgettable conflict of conscience was experienced when nurses felt their assigned care or nursing duties conflicted with their ability to protect the baby from pain and perceived suffering. Undermanaged pain and unwarranted suffering, particularly at end-of-life, was clearly articulated as a deep source of moral conflict amongst the neonatal nurses. This appears in other studies of neonatal nurses, as well, with nurses reporting they feel they are harming babies versus comforting them at end-of-life (Catlin et al., 2008). Solomon et al. (2005) found nurses and other health professionals in their study of new and ongoing ethical controversies in the PICU, expressed "at times, I have acted against my conscience in providing treatment to children in my care" (p.874). These researchers conclude that pain and end-of-life are sources of common concerns of conscience in intensive care units for infants and children (Solomon et al., 2005).

The Alberta nurses in this thesis explained when they felt they were witnesses to a baby's unnecessary suffering and undermanaged pain, they felt, "*extremely sad for the baby, ached for them"* and felt it was *"awful and torture.*" One nurse implied circumcision was a form of torture because it was "*barbaric*" and caused "*mutilation*". She felt the end result of this act did not promote any form of human flourishing. Conflicts emerged within the nurses when they believed the baby's pain was not properly managed during procedures and when the baby experienced unnecessary suffering when death was inevitable. One nurse felt she was "*torturing*" the baby at end-of-life instead of providing comfort. The word "torture" has been used by other neonatal

nurses (Hefferman & Heilig, 1999; Catlin et al., 2008) and ICU nurses (Ferrell, 2006) who felt they were inflicting pain and suffering on their patients. For the nurses to believe they were "torturing" the babies meant they felt it was by their hands that the babies suffered and experienced pain. This notion of causing the babies to suffer or experience pain caused the nurses to experience both emotional and physical distress. Wilkinson (1988) reported nurses' self-worth was negatively affected when they believed their actions were wrong. Similar to this, one Alberta nurse articulated that she felt condemned to hell for torturing babies, signifying her personal worth was reduced because of her actions, as Wilkinson suggests.

When the nurses acted against their conscience, they expressed "*anger, guilt, sadness*, and *discomfort"*. One nurse "*dreaded to come to work"*, knowing she would have to continue to act against her conscience again. Tiedje (2000) explains these feelings can be present when the nurse knows the right thing to do but they are unable to accomplish it. Catlin et al. reported that the neonatal and pediatric nurses in their study felt "angry, frustrated, and sad" when they were unable to object to a care order that conflicted with their conscience (2008, p.105). This feeling of powerlessness to make a moral action at times of a conflict of conscience was also articulated by the Alberta nurses.

The scenarios of pain and suffering were not out of the ordinary in the NICU. What seemed to make these experiences unforgettable, however, was an *inability* or *failure* to stop unwarranted pain when analgesic was available or to minimize unnecessary suffering for the baby when death was inevitable. They expressed reaching this failure because they felt "*helpless",* and "*powerless"* to change what was happening in front of them. Despite sometimes numerous attempts to advocate for better pain control or reduction in interventions which caused potential suffering for the baby, they were unsuccessful. This feeling of failure or inability to

achieve what the nurse feels is right is alarmingly common in nursing literature. Neonatal nurses have used the words, "helpless" and "powerless" when they were unable to stop pain and suffering in the NICU (Yam et al., 2001; Catlin et al., 2008). Consequently, the inability to intervene at times of pain and suffering at end-of-life has been frequently cited as a source of moral distress in the NICU (Yam et al., 2001; Kain, 2007; Hefferman & Heilig, 1999; Catlin et al., 2008). Nurses hold a large amount of responsibility but lack the appropriate authoritative power which often contributes to moral distress (Tiedje, 2000). Expressing a sense of powerlessness, one Alberta nurse stated "*I try to minimize whatever discomfort I can for that baby"*. Similarly Yam et al. (2001) found at times of inevitable death, physical comfort and reduction in pain and suffering in the dying infant became the primary goal for the neonatal nurses in their study.

When exploring the neonatal nurses' experiences in the interviews they vividly described how they felt throughout their experience. However, it was difficult to get the nurses to clearly articulate the exact source of conflict and the corresponding belief which was threatened. "*It is the fact these kids are suffering*" one nurse responded. In order to declare a conflict of one's conscience, a clear rationale or morally defensible reason for the conflict must be produced. This requirement can quickly surface as an antagonist to a claim such as "suffering". The concepts of suffering and pain can be argued as subjective feelings which cannot be validly assessed or objectified by another (Carnevale, 2009), making it extremely difficult to defend. Additionally, the Alberta nurses commonly perceived unnecessary suffering at end-of-life. It can be argued if one is able to die without some form of suffering. In the words of one participant, "*Palliative care is part of neonatal nursing*". The argument can be made that if death and dying are fundamental aspects of neonatal nursing, a neonatal nurse who has a conflict of conscience with

that aspect of care is disagreeing with a fundamental aspect of neonatal nursing. Or at least, this is how one participant in this study perceived it.

As muddy as the concept may seem, conflict against suffering mirrors core values of nursing. That is, in all practice settings "nurses work to relieve pain and suffering" and at end of life, the nurse is to "foster comfort, alleviate suffering, advocate for adequate relief of discomfort and pain and support a dignified peaceful death" (CNA, 2008, p.14). Neonatal nurses in the Swedish study by Jenson and Lidell (2009) articulated a similar finding, particularly which they felt that the conscience acted as guide to follow the codes and duties set by nursing, in addition to seeking high quality care. Nathaniel (2006) also found the core beliefs of the nurses in her study were relieving suffering, advocating for patients, and upholding professional norms. Aspects of suffering remain grey despite having the potential ability to reference moral values in the Code of Ethics as rationale for a conflict of conscience.

Overall the Alberta nurses in this study felt providing the best care for the baby was following their conscience. When they could not obtain this through relieving pain or reducing perceived suffering, they experienced conflict. If they continued to act against their conscience, as many described doing in their unforgettable experiences, they expressed outcomes of moral distress, such as feelings of failure and regret. For some, their sense of personal failure pulled at their soul's even years after the incident. Webster and Baylis (2000) have termed this "moral residue", a phenomenon which can last a lifetime. For some participants in this study, moral residue was still present after 20 years. Webster and Baylis (2000) argue moral residue, from an acute experience of compromised integrity, has the potential to add clarity to one's moral commitments. After one nurse's conflict of conscience, she expressed, "*that will never happen to me again*". Over time the nurses expressed developing clarity to know what to do when they felt

their conscience was challenged. However even with clarity, restrictions to act on their conscience were present. These concepts were captured in the theme, *finding the nurse's voice*.

Finding the Nurse's Voice: Recognizing Conflict and Opportunity

The nurses in this study experienced their conflict of conscience in a staged process. The stages of recognizing they were overstepping moral boundaries, naming their distress as a conflict of their conscience, and attempting a moral action to appease their conscience could be identified within the descriptions of their experiences. (Only one nurse, however, articulated the stages, as such). Similar to this finding, in 2006 Nathaniel published her research asking the question, "What transpires in morally laden situations in which nurses experience distress" (p.421). Using grounded theory she developed the concept of "moral reckoning". Although not using the words "conflict of conscience," she describes a similar staged process. She explains the nurse develops a "stage of ease," involving a feeling of being rewarded and fulfilled at work once they have conquered the "new nurse jitters" (Nathaniel, 2006, p.425). She then describes a "situational bind" when the nurse experiences conflict between their core moral beliefs and professional and institutional barriers. During this time the nurse is conflicted with being a "good nurse" who follows orders or doing what she feels is morally right (Nathaniel, 2006, p.428). This is comparable to a nurse's confrontation with a conflict of conscience. Nurses in her study also felt responsible to maintain their promise to the patient to reduce suffering. After the conflict, or "situational bind", they enter a "stage of resolution" in which they seek to resolve the problem (Nathaniel, 2006, p.430). They may "take a stand" or "give up," however, both of these actions may only be successful to address the problem in the short term (Nathaniel, 2006, pp.430-431).

In this Alberta research study, nurses recognized they were stepping over the boundaries of their conscience by an initial internal warning. They felt "*uneasy, uncomfortable"*, or became

"*sick to their stomach"*. This prompted them to question the current care and identify the incongruence between the baby's care and their core beliefs. Morton and Kirkwood (2009) conclude the conscience acts as a warning when values are conflicted. When faced with providing care which causes suffering or harm, nurses experience an internal questioning of their values in relation to the treatment being provided (Catlin et al., 2008). However, the conscience is dynamic as it gains experience (Morton & Kirkwood, 2009), and it can take time to become at ease with one's core beliefs (Nathaniel, 2006). Even though the nurses recognized they were overstepping a line of comfort they often did not know or feel they could to anything to change it. Wilkinson (1988) concurs that as nurses become more knowledgeable and experienced they become more aware of strategies that allow them to follow their conscience through manipulating the system.

A commonality among the nurses' experiences was the occurrence of the conflict happening early in their career. This finding does not necessarily mean the frequency of a conflict of conscience happens more for the young nurse. It may be simply that it is experienced differently. Uncomfortable with her convictions as a young nurse, one participant turned to questioning herself and the validity and timing of her advocacy for more pain control. Similarly, another nurse lacked the confidence to approach the physicians regarding the palliative care plan of the dying infant whose situation was causing her distress. A third nurse also felt she did not have the confidence or ability to talk to the resident executing the insertion of yet another chest tube. As Catlin et al. (2008) point out, after recognizing a conflict of conscience the nurse might not know the next step when they lack comfort and expertise. Wilkinson (1988) argues more experienced and knowledgeable nurses suffer fewer instances of moral distress because they can work within the system and fully understand possible consequences of their actions. This

argument is yet to be fully supported. Despite the level of expertise the nurses felt they had, they articulated a sense of restriction regarding the declaration of a conflict of conscience embedded within the culture of nursing. There was an expectation of silence, it can be said.

How the nurses depicted the ideal nurse influenced the restrictions they felt within the culture of nursing. This was similar to Nathaniel's finding of nurses questioning the actions of a good nurse during times of situational conflict. The historical notion that the nurse is self-sacrificing (Forsberg, 2001), a caregiver (Moland, 2006), and a servant (Dickens & Cook, 2000), while being compassionate towards the delivery of care (CNA, 2008) adds complexity to the notion of what should ideally happen at times of conflict. According to the CNA, nurses are to "provide care directed first and foremost towards the health and well-being of the person, family, or community in their care" (2008, p. 10). In this Alberta study, nurses placed the patient at the forefront of their decision-making and turned to advocacy as a means to question orders and discuss their concerns at bedside. This allowed them to justify their conflict towards the procedure or scenario while giving them an opportunity to follow their conscience within certain parameters of nursing. Although their conflict occurred within their nursing role, the distress they experienced when they violated their conscience at work bled into their personal lives.

Being a nurse, some feel, is a lifelong commitment; maybe even the person and the nurse are one in the same (Bishop & Scudder, 1999); a calling perhaps (Moland, 2006). Nurses in this study expressed a personal guilt regarding some of their nursing actions. In this sense, there was no separation of their personal selves from their selves as a "nurse." Even though one nurse felt she was following nursing orders, she would still personally end up in hell. Despite feeling tormented by her actions, that nurse concluded it was a fundamental element of being a nurse to

place the patient before herself. She supported a self-sacrifice belief in that she must place the patient's flourishing before her own.

Sellman (2011) argues that a legitimate end in nursing can be that of human flourishing. However, the restraints the nurses felt against the support of human flourishing during times of pain and suffering caused them distress. One participant described the nurse as bound to certain obligations at work, "*Our hands are tied*" she explained. The nurses in this study often expressed being bound to concepts and ideas that were perceived as accepted norms of nursing, such as following orders and not questioning. One nurse felt that in nursing, "*You do what you are told*" and strive to remain an "*unbiased information giver*". However, she did not believe this was the approach she should choose if she was also to be an advocate for best care.

The nurses felt conflict with the obligation to protect the patient from harm and suffering in accordance with their conscience and the need to adhere to the professional responsibilities within in their institution. They strained to find a balance between the competing obligations: to follow orders, to protect their patients, and to live true to their conscience. Multiple and competing responsibilities were experienced by the Alberta nurses. This position has been described as "being in the middle" (Hamric, 2001, p. 254). It can be experienced, not only between the nurse and physician, but also with the needs of the patient and the nurses' own personal values (Hamric, 2001, p. 254). The unique placement of the nurse within the system of health care and within the organization of intimate patient care can create extraordinary challenges for the nurse. As previously described by Tiedje (2000), nurses often experience high responsibly but are limited by a lack of authority or decision-making power in meeting such responsibility.

This lack of formal power and control did not, however, minimize the perception of the nurses regarding the potential effects of their care on their patients. In the words of one nurse, "*Your care will impact that baby for the rest of his life".* The neonatal nurses described a distinct intimacy with their patients which affected their choice of moral action at the time of their conflict of their conscience. This intimacy and moral decision-making was captured in the theme *the unique proximity of nurses*.

The Unique Proximity of Nurses: Intimacy and Following Their Conscience

Within the interviews, the nurses described both a physical closeness and a relational intimacy to the perceived pain and suffering of the babies in their care. One nurse believed this unique proximity of nurses to their patients made them more vulnerable to a conflict of conscience. "*I think it is because we are at the bedside. We see the physical and emotional responses".* Sellman, who argues that the patient can be viewed as "more-than-ordinarily vulnerable" because of their varying dependency for care, also emphasises that nurses are vulnerable, too (2011, p.67). The unique relationship and interactions of nurse to patient has been articulated in various lights within moral distress and nursing ethics literature (see Austin et al., 2005; Cavaliere et al., 2010; Wilkinson, 1987). The work and definition of nursing cannot be defined in a single way (Sellman, 2011). However, commonalities of the intimacy and certain proximity to the patient have been highlighted within the literature. In 2006 Nathaniel wrote of the nurse's intimacy with the patient:

> "Nurses attend to the most personal and private needs of patients and learn tremendous amounts about their hopes, fears, and desires. They intimately know about suffering patients-from touch, sight, small, and sound…Doing the work of nursing includes

knowing the patients, witnessing their suffering, accepting the responsibility to care, desiring to do the work well, and knowing what to do" (p. 427, para 1- 2).

The neonatal nurses in this study knew their job as a nurse encompassed more than technical tasks. For instance, during medical procedures, such as a chest tube insertion, the nurses were angered and frustrated when the success of the procedure was determined by the technical accomplishment of the insertion versus the overall experience of the baby. Their proximity with the baby's care was so strong they experienced physical and emotional distress when they perceived the baby was experiencing pain and suffering. It is this proximity which persuades the nurse to act, but also can force them to turn away from their patient (Peter & Liaschenko, 2004).

The recognition of the need for the nurse to maintain a unique proximity to the patient meant there would be both physical closeness to perceived pain and suffering of the baby and an emotional investment. Peter and Liaschenko (2004) concur, "Patients' needs posses an immediacy and intensity that cannot be ignored in good conscience by nurses" (p.223). These obligations added to the nurses' vulnerability. If the nurses were unable to work within the boundaries of their conscience, they acted to change the proximity to the patient in order to subsequently distance themselves from the conflict and potential distress. They distanced themselves or changed the proximity to the patient by modifying or ending the relationship they had with the baby. By doing so, they changed the obligations they had with that patient and distanced themselves from the source of their conflict.

The idea of the nurse modifying the environment to live within the boundaries of one's conscience has been described by Catlin et al. (2008). They termed this concept "living within moral frameworks" and it involves the nurse utilizing techniques to preserve their integrity by

following their conscience (Catlin et al., 2008, p.106). These authors entertained the potential use of CO by nurses as a means of acting against care orders which produced harm and suffering, thus living within their moral frameworks. Although the nurses in their study were very interested, their results were inconclusive about this potential, and the results highlighted fears and barriers to declaring a CO.

Within this Alberta study, the nurses did not use the words "conscientious objection," even though they demonstrated ways they objected in efforts to follow their conscience. The nurses described informal objections to tasks or aspects of care which did not follow their conscience or core moral beliefs. The act of refusing an assignment or an aspect of care as a formal CO was not readily considered nor utilized as a strategy to protect the conscience. The nurses felt they were "*not allowed to refuse care*". Certainly, there are several provisions in the CNA Code of Ethics which legitimately inhibit a CO in health care including fear, discrimination, prejudice, convenience, emergency situations (CNA, 2008) and selfish motivation (Dresser, 2005). However, the CNA also outlines the nurse's right to refuse an assignment or "refrain from providing care because a practice or procedure conflicts with the nurse's moral or religious beliefs" (CNA, 2008, p. 23) as long as another nurse is available to take over the patient's care.

The nurses gauged the extent of their moral actions to follow their conscience on the intensity of the distress they would experience from not doing so. For example, one nurse felt she was able to tolerate the feelings of distress incurred when she directed parents towards circumcision. Somehow there was something theoretical about the procedure if she was not there to assist in it; her actions did not then directly cause the circumcision. Providing information for the parents did not cross her line of "moral complicity" (Orr, 2010, p.51) for circumcision.

However, if she were to directly contradict her conscience or core moral beliefs by directly assisting in the procedure, she believed that the intensity of her distress would "*spill over*" into her life. Providing nursing care during the circumcision required a close proximity to the patient and the procedure. From this, the distress she would feel would be too much to bear, forcing her to enact a CO to remove her from the assignment. Baker (1996) believes the integrity and wholeness of a health professional's personality and character is preserved with CO. She continues to insist it would be dehumanizing to violate deeply held beliefs within one's conscience (Baker, 1996). Although the CNA Code of Ethics does not endorse integrity of the nurse as "wholeness", the definition of integrity includes consistency of one's emotions, actions, and convictions (CNA, 2008). In the case of assisting with circumcision, CO and removal from the actions would then preserve the nurse's integrity.

In 2006 Nathaniel's research of "morally laden situations," previously described, after the nurses experienced a moral conflict they either chose to "take a stand" or "give up" (p.430-431). Lynch (2008) believes a conscientious refusal must contain an intention to avoid deep regret. In the one Alberta nurse's case, assisting in a circumcision would have generated regret for acting against her beliefs. CO against elective infant male circumcision has gained recognition both in North America and across the world. In 1994 St.Vincent's Hospital in Santa Fe, New Mexico became the first hospital in the world which recognized RN CO to infant circumcision, including pre- and postoperative assistance (Katz Sperlich, Conant, & Hodges, 1996). Despite certain gains in CO or accommodating for individual moral beliefs in nursing, there remains a major controversy in health care. What was particularly highlighted in this study was the ambiguity and complexity of a conflict of conscience during less defined circumstances, such as those which involved perceived pain and unnecessary suffering.

Even if the act of refusing an assignment as a CO could protect the nurse's integrity or moral beliefs, findings in this study suggest it is not always welcomed. One nurse felt "*unsupported*" when an individual nurse would refuse an assignment during a case that caused distress for many other nurses, as well. She articulated that is was not "*fair*" to remove one's self if it left others, who also felt distress, to take care of the baby. There seemed to be a sense of "we are all in this" or "this is part of neonatal nursing" during cases of prolonged suffering or death. Another nurse articulated that in her experience of a conflict of conscience, the communal suffering of the staff actually helped create a bond between the staff. However, in the description of the individual nurse who refused to continue care of her assigned baby's family after the baby abruptly died, it left other nurses scrambling to take over. Even though staff members were able to accommodate for that individual, there was an articulated feeling of patient abandonment because the nurse left at the family's time of need. Waller-Wise (2005) has identified the appearance of patient abandonment is just as critical to consider as actual patient abandonment at times of a conflict of conscience.

After reflecting more deeply into the actions of the individual nurse who refused to remain at bedside after the death of her patient, she seemed to refuse to continue to provide care due to a lack of emotional fitness in that situation versus a conflict of conscience. The CNA describes the nurse's responsibility to monitor their fitness to practice when they feel they do not have the mental, physical, or emotional capacity to practice safely or competently (CNA, 2008, p.18). It could be possible for a conflict of conscience to develop into a concern of fitness to practice if one's distress became too much for them to function and provide safe and competent care at bedside. But, if one only finds death too sad or emotional, this would not be defined as a conflict of conscience. This difference would be very important for the nurse managers of the

unit to decipher when a nurse is requesting a reassignment to ensure proper supports for the nurse. This difference may not have changed the outcome for the other staff members, as they would still be left to accommodate the assignment. Despite some confusion of the intent of the nurse's actions who refused to continue to provide patient care, what remains clear in the stories of the Alberta nurses, and in the literature, is that the well-being of the patient and relationship with the family is to come first, even at times of a conflict of conscience.

The Canadian Code of Ethics takes into consideration this critical relationship between nurse and patient by, in cases other than emergency, the option of reassignment without abandoning the patient (CNA, 2008). Perhaps the 'accommodation' which is referenced in these guidelines does not only pertain to the nurse but also to the patient. The current nursing literature endorsing CO primarily focuses on the potential benefits of preserving the nurse's integrity when a CO is employed. However, findings in this study suggest a broadening of this perspective by the suggestion that the quality of patient care might not be ensured if a nurse was unable to claim a CO and remove themselves from an assignment or procedure which was against their conscience.

One nurse explained her request for a reassignment with a 23-week old neonate influenced the care the baby would receive. She requested the charge nurse reassign her on the next shift, "*If you want me to do good patient care".* This statement suggests that, due to her conflict of conscience or disagreement with the care she was assigned, she would not be able to provide the same quality care she equated to "*good patient care*". She also went as far as saying she is not "*the best nurse for this*," indicating again that patient care would be affected if she were to remain the baby's nurse. The nurse was able to have her request accommodated and her

assignment was changed. Complete separation may seem the ideal for nurses who are experiencing a conflict of conscience; however, this is not always practical.

If the nurses were unwilling or unable to formally declare a conflict of conscience, adaptations within the patient assignment took place. Short assignments were employed when the nurse's felt they could only handle the proximity and emotional investment with the patient for small periods of time. They attempted to provide physical comfort or tried to reduce painful interventions, such as lab work, to help reduce perceived pain and suffering. These adaptations, or compromises, by the nurses may have been a short-term solution for their conflict; however it was clear the nurses were severely compromised from this. Lynch (2008) explains with compromise neither party receives an ideal. Even though one nurse described she had held the seemingly unwanted baby during his death, it did not satisfy her conscience and she still wept 20 years later. Another nurse, although she took turns caring for the baby who was slowly dying in front of her, still "*dreaded coming to work*".

Researchers in Sweden found nurses and care workers who perceived they experienced a heightened understanding of their patient's needs were associated with burnout and stress (Gustafsson et al., 2010). They also found nurses have needed to mute their conscience in order to keep working within health care (Gustafsson et al., 2010). The nurse may eventually suffocate her conscience through constant dismissing (Morton & Kirkwood, 2009) and may become a "technician" at the bedside (Oberle & Raffin Bouchal, 2009, p. 259).

One nurse in this study revealed she had to emotionally distance herself from the situations at work if attempts to follow her conscience were unsuccessful and she could not physically distance herself. This detachment or emotional disconnection to the proximity of the nurse to the patient has been described in other studies. The detachment or disconnection allows

the nurse to continue completing mandatory tasks required at bedside. “I can detach myself emotionally and just be a highly skilled, highly technical RN. It seems I must do this in order to handle 22-25 week infants” (Hefferman & Heilig, 1999, p.176). The repeated exposure to ethical conflict in the NICU for another nurse in Hefferman and Heilig’s, study eventually stifled her emotions completely. This permanently altered the proximity of all her care. “Basically after working in the NICU for 10 years, I have become numb to my emotions involving ethical concerns” (Hefferman & Heilig, 1999, p.175). The response of the nurse in their study has been termed “moral disengagement”. Moral disengagement is described as the act of focusing only on the skills and mechanical tasks of nursing in efforts to distance oneself from the relational aspect of nursing care (Oberle & Raffin Bouchal, 2009). Perhaps it was elements of moral disengagement which Lexi wanted to avoid when she requested another assignment. This remains uncertain.

Overall the neonatal nurses described their conscience as leading them to seek what they believed to be the best care for the baby. In the official journal of the American Academy of Pediatrics The Committee of Bioethics (2009) published their view to respect the conscience of health professions as it may encourage reason, encourage tolerance, empower individuals, and support moral action. Specific to nurses, the Canadian Nurses Association expects nurses to act with moral reasoning, moral judgement, and continually evaluate their moral fitness through ethical reflection (see CNA Code of Ethics 2008). Benjamin (1995) believes those who remove or disassociate themselves in procedures or practices due to a declaration of conscience may be among the more effective and caring health professionals. This suggests respecting individuals who declare a conflict of conscience promotes caring and valuable team members.

The seriousness of formal actions to follow one's conscience while in the health practitioner role has long been recognized within the literature of medicine and theology. Similarly in this study following and respecting one's conscience or core moral beliefs was viewed as important for the functioning of the nurse and integral to keeping the nurse in the profession. The Alberta nurses who acted against their conscience felt failure, and some even showed evidence of emotional distress years after the incident. The unequivocal risks of not addressing moral compromise which may occur when one act's against their conscience is best described by Webster and Baylis: "Serious moral compromise (that is compromised integrity) irreversibly alters the self. One does not experience serious moral compromise and survive as the person once was" (2000, p.224).

Nurses in this study suggested at times of a conflict of conscience they required support and clear avenues to voice their disagreements with colleagues and upper management. Derived from the findings, occurrences of a conflict of conscience emerged at times of day-to-day scenarios in the NICU. Their stories of pain and suffering shared frequent similarities regarding a vulnerable infant requiring the protection of the nurses. Conflict with perceived pain and suffering is common within the moral distress literature for nurses. The frequency of procedures and care plans which have the potential for pain and suffering are high in the NICU. As one nurse described, "*As a profession we have to identify this is a part of what we do everyday*".

Implications for Clinical Practice

Perhaps one of the most challenging aspects I, as the researcher, found was getting to the core of the conflicts of conscience with the nurses. The nurses seemed to struggle with clearly identifying the source of their conflict with their conscience. The Committee of Bioethics (2009) agrees it may be difficult to validate what constitutes a violation of conscience. However in the

pilot study by Catlin et al. (2008) NICU and PICU nurses also reported pain and suffering as their major concerns of conscience. If pain and suffering are used to describe sources of conflict for a neonatal nurse, it may easily be dismissed as it is an everyday occurrence in the NICU. This also adds complexity to the situation of nurses who are advised to declare any conflict of conscience at time of hire as suggested by the 2008 CNA guidelines.

Despite some increased clarity to the individual experiences with a conflict of conscience in the NICU, many questions remain. What makes one particular incident of pain and suffering unforgettable? Where does one draw the line in the sand that *this* situation comprises a conflict of conscience when suffering and pain happen routinely in the NICU? Finally, if a nurse declares a CO on the premise of suffering and pain should the nurse then be excused from all procedures or cases which involve potential pain and suffering, or just individual cases? Context for each case is perhaps then the most influential determinant of the objection. Context forces the nurse to consider moral judgement before declaring a CO.

Certainly the health care system would be jeopardized if every nurse began to question or refuse physicians orders (Hamric, 2001) or care practices. However, both the findings of this study and nursing literature promote institutions and health professionals to respect nurses at times of a conflict of conscience. The nurses in this study often felt unheard in their recommendations to minimize pain and unnecessary suffering, leading to feelings of powerlessness. They also experienced intense physical and emotional distress within their experiences of a conflict of conscience.

The value of support during conflicts of conscience in the NICU may be immeasurable to those who are experiencing it. A non-judgmental ear from their co-workers and support from their charge nurse allowed the nurses to discuss their conflicts and validate their feelings.

Gustafsson et al. (2010) encourage discussing and sharing the ideals of one's conscience to help reduce stress and burnout.

The Alberta nurses expressed the need for strategies and conversation to help guide them through the complexities of a conflict of conscience, particularly when they had limited nursing experience. Findings in this study point to a lack of unified language at times of a conflict of conscience. Developing a unified language to describe conflicts of conscience may help to guide the discourse of this phenomenon within nursing. It is important to recognize one does not have to "object" if one declares a conflict of conscience; however, the practicality and success of this may cause a moral dilemma for the nurse. As Carper (1978) points out, "Moral dilemmas arise in situations of ambiguity and uncertainty, when the consequences of one's actions are difficult to predict and traditional principles and ethical codes offer no help or seem to result in contradiction" (p. 252).

The new addition to the 2008 Code of Ethics has certainly helped highlight the formal language needed in declaring a "conflict with one's conscience". However, the terms and phrases such as CO, conflict of conscience, and conscience are not readily used in the current nursing literature nor consistently used by nurses in this study. The current guidelines in the CNA also are extremely broad when considering the examples of nurses discussing a conflict of conscience. In these guidelines the nurse may object to practices or procedures against their conscience or moral or religious beliefs. Similarly, if the nurses in this Alberta study were to claim pain and suffering was against their beliefs, it is unknown how morally justifiable this could be. The complexity of CO and the concept of conflicts of conscience certainly need to be considered for nurses who feel they are violating their conscience and are seeking moral action. Conscientious objection in particular is not a concept that should be addressed alone (Catlin et

al., 2008). As Dresser (2005) states, "Conscientious objection is not simply a matter for individuals, it is a matter for the professions and the broader society" (p. 10).

Suggestions for Further Study

Nursing research on the experiences of conflicts of conscience remains limited. The findings of this research were derived from five interviews of neonatal nurses within Alberta. Rich understandings of the individual experiences of neonatal nurses with a conflict of conscience can be collected from other neonatal nurses willing to tell their story. Inquiring deeper into the implications of a conflict of conscience involving pain and suffering for the neonatal nurse can provide more clarity for clinical practice. Exploring the experiences of nurses who have left the profession who felt s/he experienced a conflict of conscience could further enrich our understanding of the penalties of acting against the conscience.

Recruitment strategies should be broadened to capture the interest of more potential study participants. As recognition of the terms used in conflicts of conscience become better known, it may also become easier to invite nurses to participate in research about this concept. Exploring the different language used to describe conflicts of conscience may illuminate more commonalties within the experience of conflict with one's core moral beliefs.

Qualitative research utilizing focus groups to ask how nurses understand the uses of "Ethical Considerations in Addressing Expectations that are in Conflict with One's Conscience" in the 2008 Code of Ethics (CNA, 2008) would potentially add to our understanding of nurses' perceptions of this addition to the CNA Code of Ethics. The findings of this thesis reinforce the critical nature of gaining insight and understanding of the experiences of conflicts of conscience in high tech units such as the NICU. As technology and research continue to expand, nurse

researchers should continue to identify the vulnerabilities of the human interactions involved in nursing.

Conclusion

The findings of the thesis research emphasize the ambiguity and complexity involved with conflicts of conscience in nursing. Interviews from five neonatal nurses shared commonalties which were captured in three themes. These themes were compared to the current literature in this chapter. Just as researchers in current nursing literature continue to highlight the consequences of moral distress in the profession, experiences with a conflict of conscience pose similar restraints and feelings of distress. Undermanaged pain and perceived unnecessary suffering were the main sources of conflict of conscience for the five neonatal nurses interviewed. Nurses experienced both physical and emotional responses to the perceived suffering and pain of their tiny patients, forcing them to consider moral action. The unique proximity and relationship the neonatal nurses shared with the babies magnified the intensity of the distress they experienced when they encountered conflicts. Duty to care obligations, formal penalties of refusing an assignment, the perceived inability to discuss the conflict with the physicians, and lack of personal confidence were barriers to declaring or acting on ones conscience in this study. These findings are similar to that of Catlin et al. (2008) who studied CO as potential response to moral distress in neonatal nursing. Perceived barriers to voicing moral objections included formal penalties such as legal consequences or job loss, restrictions within administration, physician orders, and excessive influence from parents (Catlin et al., 2008, p.106).

The conscience or core moral beliefs of the NICU nurses in this study mirrored those embedded within the core values of nursing. Similar to other studies, the nurses were prompted

by their conscience to seek high quality care for the patients. The personal distress they felt when they were not able to achieve the best care for their baby patients suggests a heightened sensitivity in these nurses between their own beliefs and that of the nursing profession. Findings also raise the question of quality patient care at times of a conflict of conscience. There remains much to learn about the experience of a conflict of conscience in the NICU. Advancing the discourse on moral conflict by research in this area may allow nursing to continue to promote quality care for critically ill infants while protecting the integrity of the neonatal nurse.

Bibliography

American Nurses Association. (2001). *Code of ethics for nurses*. Retrieved March 6, 2012 from http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx

Austin, W., Kelecevic, J., Goble, E., & Mekechuk, J. (2009). An overview of moral distress and the paediatric intensive care team. *Nursing Ethics, 16*(1). 57-68.

Austin, W., Lemermeyer, G., Golberg, L., Bergum, V., & Johnson, M.S. (2005). Moral distress in healthcare practice: The situation of nurses. *HEC Forum, 17*(1), 33-48.

Australian Nursing Federation. (2011). *Conscientious objection*. Retrieved March 6, 2012 from http://www.anf.org.au/pdf/policies/P_Conscientious_Objection.pdf

Australian Nursing Federation (Victorian Branch). (2006). *Conscientious objection*. Retrieved March 6, 2012 from http://www.anfvic.asn.au/multiversions/3196/FileName/Conscientious%20Object ion.pdf

Baker, T. P. H. (1996). Descriptive and normative ethics: Conscientious objection. *Nursing Management, 27*(10), 32DD-32FF.

Benjamin, M. (1995). Conscience. In W.T. Reich (Ed.), *Encyclopedia of Bioethics: Revised edition.* (Vol. 1, pp.469-473). New York, NY: Simon & Schuster MacMillan.

Bishop., A. H., & Scudder, J. R. (1999). A philosophical interpretation of nursing. *Scholarly Inquiry for Nursing Practice: An International Journal, 13*(1), 17-27.

Cameron, M. (1986) The moral and ethical component of nurse-burnout. *Nursing Management,* 17(4), 42B-2E.

Canadian Medical Association. (2011). *Joint statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care.* (Approved 1998). Retrieved March 6, 2012 from http://www.cma.ca/index.php/ci_id/3217/la_id/1.htm

Canadian Nurses Association. (2008). Code of ethics for registered nurses: 2008 centennial edition. Ottawa: *Canadian Nurses Association.* Retrieved March 6, 2012 from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf

Canadian Nurses Association. (2004). *Position statement: Registered nurses and human rights*. Retrieved March 6, 2012 from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS78_Human_Rights_e.pdf

Canadian Nurses Association. (2003). *Ethical distress in health care environments: Ethics in practice.* Retrieved March 6, 2012 from http://www2.cna-aiic.ca/cna/documents/pdf/publications/Ethics_Pract_Ethical_Distress_Oct_2003_e.pdf

Catlin, A., Armigo, C., Volat, D., Valle, E., Hadley, M. A., Gong, W., et al. (2008). Conscientious objection: A potential neonatal nursing response to care orders that cause suffering at the end of life? Study of a concept. *Neonatal Network, 27*(2), 101-108.

Card, R. (2009). Federal provider conscience regulation: Unconscionable. *Journal of Medical Ethics, 35*(8), 471-472.

Carper, B.A. (1978). Fundamentals patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13-23.

Carnevale, F. A. (2009). A conceptual and moral analysis of suffering. *Nursing Ethics, 16*(2), 173-183.

Cavaliere, T., Daly, B., Dowling, D., & Montgomery, K. (2010). Moral distress in neonatal intensive care unit RNs. *Advances in Neonatal Care, 10*(3), 145-156.

College of Registered Nurses of British Columbia. (2007). *Practice standard: Duty to provide care*. Retrieved March 6, 2012 from https://www.crnbc.ca/Standards/Lists/StandardResources/398DutytoProvideCarePracStd.pdf

Committee of Bioethics. (2009). Physician refusal to provide information or treatment on the basis of claims of conscience. *Pediatrics, 124*(6), 1689-1693.

Department of Justice Canada. (1982). *Canadian Charter of Rights and Freedoms: Schedule B, Constitutional Act.* Retrieved March 6, 2012 from http://laws.justice.gc.ca/en/charter/1.html

Dickens, B. M. & Cook, R. J. (2000). Ethical and legal issues in reproductive health: The scope and limits of conscientious objection. *International Journal of Gynecology and Obstetrics, 71*, 71-77.

Dresser, R. (2005). At law: Professionals, conformity, and conscience. *Hastings Center Report. 35*(6), 9-10.

Edgar, A. & Pattison, S. (2011). Integrity and the moral complexity of professional practice. *Nursing Philosophy, 12*(2), 94-106.

Ferrell, B. R. (2006). Understanding the moral distress of nurses witnessing medically futile care. *Oncology Nursing Forum, 33*(5), 922-930.

Ford, N. J., Fraser, K. D., & Marck, P. B. (2010). Conscientious objection: A call to nursing leadership. *Canadian Journal of Nursing Leadership, 23*(3), 46-55.

Forsberg, R. P. (2001). Teaching virtue theory using a model from nursing. *Teaching Philosophy, 24*(2), 155-166.

Gustafsson, G., Eriksson, S., Strandberg, G., & Norberg, A. (2010). Burnout and

perceptions of conscience among health care personnel: A pilot study. *Nursing Ethics, 17*(1) 23-38.

Hardingham, L.B. (2004). Integrity and moral residue: Nurses as participants in a moral community. *Nursing Philosophy, 5(2),* 127-134.

Hefferman, P. & Heilig, S. (1999). Giving "moral distress" a voice: Ethical concerns among neonatal intensive care unit personnel. *Cambridge Quarterly of Healthcare Ethics, 8*(2), 173-178.

Hamric, A. B. (2001). Reflections on being in the middle. *Nursing Outlook, 49*(6), 254-257.

International Council of Nurses (2006). *The ICN code of ethics for nurses.* Retrieved March 6, 2012 from http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

Jacobson, J. (2005). When providing care is a moral issue. Is nurses' first priority protecting the patient or their own moral convictions? *American Journal of Nursing, 105*(1), 27-28.

Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues, 1*(4), 542-551.

Janvier, A., Nadeau, S., Deschenes, M., Couture, E., & Barrington, K.J. (2007). Moral distress in the neonatal intensive care unit: Caregiver's experience. *Journal of Perinatology, 27*, 203-208.

Jensen, A. & Lidell, E. (2009). The influence of conscience in nursing. *Nursing Ethics, 16*(1), 31-42.

Kain, V. J. (2007). Moral distress and providing care to dying babies in neonatal nursing. *International Journal of Palliative Nursing, 13*(5), 243-248.

Katz Sperlich, B., Conant, M., & Hodges, F. (1996). R.N. conscientious objectors to infant circumcision: A model for nurse empowerment. *Revolution, The Journal of Nurse Empowerment, Spring*, 86-89. Retrieved on December 29, 2011 from http://nurses.cirp.org/R.N._Conscientious_Objecto.html

Lawrence, R. E. & Curlin, F. A. (2007). Clash of definitions: Controversies about conscience in medicine. *American Journal of Bioethics, 7*(12), 10-14.

Lynch, H. F. (2008). *Conflicts of conscience in health care: An institutional compromise.* Cambridge, MA: Massachusetts Institute of Technology.

Mahle, J. V. (2009). Conscientious objection and the nurse: A right or a privilege? *British Journal of Nursing, 18*(20), 1262-1263.

McLeod, C. (2010). An institutional solution to conflicts of conscience in medicine. Review. *Hastings Center Report, 40*(6), 41-42.

Mennonite Central Committee. (2011). *Conscientious objection Canada*. Retrieved March 6, 2012 from http://canada.mcc.org/category/topics/conscientious-objection

Moland, L. L. (2006). Moral integrity and regret in nursing. In S. Nelson & S. Gordon (Eds.), *The Complexities of Care* (pp. 50-68). Ithaca, NY: Cornell University Press.

Morton, N. T. & Kirkwood, K. W. (2009). Conscience and conscientious objection of health care professionals refocusing the issue. *HEC Forum, 21*(4), 351-364.

Nathaniel, A. K. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research, 28*(4), 419-438.

National Association of Neonatal Nurses. (2006). *Position statement #3015: NICU nurse involvement in ethical decisions. (Treatment of critically ill newborns).* Retrieved March 6, 2012 from http://www.nann.org/uploads/files/3015_reviewed_February_2010.pdf

Nursing and Midwifery Council. (2010). *Conscientious objection*. Retrieved March 6, 2012 from http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Conscientious-objection/

Oberle, K. & Bouchal, S. R. (2009*). Ethics in Canadian nursing practice: Navigating the journey.* Toronto, ON: Pearson Education Canada.

Olsen, D. (2007). Editorial comment. *Nursing Ethics, 14*(3), 277-278.

Orr, R. D. (2010). Medical ethics and the faith factor: The endangered right of conscience. *Ethics & Medicine, 26*(1), 49- 54.

Pattison, S. & Edgar, A. (2011). The problem with integrity. Editorial. *Nursing Philosophy, 12*(2), 81-82.

Peter, E. & Liaschenko, J. (2004). Perils of proximity: A spatiotemporal analysis of moral distress and moral ambiguity. *Nursing Inquiry, 11*(4), 218-225.

Robinson, P. (2009). Integrity and selective conscientious objection. *Journal of Military Ethics, 8*(1), 34-47.

Royal College of Nursing (1998). *Position statement: Conscientious objection*. Retrieved March 6, 2012 from http://www.rcna.org.au/WCM/Images/RCNA_website/Files%20for%20upload%20and%20link/policy/documentation/position/Conscientious_objection-under_review_25Nov04.pdf

Salmasy, D. P. (2008). What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics 19*, 135-149.

Sanders, K., Pattison, S., & Hurwitz, B. (2011). Tracking shame and humiliation in accident and emergency. *Nursing Philosophy, 12*(2), 83-93.

Savulescu, J. (2006). Ethics: Conscientious objection in medicine. *British Medical Journal, 332*(4), 294-297.

Sellman, D. (2011). *What makes a good nurse. Why the virtues are important for nurses.* Great Britain. Library of Congress Cataloging in Publication Data.

Solomon, M.Z., Sellers, D.E., Heller, K.S., Dokken, D.L., Levetown, M., Rushton, C, Truong, R.D., Fleischman, A.R. (2005). New and lingering controversies in pediatric end-of-life care. *Pediatrics, 116*(4), 872-883.

Sundin-Huard, D. & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorizing the relationships. *International Journal of Nursing Practice, 5*, 8-13.

Tiedje, L. B. (2000). Moral distress in perinatal nursing. *Journal of Perinatal & Neonatal Nursing, 14*(2), 36-43.

Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press Inc.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in Interpretive Description. *International Journal of Qualitative Methods, 3*(1). Article 1.

Thorne, S., Reimer Kirkham,S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*, 169-177.

United Nations. (2010). *Declaration of Human Rights: Article 18.* Retrieved March 6, 2012 from http://www.un.org/en/documents/udhr

Vaiani, C. E. (2009). Personal conscience and the problem of moral certitude. *Nursing Clinical of North America, 14*(2), 36-43.

Waller-Wise, R. (2005). Conscientious objection. Do nurses have the right to refuse to provide care? *AWHONN Lifelines, 9*(4), 283-286.

Webster, G. C. & Baylis, F. (2000). Moral residue. In S.B. Rubin & L. Zoloth (Eds), *Margin of error. The ethics of mistakes in the practice of medicine.* (pp.217-228). Hegerstown, MD: University Publishing.

Wilkinson, J. M. (1988). Moral distress in nursing practice: Experience and effect. *Nursing Forum, 23*(1), 16-29.

Yam, B. M. C., Rossiter, J. C., & Cheung, K. Y. S. (2001). Caring for dying infants: Experiences of neonatal intensive care nurses in Hong Kong. *Journal of Clinical Nursing, 10*, 651-659.

APPENDIX A

STUDY ADVERTISEMENT

Study Advertisement

Are you an NICU nurse? Have you experienced a conflict of conscience[1] as a NICU nurse?

If so, I would like to hear about your experience.

To participate in this study you must:

- Have at least one year of neonatal nursing experience
- Be willing to be interviewed over the phone or in person by the researcher
- Feel able to describe your experiences with conflicts of conscience as a neonatal nurse in the NICU

[1] A conflict of conscience can be defined as feeling a practice or procedure is against your deeply held moral or religious beliefs. By asking to refrain from an aspect of care because of this conflict is called conscientious objection (CNA, Code of Ethics, 2008).

For more information about the study please contact me, Natalie Ford.

Please pass this invitation on to your neonatal colleagues!

Thank you!

Natalie Ford [redacted] **Email:natalie.ford@ualberta.ca**	**Natalie Ford** [redacted] **Email:natalie.ford@ualberta.ca**	**Natalie Ford** [redacted] **Email:natalie.ford@ualberta.ca**	**Natalie Ford** [redacted] **Email:natalie.ford@ualberta.ca**

APPENDIX B

INFORMATION LETTER

Information Sheet

Project Title: **Conflicts of Conscience in Neonatal Intensive Care Units: Perspectives of Neonatal Nurses in Alberta**

Researcher: Natalie Ford, MN Student, Faculty of Nursing, University of Alberta: Phone: [redacted]

Supervisor: Dr. Wendy Austin, Professor, Faculty of Nursing, University of Alberta. Phone: (780) 492-5250

Background

Current research of moral distress in nursing continues to demonstrate distress when the nurse provides care to which they are morally opposed. The 2008 Centennial Edition of the Canadian Code of Ethics for Registered Nurses included a new section highlighting appropriate action to follow when the nurse finds assigned care is in conflict with their religious or core moral beliefs(conflicts of conscience) (CNA, 2008). This action has been termed "Conscientious Objection".

Purpose of Study

This study is asking registered nurses working in neonatal intensive care within Alberta to describe their individual experiences with conflicts of conscience in the NICU. By capturing these experiences I hope to further develop the understanding of conflicts of conscience for neonatal nurses in NICU.

Eligibility

Neonatal nurses who meet the following criteria are eligible to participate:

Neonatal nurses who feel they have had an experience with conflicts of conscience in the NICU, have worked an NICU within Alberta for at least 1 year within the past 5 years, and are willing to discuss their experiences with the nurse researcher (Natalie Ford, MN student). Neonatal nurses in Alberta who have left the profession within the last year, who meet the above criteria, are also eligible to participate.

Study Procedures

Eligible neonatal nurses are asked to contact the researcher and a mutually agreed upon time will be arranged to conduct the interview either by telephone or in-person (Edmonton area) according to the participant's preference. Interviews will last from 40-90 minutes. The nurse participant will be asked to describe his or her experience with conflicts of conscience while working in the NICU. Open-ended questions will be used to further explore these experiences of the nurse. The interviews will be audio-taped and then transcribed (typed out word for word) to allow for data analysis. Participants may withdraw from this study without question at anytime. Additionally the participant may request that the audio recorder be shut off during the interview at any time.

Risks and Benefits

A potential benefit of study participation includes the freedom to explore experiences of conflicts of conscience in an anonymous and confidential arena. It is recognized that some nurses may not feel comfortable talking about these issues at their current worksite. As well, it is an opportunity for nurses to contribute to the understanding of this aspect of nursing ethics. It is recognized that discussion of conflicts of conscience may be distressing for some participants. My supervisor, who has a mental health background, will be available to assist in debreifing sessions if any are requested. If an alternative counselling option is requested this will be addressed on an individual basis and local resources can be explored.

Confidentiality

Ethics approval has been obtained by the Health Research Ethics Board of the University of Alberta. Confidentiality and anonymity (protection of identifying factors) of the participants will be maintained according to Research Ethics involving Human Subjects guidelines. Names and identifying factors will be removed from the transcript and will not appear in the publication of the data. Pseudonyms will be used. Transcripts will only be available to my supervisor and myself for data analysis. All data collection materials will be protected in a locked cabinet for a period of 7 years. In the province of Alberta, the law requires the reporting of any harmful or illegal activities revealed by the participant. As well, if the participant declares to the researchers that s/he is "not fit to practice", the researchers are required to report this to the College and Association of Registered Nurses of Alberta.

Further Contact

Please contact Natalie Ford for any further information at natalie.ford@ualberta.ca or by personal phone [redacted]

Contact Names and Telephone Numbers:
If you have concerns about your rights as a study participant, you may contact the Research Ethics Office at (780)492-2615. This office has no affiliation with the study investigators.

Please contact any of the individuals identified below if you have any questions or concerns:
Name and title: Natalie Ford *Telephone Number:* [redacted]
Name and title: Dr. Wendy Austin *Telephone Number: (780) 492-5250*

Reference: Canadian Nurses Association. (2008). Code of Ethics for Registered Nurses: 2008 Centennial Edition. Ottawa: *Canadian Nurses Association.* Retrieved on December 6, 2010 from http://www.cnaaiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf

APPENDIX C

INTERVIEW QUESTIONS

Interview Questions

Demographic data:

Age, gender, years as a neonatal nurse, years as a nurse, religious (yes/no)

1. How did you come to work in the NICU?
2. Tell me about an experience when you felt you had a conflict with your conscience or core moral beliefs in the NICU.
3. How did this conflict make you feel? What was the conflict like for you?
4. How did you react to this conflict? What did you do?
5. Did you feel supported?
6. What barriers, if any, inhibited you from declaring or talking about this conflict?
7. Have you experienced moral distress when you did not act on your conscience as an NICU nurse?
8. Have you ever declared a conflict in CO? Prior to employment? To what? Tell me about it.
9. What concerns you about CO?
10. Suggestions for change?
11. Do you know of any guidelines or policies that a neonatal nurse can follow if they want to declare a conflict of conscience? What do you know about them?
12. How do you feel now after talking about these conflicts?
13. How did you feel about this interview? (added to the end of all interviews)

Additional interview questions added after data analysis of first three interviews:

14. Is acting on your conscience or moral beliefs important? Why?
15. Do you think it is part of the nursing role to identify these conflicts? How's so?

APPENDIX D

CONSENT FORM

Consent Form (On University of Alberta Letterhead)

CONSENT CHECKLIST

Part 1 (to be completed by the Researcher):

Project Title: Conflicts of Conscience in Neonatal Intensive Care Units: Perspectives of Neonatal Nurses in Canada

Researcher: Natalie Ford, MN Student, Faculty of Nursing, University of Alberta

Supervisor: Dr. Wendy Austin, Associate Professor, Faculty of Nursing, University of Alberta (780) 492- 5250

Part 2 (to be completed by the research participant):

Do you understand that you have been asked to participate in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you and do you understand who will have access to the interview data?	Yes	No

This study was explained to me by __Natalie Ford_____

I agree to participate in this study.

_____ _____

Signature of Study Participant Date

_____
Printed Name

_____ _____
Witness Date

_____
Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Researcher Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH PARTICIPANT.

Contact Names and Telephone Numbers:
If you have concerns about your rights as a study participant, you may contact the Research Ethics Office at (780)492-2615. This office has no affiliation with the study investigators.

Please contact any of the individuals identified below if you have any questions or concerns:
Name and title: Natalie Ford *Telephone Number:* [redacted]
Name and title: Dr. Wendy Austin *Telephone Number: (780) 492-5250*