A Comparison of Physicians' and Nurses' Responses to Selected Ethical Dilemmas

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Abstract

In ethical decision making, some research shows that nurses stress patient autonomy while physicians stress beneficence (Robertson, 1996). When these two ethical principles are in conflict, which takes precedence? In addition, other research states that nurses encounter more moral distress than physicians in their everyday ethical environment. The purpose of this study was to explore the similarities and differences of physicians' and nurses' responses on four different ethical dilemmas. The dilemmas included surgical error; end-of-life care; possible physician or nurse drug use; and the medical repatriation of an illegal immigrant. Additional questions were asked relating to any formal ethics training as well as if the participant had ever experienced any moral distress at the outcome of an ethical situation. The physicians and nurses were invited to share written comments after each dilemma.

Exactly 67 nurses and 26 physicians completed the questionnaires. Descriptive statistics were used to show participant characteristics with all the variables as well as the numbers of persons choosing the different responses to the dilemmas. Tests of significance were done to assess these relationships. Interestingly, this study found that physicians and nurses reason more alike than differently on ethical dilemmas. There was only one response where physicians and nurses reasoned significantly different. Similarly, an equal number of physicians and nurses had experienced moral distress in the past. The variables of religion, gender, education, and ethnicity were significant for some of the responses to the dilemmas. Strategies will be suggested to enhance moral reasoning and possible lessen some moral distress.

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Introduction

In a perfect world, physicians and nurses practice with the same goal in mind—ethical caring for all persons served. With multiple stressors and institutional pressures present, is the moral work of healthcare getting done? In practice settings today, healthcare is not seen as moral work, but whatever needs to be done to get the job accomplished to meet the bottom line (Storch and Kenny 2007). In a list of priorities, moral work would come at the end. Anyone in a health care setting recently knows that it's in chaos. Ethical dilemmas abound. Everyone expects healthcare workers to act at a Ghandian level of moral reasoning. Certainly patients expect this and have every right to.

Professional experiences and personal values in prior studies influenced the attitudes of physicians and nurses when pondering ethical dilemmas. Research has shown that nurses are more concerned about the inappropriate use of end-of-life treatment than physicians (Carmel, et al. 2007). This study also showed that the law was the driving force for nurses and that they placed more importance on autonomy, while patients' wishes were the most important factor for

physicians. Of note is that most nurses are institutional employees where legal norms are expected. Physicians have more difficulty with dealing with psychosocial and spiritual care at patients' end-of-life, and religion was more important to nurses (Carmel, et al. 2007).

With much conflicting information regarding physicians' and nurses' reactions to ethical situations, the current study was conducted to compare their choices to four selected dilemmas. Responses to the dilemmas reflect different ethical principles. Reasoning using ethical principles as a guide reflects reasoning at a principled level, the highest level in moral development.

Review of Literature

Moral Development

Lawrence Kohlberg, the Father of Moral Development, used Piaget's cognitive-development approach to analyze the different ways that individuals perceive themselves in the social world. Like Piaget, Kohlberg saw moralization as a process of internalization of cultural or parental norms (Kohlberg 1976). Kohlberg identified six stages of moral development, encompassing three levels, through which an individual progresses in developing principled moral thinking as shown in Table 1. The third postconventional level (Stages 5 and 6) is the Principled level and may occur after age 20 in a minority of adults. A person at this level attempts to clearly define universal moral values in terms of self-chosen principles. In health care, those principles include autonomy, beneficence, nonmaleficence, justice, veracity, fidelity, and justice. The stages of moral development are hierarchical and attainment of each stage of moral judgment is prerequisite to attainment of the next higher stage (Kohlberg 1976). Movement to the next step of development rests not only on exposure to the next level of thought, but to experiences of conflict of the individual's current level of thought with ethical situations (Kohlberg and Blatt, 1973, 4). Higher state reasoning is assimilated only if cognitive conflict is stimulated. Moral reasoning at a stage higher than one's own leads to increased moral thinking at the next higher stage, only if it disagrees with, or introduces uncertainty into, the individual's own decision on moral dilemmas (Kohlberg and Blatt 1973,5; Rest, Turiel, and Kohlberg 1969, 237).

Table 1 Kohlberg's Theory of Moral Development

Levels and Stages	Orientation
Preconventional Level	
Stage 1	Punishment and Obedience Orientation
Stage 2	The Instrumental Relativist Orientation
Conventional Level	
Stage 3	The Interpersonal Concordance or "Good Boy-Nice Girl"
Stage 4	Orientation
	Society Maintaining Orientation
Postconventional, Autonomous, or Principled Level	The Social Contract Orientation
Stage 5	The Universal Ethical Principle Orientation
Stage 6	

(Kohlberg 1981,p. 17-19)

The majority of adults in American society use conventional (Stages 3 and 4) moral judgment (Rest, Turiel, and Kohlberg, 1969, 241; Kohlberg 1981). Kohlberg's stages do not reflect the outright decision of the individual, but the reasons which reflect how one reached the decision. While Kohlberg's theory does not predict what action a person will take, it does serve to clarify ethical reasoning, which permits more effective discussion of moral issues. The ethical theories which correspond to each of Kohlberg's levels tend to move from egoistic to altruistic concerns (Allen and Fowler, 1982, 20).

Gilligan (1977, 1982) who studied with Kohlberg questioned his research findings as they were focused solely on males. She found that the moral reasoning and development of women and men differed. Her research showed that women placed more importance on relationships and caring for themselves and others rather than rules and principles. Gilligan's theory on women focused on care considerations. In a research study by Peter and Gallop (1994), it was found that the differences between nursing students and medical students were not related to position, but rather to gender. Females used care considerations more frequently than males.

Ethical reasoning of physicians and nurses

Almost thirty years ago, nursing theorists Crisham (1981) and Ketefian (1981) showed the significance of formal education in improving one's moral reasoning abilities. The higher the educational level, the higher the level of moral development. Autonomy is usually cited as the most important principle held by nurses. Carmel et al.'s (2007) study found that physicians rated personal autonomy or patients' wishes higher than nurses. The authors stated that one reason might be that physicians are more autonomous and the decision makers, whereas nurses perceive the law as the driving force and follow physicians' orders. These nurses were all working in institutions where convention is the rule. de Casterlé's (2008) study used Kohlberg's stages of moral development and found that while nurses tended to use conventions as their predominant decision-guiding criteria (which is stage 4); nurses in general evaluate stage 5 statements as most important arguments in making an ethical decision. Stage 5 is the first of two stages in the postconventional or principled level of moral development. Other studies show that nurses are in stage 3 (Kudzma 1980; Aroskar 1982). Seventy percent of all Americans reason at the conventional level of moral reasoning which is stage 3 or 4. Nurses tend to use conventions or laws to guide their decision making in ethical dilemmas rather than patients' personal needs. (Carmel, et al. 2007; de Casterlé, et al. 2008).

Oberle and Hughes (2001) conducted a small qualitative study comparing physicians and nurses perceptions of ethical problems and found that the differences were a function of the professional role rather than differences in moral reasoning. They cited that while physicians make the decisions, nurses must live with the ultimate decision. In a historical article regarding nurses and physicians in the nineteenth century, Nolte (2008) shares that physicians were always responsible for truth telling (fidelity) to patients but that nurses were able to circumvent some of these 'rules' as they were perceived as being responsible for the spiritual care of patients. With this in mind, nurses were able to share information with patients related to meeting their spiritual needs, superseding physicians' wishes.

Moral distress

Moral distress has been prevalent for decades. The first author to discuss this was probably Jameton (1984) with his seminal work more than 25 years ago. A new nursing

diagnosis for moral distress was listed as of 2007. Moral discomfort is extreme discomfort in a patient care situation that results when one knows what one ought to do, but because of internal or external constraints, ends up doing what one knows is morally wrong (Corley, 2002; Pendry, 2007; Badger and O'Connor 2006). The discomfort may affect mind, body, spirit, or relationships. Many nurses leave the profession because of the inability to handle this added moral stress to everyday home and work stress (Pendry 2007).

Tools have been developed to measure moral distress (Corley et al. 2001; Sporrong et al. 2006) and models have been constructed to guide nurses through the process to hopefully manage moral distress (Fry et al. 2002; Corley 2002; and Nathaniel (2006).

Methods

Approval for the current research was obtained from the Institutional Review Board of a southeastern American university as well as an Ethics Board from a for-profit hospital in southeast Florida. Full approval was also granted by the hospital administration. Two hundred packets were disseminated throughout the hospital. Each packet contained an introductory letter with informed consent information from one of the researchers; a demographic sheet; four case studies; and a return envelope. The sealed envelope was to be returned to one of several locations within the hospital. Because the envelopes were sealed and bulky, when the researcher was called after several weeks to pick them up, it was assumed that the majority had been completed. Upon further note, only 93 (48%) of the packets were returned. When one of the Directors at the hospital was questioned about this, she asked some physicians and nurses. They stated that the packet was sitting on their desk; they meant to complete it and didn't get around to it; or said they were waiting for time to write in additional comments; or asked if they could now fill it out. As quite a bit of time had elapsed, the researchers went with what was completed.

The four case studies can be seen in Table 2. Each case study came with a set of responses that the participant could choose as well as writing in additional comments. The case studies are hypothetical and no reference to any person is intended. Each case study involves vastly different ethical content areas. The purpose of this research was not to expound on these content areas but rather to examine the choices that participants made to see the similarities and differences of choices made by physicians and nurses to the dilemmas.

Table 2. Case Studies

Scenario Number	Scenario
1	Dr. M. is a 64 year old surgeon. His surgical nurse, Sally, has lately been suspecting some kind of neurological problem as Dr. M's hands seem to have a small tremor during surgery. No one else seems to notice anything amiss. Sally's friend Marjory recently underwent surgery by Dr. M. for uterine fibroids and during the surgery her colon was nicked. Subsequently Marjory has had an extended stay in the hospital and developed septicemia. Marjory's husband, Frank, asks Sally what happened during surgery because Marjory was supposed to be home by now.
2	Mr. Michael is a 49-year old patient with hypertension, diabetes, hyperlipidemia, and obesity. He has been on dialysis for 6 years and has exhausted all access sites for dialysis catheters. His fistulas never last very long due to his advanced diabetes. With his frequent infections, the staff know that without dialysis he won't live more than a week. He probably has a few sites left for temporary catheters. Mr. Michael has become increasing less responsive and his family is expecting everything to be done for him. He has no advanced directives.
3	George M. (could be a physician or a nurse) has been under a lot of stress lately. He is going through a very public divorce and his 15 year old daughter was just admitted to a rehab center for drug abuse. Last week you personally saw him very upset, enter the lounge, have a cup of coffee, read the paper, and then walk out seemingly calm and collected. Tonight, as you walk in the lounge, you see George sitting in the corner by himself, emptying a capsule into his coffee. You walk out unseen, and wonder what to do.
4	Jose Rivera, age 25, is an illegal Honduran immigrant. He was admitted to the hospital after the landscaping truck he was riding in overturned on the highway. After multiple surgeries, bilateral above the knee amputations, and over a million dollars in bills, he is ready to go to a rehabilitation facility. There is no rehab facility that will accept Mr. Rivera because of reimbursement issues. The hospital is contemplating medical repatriation where they would pay $30,000 for an air ambulance to forcibly return him to a hospital in Honduras. The hospital can no longer give free medical care for an extended stay.

Sample

In addition to the usual demographic questions of position; gender; level of education; years of experience; ethnicity; and religion; there were two additional questions. One question asked if the participant had any formal ethics training, and the other question asked if the participant had ever experienced moral distress in the outcome of an ethical situation. The

characteristics of the sample can be seen in Table 3. Of the 26 physicians and 67 nurses, 7 (27%) of the physicians were females and 6 (9%) of the nurses were males.

Table 3 Participant Characteristics (N=93)

Variable		*n*	(%) [a]
		93	
Position	Nurses	67	72
	Physicians	26	28
Gender	Males	25	27
	Females	68	73
Educational Level	ADN	32	34
	BSN	22	24
	MSN	9	10
	MD	23	25
	DO	3	3
	Not stated	4	4
Ethnicity	White, non-Hispanic	63	68
	Hispanic	4	4
	African American	3	3
	Asian	15	16
	European	1	1
	Pacific Islander	4	4
	Other	3	3
Years of Experience	<5years	12	13
	5-9	12	13
	10-14	18	19
	>15	51	55
Religion	Spiritual, no religion	17	18
	Atheist	1	1
	Protestant	9	10
	Catholic	44	47
	Jewish	6	7
	Other	16	17
Prior ethics training	Yes	41	44
	No	50	54
	Not stated	2	2
Experienced moral distress in the past	Yes	32	34
	No	59	63
	Not stated	2	2

Note [a] Totals may not equal 100% because of rounding

With the question regarding formal ethics training, less than half of the respondents stated that they had received any. Many interpreted this question as to any ethics training at all such as

several hours at a continuing medical education (CME) seminar or a continuing education unit (CEU) meeting. The question meant to elicit information about formal education in ethics such as a college credit course, etc. Surprisingly, even with CME and CEUs, more than half (54%) stated that they had no training whatsoever. Over half of the participants reported they had never experienced moral distress related to the outcome of an ethical decision and 34% stated they had.

Results

Descriptive statistics were used to show participant characteristics with all the variables as well as the numbers of persons choosing the different responses to the dilemmas. Chi square tests of significance were done to assess the relationship between the variables and the choices made to the responses to each of the case studies. Different variables were significant related to different choices on each of the case studies as shown in Table 4. After the choices following each case study was an open ended question asking for the participants' thoughts and feelings.

At the end of the structured questionnaire, participants were asked to share an experience that they would describe as morally distressing. Fourteen participants or 15% chose to do so. Ethnicity was significant ($p<.01$) for this variable. 87% of Asians had never experienced moral distress. The ratio was much more evenly distributed for other ethnicities. Some of the participant responses to the question related to moral distress include the following examples:

"A child was extubated prematurely and had epiglottis, eventually was brain dead and required meeting to discontinue the ventilator"

"Patients being kept alive when no functional outcome is expected"

"Patients being heavily sedated for safety reasons"

"Patients not shipped off to trauma hospitals that were in critical status"

"It is distressing to try all known methods to treat the patient and for all the effort not to save the patient's life. I worry when I reach the 'pearly gates' if I will be held accountable for all I put patients through before they died".

Case Study #1 Suspected Surgical Error

Religion was significant for two different responses to this scenario as shown in Table 4a. The majority of respondents did not think that the surgical nurses should admit to the patient's (her friend) husband that there was a complication during surgery. Religion was also significant for the fact that the surgeon should not share his physical problem with the Chief of Surgery but rather wait until a 'work-up' of his hand tremors was completed. Beneficence or acting

positively to do good is reflected here by not jumping to conclusions and getting all the facts regarding the surgeon's hand tremors before making a career altering decision.

There was an overwhelming majority of respondents who felt that Sally should tell Dr. M that she has been aware of the tremors for some time. 89% of the nurses and 81% of the physicians felt this way. In addition, 87% of females and 88% of males concurred.

There were 27 (29%) additional comments written in after case study #1. While nicking the bowel is a potential complication of abdominal surgery, it cannot be assumed that it was due to the hand tremors of the surgeon. Comments addressed veracity and confidentiality. Respondents wrote that the conversation between Sally and the surgeon should have occurred long before this surgery as she was aware of his hand tremors for some time. Dr. M. has an ethical responsibility for admitting the complication (and not call it an accident) both to the family and to the Chief of Surgery. Several commented that an incident report should be done and whether the surgeon does it or the surgical nurse, the Risk Manager, needs to be aware of this. Dr. M. needs to be honest with the family and in truth, at this point in time, it is an accident. One last comment stated that due to confidentiality, Sally should notify her supervisor and certainly not the family.

Table 4a. Scenario 1 (Suspected Surgical Error) Responses

	Item	Response	%
A.	Should Sally admit to Frank that there was a complication during surgery?	Yes	34
		No	64
		Religion* (selected 'no')	
		Catholics	80
		Protestants	66
		Spiritual but no religion designated	53
		Jewish	50
		No religion identified	42
B.	Should Sally confront Dr. M. about his tremors and tell him that she has been aware of them for some time?	Yes	87
		No	13
C.	Should Dr. M. tell Frank that there was, but not admit he caused it a problem during the surgery?	Yes, but not admit he caused it	25
		Yes, say it was an accident	70
		No	5
D.	Should Dr. M. share his physical	No, he should wait until the 'work	11

	up’	
problem with the Chief of Surgery and stop doing surgery until he can be ‘worked’ up?	Religion** (selected ‘no’)	
	Catholics	50
	Protestants	16
	No, it’s his personal problem	2
	No answer	4
	Yes	83
	Nurses*	93
	Physicians	62

* P. < .05

**p. < .01

Case Study #2 End-of-Life

In scenario #2, the variables of education and ethnicity were significant. One hundred percent of Master’s prepared nurses felt that Mr. Michael’s competency should be determined the next time he was awake and lucid. With the question whether the Hospital Ethics committee should get involved in this situation, the majority of most ethnicities felt that the decision should be left to the physician and the family. 75% of the Hispanics felt that getting the ethics committee involved would get everyone focused on the same goal.

Supporting Mr. Michael’s autonomy and his right to make his own decisions should he be lucid for a brief period were 72% of the nurses and 77% of the physicians. 88% of the males and 85% of the females felt this way. There were 17 (18%) additional comments written in following the case study. Communication was mentioned in every one of them. Respondents felt that communication should have been from day one between all persons involved. One person said that “reality needs to be faced before it actually hits one in the face.” Most felt that the physician and the family should try to come to a consensus before the ethics committee is consulted. As this case scenario has continued for so long, 64% of males and 63% of females felt that an ethics committee should get involved now.

Table 4b. Scenario 2 (End of Life) Responses

	Item	Response	%
A.	What level of treatment should be considered?	Continue as is until dialysis sites are exhausted	89
		Terminate treatment now	10
		No answer	1
B.	Is Mr. Michael competent?	Determine competence when he's awake	85
		Education*	
		MSN prepared nurses	100
		Nurses	89
		Physicians	77
		Obviously, he's not competent as he's in renal failure	11
		No answer	4
C.	What should be the level of family involvement?	Respect family's wishes and do everything possible	19
		Ask family about prior wishes related to directives	74
		Have family sign DNR now	2
D.	Should an Ethics Committee get involved?	No, leave it to the Dr. and family	34
		Ethnicity*	
		African-Americans	67
		Caucasians	63
		Asians	60
		Yes, it may get everyone focused on the same goal	64
		Ethnicity*	
		Hispanics	75

* P. < .05

Case Study #3 Potential Healthcare worker drug abuse

Years of experience and gender were the two variables that were significant in this scenario. Persons with more than 15 years of experience felt that the situation called for watching George's behavior and seeing how he acts. 78% of females felt that George should be confronted and asked what it was that he actually was putting in his coffee while only 22% of males felt this way. Veracity involves truth telling and confronting George might encourage him to open up and tell the truth.

88% of males and 93% of females supported George's autonomy by agreeing to watch his behavior and see how he reacts. There were 13 (14%) additional written comments following this scenario. Several people mentioned patient safety in that it "comes first despite our own personal stress levels. Again, it is professional responsibility to keep principles, honesty and integrity in our position." Some agreed with patient advocacy and stated that we must protect the patient and not wait for something injurious to happen. Confidentiality was cited and a remark made that all the evidence was circumstantial and that to intervene is an invasion of privacy. One mentioned the need for "compassionate confrontation."

Table 4c. Scenario 3 (Potential Drug Abuse) Responses

	Item	Response	%
A.	What is your initial response?	It was probably just some kind of sugar	5
		I want nothing to do with it	2
		I'll just watch his behavior and see how he reacts	91
		Participants with >15 years of experience*	98
B.	Should you confront George about what you saw?	No, I should report it up the chain of command	33
		No, I'll just watch his behavior	16
		No, I'll call security, have him go to ED for drug test	1
		No, I'll report him to the State Board	0
		Yes, I should ask George	47
		Gender**	
		Females	78
		Males	22

* P. < .05

**p. < .01

Case Study #4 Medical Repatriation

78% of the nurses and 65% of the physicians felt that Jose should be medically repatriated ASAP. 68% of the men agreed with this. 28% of the females and 18% of males felt

that Jose should stay and the hospital absorb the bill. Ethnicity was the only variable that was significant in this scenario. The majority of persons felt that Jose should be medically repatriated back to Honduras as soon as possible. All of the African Americans felt that he should be allowed to remain in the U.S. and receive free treatment here.

This scenario had the most written comments following the choices. There were 44 (47%) additional comments. Many comments referred to the negative impact on the economy and that if "this country cannot take care of its own, why should we take care of someone else?" Many felt that other resources should be explored such as charitable organizations. Several respondents referred to the humaneness of care and that Jose was a hard worker ("unlike some U.S. citizens") and deserves the same treatment as American citizens. Other respondents cited different cases in the hospital where patients are receiving 'free care' and stated that Jose is just as deserving as those patients are.

This study seems to support Oberle and Hughes' (2001) study comparing physicians and nurses perceptions of ethical problems which found that the differences were a function of the professional role rather than differences in moral reasoning. Case study #1 was the only situation where there was a significant difference in the nurses and physicians findings and that was only to one response. This case study involved vastly different professional roles- that of a surgeon and his surgical nurse.

Table 4d. Scenario 4 (Medical Repatriation) Responses

	Item	Response	%
A.	What is your initial response?	Jose will have to stay in the U.S. and the hospital will have to 'eat' the expense	21
		Medically repatriate ASAP	74
		Ethnicity**	
		Asians	85
		Caucasians	80
		Hispanics	75
		African-Americans	0
		If the hospital cuts back on other expenses, such as raises, patients like Jose could stay here	2

* P. < .05

**p. < .01

Discussion

The fact that Asians had never experienced moral distress before is interesting. A large percentage of Asian nurses in southern Florida are invited to leave the Philippines and relocate to S. Florida. They are given many incentives. How are the Philippines preparing nurses to handle moral distress? Are they doing a better job than nursing programs in the U.S. or are Philippine nurses not exploring all aspects of moral situations? The focus of this article is not on moral distress. A research study on this topic is currently being conducted by the authors.

Carmel et al. (2007) found that religion was more important to nurses than physicians. The majority of all respondents regardless of religion felt that in scenario #1 that fidelity was important in that disclosure should not be hastily shared and there is loyalty to the institution. Respondents were also loyal to the surgeon and giving him the benefit of the doubt until he could have a 'work-up' of his hand tremors and a diagnosis be made. They were also supporting the surgeon's autonomy.

Crisham (1981) and Ketefian (1981) found that the higher the education level, the more support for autonomy. This was supported in scenario #2 when 100% of master's prepared nurses, as well as the majority of nurses and physicians supported the patient's autonomy by asserting that Mr. Michael's competence should be assessed when he's awake rather than assuming he's incompetent because of lethargy due to his end-stage renal disease. The majority of the respondents also supported the families autonomy by requesting that they make decisions with the physician rather than involving an ethics committee. Decisions such as this used to be made in the bedroom of the home, then the boardroom of the hospital, now it seems like they are made in the courtrooms.

It is not surprising that respondents with more experience (>15 years) want to watch George's behavior and see how he reacts after putting something in his coffee in scenario #3. This could have been anything from a sugar pill to an herbal headache remedy. Only experience can gain one the insight to delve further into exploring all the possibilities. These respondents were respecting George's autonomy. The fact that confronting George was significant for females takes into consideration the relational caring and those care considerations (Peter and

Gallop 1994) that females are willing to explore the reasons with George rather than make assumptions about George.

Respondents identified with the dire conditions of the hospital's economic welfare with the majority of them wanting to send Jose back to Honduras in scenario #4 and not have the hospital pay any more than the one million dollars already paid. They apparently felt this was a just solution. The fact that all the African Americans wanted to keep Jose in the U.S. is interesting, but only involves 3 individuals.

Conclusion

This study found that physicians and nurses reason more alike than differently on ethical issues. There was only one response that was significant between physicians and nurses in one of the scenarios (1D) where the professional role differences were the most different. The more education one has, the higher the level of moral reasoning. This has been proven in different studies. Respecting one's autonomy and using ethical principles to guide one's actions is reasoning at a principled level. Years of experience affect outcomes with the ability to reason critically. This was shown here. Years of experience goes hand in hand with educational level as typically the older the person, the more education he/she has had. Several studies showed that religious background influences one's choices. This was also supported here in several scenarios.

Do Not Resuscitate (DNR) orders are very contentious and frequently cause a rift between families and healthcare workers. There is a move to change the terminology to AND which is Allow Natural Death. The end result is the same, but it implies a more positive approach about what is allowed to happen as opposed to a negative approach—what is not to be done at the end of life. Physicians, nurses, and ethics committees should be encouraged to make this recommendation to their facilities to align with a compassionate philosophy of caring.

When conflicts of duty arise, a nurse at the conventional level of moral reasoning will not be able to function in a client advocacy role but rather at what best suits the institution in which the individual is working. Nurses need to function at the post conventional level, which supports the need for moral development theory to prepare professionals. Both Codes of Ethics for Nurses and Physicians should be used as guides in any situation involving ethical choices.

Physicians and nurses are often faced with ethical dilemmas, which may be situations with two equally unsatisfactory choice, or situations where there is a conflict between two ethical principles. With the number of participants in this study not having had any ethics training, it is a wonder that more of them didn't state that they had experienced moral distress in the past. Although having ethics training does not preclude having moral distress. As these physicians and nurses were working in an institutional setting, that seems the likely venue for some changes to take place. Ethics education must occur for both physicians and nurses, and hopefully with them together so they can dialogue on their similarities as well as differences. Nurses need to be empowered to feel comfortable in discussing issues with physicians whether it be questioning a technique, or consent form, or sharing another point of view, or advocating for the patient. All disciplines could benefit from enhancing their intra-and inter-professional relationships.

More than thirty-five years ago Kohlberg and Turiel (1971) found that it is possible to progress to the next highest stage of moral reasoning by discussion of ethical conflicts. Certainly ethics rounds would be a way of accomplishing this. Physicians and nurses could round with other healthcare professionals in patients' rooms and include their families in their discussions. If this becomes the norm, there may not be the need for many issues to be presented at the ethics committee meetings. This may also lessen some moral distress currently encountered in healthcare facilities.

The ethics committees in hospitals need to be very visible. Staff need to know what the ethics committees' functions are, who can access them, how to access them, and how they may benefit from them. With increased experience being so important with regard to moral decision making, experienced physicians and nurses must be retained. In addition, when there is decreased moral distress in a setting, retention rates improve. Future research is needed regarding moral distress. This is the topic of a future research study by these authors.

The American Association of Critical Care Nurses has published a free handbook on "The 4A's to rise above moral distress" using Ask, Affirm, Assess, and Act. The handbook is a very positive tool that may be utilized to create a caring environment where moral distress is looked at as an opportunity for growth. It stresses the need for collaboration.

Moral development is an ongoing process. Getting involved in dialogue with all coworkers and friendly arguing about situations involving cognitive conflict is one way to raise one's level of moral reasoning. Perhaps this is a way to resolve some conflicts related to moral distress. Future studies need to be done to see what works in decreasing moral distress so hospitals and other healthcare agencies will be able to retain competent, compassionate, caring workers who are able to reason at a principled level. If this is accomplished, perhaps then health care can be seen as moral work and not only healthcare workers but patients and families will also benefit.

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