

Caring About Care in the Hospital Arena and Nurses' Voices in Hospital Ethics Committees: Three Decades of Experiences

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Introduction

Debates about care from an ethical perspective evolved in the 1980s and the work by Carol Gilligan (1982) and Nel Noddings (1984) in particular were influential in healthcare (Gallagher 2014; Kohlen 2009). In the USA at the same time, the inclusion of nurses in clinical ethics deliberations and their participation in Hospital Ethics Committees (HECs) was demanded so as to bring in their voice (Aroskar 1984; Fost and Cranford 1985; President's Commission 1983; Youngner et al. 1983).

Over the past 30 years, many countries have encouraged or mandated hospitals to have multi-professional HECs. For example, in Germany, the German Lutheran and Catholic Church Association published in 1997 a joint recommendation brochure to establish HECs (Deutscher Evangelischer Krankenhausverband and Katholischer Krankenhausverband 1997). Significant functions of HECs are to conduct ethics consultations, patient care review, develop policies and

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organize ethics education. The committees usually meet once a month at a certain time and place in the hospital.

Engagement in caring about care in the hospital arena from an ethical perspective and trying to bring in nurses' voices in HECs can be seen as a reaction to care deficits and loosening care practices that harm patients. Nurses in countries with distinctly different healthcare systems like Germany, Norway, the USA and Canada report similar shortcomings in their work environments and the quality of hospital care. A study in 2001 of more than 43,000 nurses practicing in more than 700 hospitals in 5 countries indicates that fundamental problems in the organization of work are widespread in hospitals in Europe and North America (Aiken et al. 2001, 2013). Maria Schubert and her colleagues (2008) as well as Beatrice Kalisch (2006) even refer to "missed nursing care".

Nurses reported spending time performing functions that did not call upon their professional training (delivering and retrieving food trays or transporting patients), while care practices requiring their skills and expertise (oral hygiene, skin care) were left undone (Aiken et al. 2001).

Studies in Canadian hospitals reveal what actually happens to nurses' care-giving in a hospital that is organized to be both efficient and effective in the use of its resources (Rankin and Campbell 2006). What emerges is a troubling picture for those who value and conceptualize care as a core practice for those who are dependent and vulnerable (Kittay 1999; Tronto 1993).

In this chapter, nurses' ethical problems in hospital care and their participation in HECs are traced over the last 30 years on the basis of studies in nursing ethics. HECs are seen as a discursive space to bring ethical problems to a head, including conflicts of care. Nurses' voices of care are illustrated using a field study in Germany (Kohlen 2009) as an example. While studies of nurses' participation in HECs can be traced back to the 1980s, investigations into their ethical concerns in hospital care go back to the 1990s.

Nurses' Ethical Concerns in Hospital Care

The dominant concerns found in stories and narratives of everyday nursing practice are of caring, responsiveness to others and responsibility (Benner et al. 1996). When the nurse ethicist and director of the Kennedy

Institute Carol Taylor (1997) interviewed nurses to get to know their ethical concerns, she had to realize that most of the nurses felt hard-pressed to describe the nature of their everyday nursing concerns that had ethical significance. She states that "...while some everyday nursing concerns are unique to nursing, most derive from tensions that involve the interdisciplinary team and raise broader issues about the human well-being that are best addressed by the institution or health care system at large" (Taylor 1997, p. 69). In order to investigate their concerns, she analysed collected case studies which lead nurses to request ethical consultation. She identified that nurses mostly struggle for the respect for human dignity, a commitment to holistic care, a commitment to individualized care which is responsive to unique needs of the patient, the responsibility for a continuity of care and the scope of authority and identifying the limits of care-giving (Taylor 1997, pp. 69–82). Taylor discusses that none of the concerns are unique to nursing, but they may be experienced with greater immediacy and urgency by nurses as well as other care-givers. She also observed that more nurses described their moral orientation as care-based rather than justice-based (see also Holly 1986).

Conflicts and Invisibilities

Both nurse ethicists Joan Liaschenko (1993) and Patricia Rodney (1997) have specifically investigated the concerns of practicing nurses. In an ethnographic study of nurses practicing on two acute medical units, Rodney explored the situational constraints that made it difficult for nurses to uphold their professional standards. Varcoe et al. (2004) support their findings of the serious structural and interpersonal constraints experienced, for example, excessive workloads for nurses, the absence of interdisciplinary team rounds, conflicts between team members inside and outside nursing and conflicts with patients and family members. Rodney (1997) explains that the inability of nurses to arrange space to talk with patients constrains their ability to truly focus and be attentive to the authentic needs of the patients and families. In a further study with her colleagues (Storch et al. 2002), in addition to a lack of time, another predominant theme was nurses' concern about appropriate use of resources. They struggled with decisions made by others regarding the

allocation of scarce resources. Some of the nurses interviewed described physicians as not willing to listen to or to receive the nurses' point of view and were reluctant to accept that nurses have any independent moral responsibility when caring for patients (Storch et al. 2002). Moreover, the study gives evidence that the organizational climate, including policy development, is problematic for nurses. Sometimes this is related to a lack of policy, sometimes to the presence of a binding policy, and more often, to an ambiguous policy. For example, policies that were considered to be too binding, such as resuscitation policies, were related to patients whose best interest was overseen by following a code (Storch et al. 2002).

Central to the concerns given voice by nurses interviewed in Liaschenko's study was their sensitivity to patient need. They were aware of the

... increased vulnerability to loss of ... agency in the face of disease, illness. ... Need was not seen solely in terms of a biomedical model of altered physiology but was conceived broadly to include those things which helped the individual to initiate or re-establish routines of lived experience and to cope with the settings in which they found themselves. ... In this view, need was relative to the realities of the patient's day-to-day life. (Liaschenko 1993, p. 262)

Liaschenko (1993), Rodney (1997) and Varcoe et al. (2003) identified meeting the patients' and families' needs for emotional support as being undervalued and overlooked in nursing work. "Because emotional work is a social transaction and not a product, it is invisible in a product-driven society. New nurses learn very quickly what the 'official' work is and what the unofficial work is. Emotional work is extra, frequently coming out of the personal time of nurses" (Liaschenko 2001, p. 2). The authors argue that economically driven changes imply that only certain processes are remunerated. Consequently, only certain, measurable aspects of care are accounted for and funded, while other tasks of nursing care are ignored. Hereby, different values underlie what is accounted for and what is overlooked in an evaluation and a decision-making process that follows rather managerial rules (Rankin and Campbell 2006). Dealing with social issues that actually have no place in the sphere of medicine and the mandate of the hospital, like homelessness and poverty, is also invisible in nursing work (Varcoe et al. 2003).

Moral Distress, Missed Connectedness and Fragmentation of Care

According to several research findings, there are significant personal costs associated with nurses' caring work and concerns: fatigue, guilt and personal risk as well as the experience of anger, frustration and feelings of powerlessness (Erlen 1993; Redman 1996; Rodney 1997). Nurses feel frustrated because they cannot do what they should do with regard to "good care" and nurses feel powerless to affect their working conditions (Rodney 1997). The constraints limited the competences of nurses to care and resulted in moral distress, that is knowing "... the right things to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, p. 6). Moral distress is experienced by practitioners when they confront structural and interpersonal constraints in their workplaces (Aiken et al. 2000; Gaudine et al. 2011; Rodney and Varcoe 2001). Lorraine Hardingham (2004) argues that nurses often find themselves in positions where they have to compromise their moral integrity in order to survive in the hospital or other healthcare environment. The consequences are a fragmentation of care as well as fragmented decision-making that can have negative effects for patients and families and foster feelings of powerlessness and stress on the part of nurses (Varcoe et al. 2003). Nevertheless, institutional constraints cannot be interpreted as a justification for leaving out nursing caring practices, but can only be an explanation that needs further investigation.

In the study, *Power, Politics, and Practice: Towards a Better Moral Climate for Health Care Delivery*, Patricia Rodney (2005) identifies the main problems that prevent safe nursing practice. She emphasizes the dangerousness of "normalization":

This means that serious congestion of patients in the ED, mismatches of patient acuity to available treatment / care, and overall lack of resources have started to become taken for granted. For instance, when asking hospital management for extra staff or to look for beds, nurses have told us (and we have seen) that the rebuttal is sometimes 'well, it was much worse the other day'. Nurses are sometimes asked to care for more than one ventilated patient plus other patients – a situation that would certainly not be considered 'normal' in a critical care unit. And patients are being held in

the halls for so long now that some physicians are asking to start treatment in the hall or rapid treatment area without nursing coverage or assessment. This is in violation of safe emergency practice standards. Furthermore, it has become too much the norm that patients and their families will have to put up with far less than optimal care in our currently over-stretched provincial health care system. (Rodney 2005, p. 2)

Moreover, she points out that nurses describe themselves as being disconnected to their colleagues, management, other departments in the hospital or the community and that they feel that they have no meaningful say in how the emergency department is run, but are rather expected to put up with the consequences. Feeling connected and building up relationships in healthcare are important factors of healthcare outcomes for patients and the quality of work life experienced by healthcare providers (Varcoe et al. 2003, p. 959).

One reason is that nurses' issues of concern are systematic, that is to say: the problems arise in predictable settings and not randomly. The organization can make it very difficult for nurses to fulfil their ideals of good care. The ones who carry out caring work find it impossible to approach care as a coherent process. The fragmentation of care threatens the unity of the caring process. It is not something in the nature of *care-giving* itself, but rather the low social status and the poor organization of care that can make nursing a difficult practice. Are there practices of resistance?

Practices of healthcare providers can be resistant to imposed rules, changes and dominant ways of thinking. In these situations, for example, individual nurses ignored rules and the system in order to practice care according to the needs of patients and families. Canadian researchers give the example of emergency nurses' practices of "bending the rules" to give patients pain medication to take home despite the lack of a physicians' order (Varcoe et al. 2003, p. 967). The resistant practices identified are going against both the prevailing ideologies and colleagues following them.

According to these studies, the goals and rules of the institution can become the driving force behind any kind of actions and procedures whereby nurses act as facilitators and negotiators who are no longer dedicated to the well-being of patients, but to the system of management that

implies a kind of control over patients as cases. What does it mean to know the case in comparison to knowing the patient and the person?

Knowing the Case Versus Knowing the Patient and the Person

Case histories and case records are part of a larger development of administrative technologies that can be called knowledge devices, used in professional administrative practices. Procedures for writing them are manufactured in ways that records are collected according to standards so that the individual is put into categories and interpretative schemata. The facts are abstracted from the actual events that happen at a certain place and time. Dorothy Smith remarks that they are

typically embedded in and integral to forms of organization where the immediate and day-to-day contact with the people to be processed is at the front line and involves subordinates, whereas decisions about those people are made by persons in designated positions of responsibility who lack such on-going direct contact. (Smith 1990, p. 89)

Structuring the case story in such a way that meets this form, Smith explains, is articulated to an organization of power and position in which some have authority to contribute to the production of the textual realities and others do not. "Those who are the objects of case histories are normally distinctively deprived ... those who have direct knowledge of the patient's life outside the hospital or of her daily routines in the hospital are least privileged to speak and be heard" (Smith 1990, p. 91).

Institutionalized hospital practices operate as information-based and as patient case knowledge that is business-oriented to make healthcare organizations successful, and are not necessarily consistent with caring. Nurses learn to leave out experience-based domestic elements of care that would disrupt the authoritative plan to meet desired outcomes (Rankin and Campbell 2014). The nurses are attentive to the required workflow and try to smooth over things that might disrupt it. They focus on the technologically structured work and miss other aspects of nursing activities that are unaccounted for in the formal plans, directions,

documentation and requirements. “Any effort or use of time and nursing attention that is outside the institutional version of care becomes extra-neous” (Rankin and Campbell 2014, p. 168).

Based on the analysis of their empirical research data, Joan Liaschenko and Anastasia Fisher (1999) differentiate between types of knowledge: the case, the patient and the person. Case knowledge they consider as generalized biomedical knowledge of anatomy, physiology, pathology, as well as therapeutics (Liaschenko and Fisher 1999, pp. 33–35). Liaschenko (1997) claims that case knowledge is disembodied knowledge. One could know, for example, all necessary facts about cardiac disease without perceiving that disease as being embodied in a particular individual. The disease is understood as a deviation from the biological norm. Fisher and Liaschenko unfold the idea of case knowledge:

This case, or biomedical, knowledge is the primary knowledge of the contemporary health care system in that it legitimises the practice of medicine which, in turn, controls knowledge. It also legitimises that aspect of nursing work that is concerned with monitoring disease processes and therapeutic responses. (Liaschenko and Fisher 1999, p. 33)

This case knowledge is the standard against which the specific features of an individual care receiver are measured. The shift from case knowledge to patient knowledge is made when the care-giver encounters the actual body of the care-receiver and, in doing so, knowledge transcends case knowledge and grows to patient knowledge. The care of the patient at the bedside requires knowledge of how the disease is manifest in this particular patient. It includes any unique features of anatomy and physiology in this patient, and how this patient responds to care and treatments. Patient knowledge also implies knowing how things get done for the individual within and between institutions as well as knowledge of other care providers who are involved. The complexity of patient knowledge is based on “... the fact that its content is no longer limited to generalized case knowledge and the expectancies for action which it generates. Rather, it consists of the nurse’s interaction with a particular body, the responses of which will be compared to generalized case knowledge” (Liaschenko and Fisher 1999, p. 36).

In contrast to case and patient knowledge, person knowledge is defined as knowledge of the individual within his or her personal biography (Brody 2002). It implies knowing something about what the specific history means to the individual. Studies revealed that person knowledge was used when there was some conflict between courses of action desired by the individual and those desired by the therapeutic team (physician, physiotherapist, social worker etc.). Person knowledge is useful for nurses “to defend their arguments for an alternative management of disease trajectories and to justify their actions when those actions support an individual’s agency, even though this can conflict with established biomedical or institutional courses of action” (Liaschenko and Fisher 1999, p. 39). In other terms, this differentiation could be understood as a confusion of means and purpose. While the case knowledge assumes certain features that make up a certain profile of a person that fits the use of certain procedures, diagnostic techniques and therapeutic possibilities, the person knowledge assumes an individual whose own biography and voice count to understand the case. Within the logic of the case knowledge, the individual can become a means to an end since you watch out for a profile that fits your available or prospective answers. Within the logic of the person knowledge, the individual is the purpose and transitional means, and answers have to be found in the process of getting to know the individual by listening to his or her own voice and unique history. The person knowledge takes caring time and “understanding” becomes decisive, while case knowledge saves time and understanding becomes unnecessary. The organization of care serves to separate the individual from the context in which interactions take place. To be taken away from that context means to become detached from the context of one’s living. It becomes the organization’s business. Individual histories can be rendered invisible or abstracted into a package of reports.

Besides being resistant and bending the rules, nurses could articulate the dilemmas of and in nursing care practices within the hospital arena and bring in patient as well as person knowledge. Hospital Ethics Committees can offer such a forum and space for nurses’ voices. Joan Tronto (2010) convincingly describes in her article on how to *create caring institutions* that this can never happen without a “rhetorical space” (Code 1995) or a “moral space” (Walker 1993, 1998) or “a political space” (Tronto 2010) within which caring issues can be debated.

Thinking along the lines of John Dryzek's idea (2000) of fostering a discursive way of communication and deliberation, I am in favour of a discursive space. HECs can serve as a discursive space in the sense that an expansive kind of communication is supported that allows unruly and contentious voices from the margins. The characteristics are: (1) the presence of a hitherto scarcely represented group and their voices increase among the actors who are in a position of decision-making; (2) the implication of inequality and power relationships being bound to traditions is seen as a problem to be expounded when issues are raised and struggles for attention occur; (3) participation becomes real rather than symbolic (Dryzek 2000, p. vi; Kohlen 2009, p. 159).

Nurses' Membership, Voice and Participation in Hospital Ethics Committees

From their start, Hospital Ethics Committees (HECs) have recognized the importance of including individuals from different backgrounds as members. The legitimacy of the nurse's participation and their potential contribution as members of these committees has been acknowledged. Nursing as well as medical literature pays attention to the benefits of including nurses in ethics deliberations (Aroskar 1984; Aroskar et al. 2004; Fost and Cranford 1985; Fowler 1997; President's Commission 1983; Youngner et al. 1983). Nurses are supposed to add further dimensions to the decision-making process because they are usually in close proximity to their patients and spend more time at the bedside than any other member of the healthcare team. What are the experiences of nurses with regard to membership, participation and contributing their voice?

Membership indicates who can speak, whose opinions are counted, and whose discounted. Membership may determine even which issues are seen as legitimate ethical concerns and which are not. ... So, to say that a hospital has an ethics committee tells us very little unless we know as well: who serves on the committee and under what authority. (Bosk and Frader 1998, p. 16)

In 1991, a study on *Physicians' Attitudes Toward Hospital Ethics Committees* found that merely 69% believed that nurses should be members in clinical committees and only 59% thought that they should have access (Finkenbine and Gramelspacher 1991), and when the number of Hospital Ethics Committees rose drastically, the American nurse ethicists Barba Edwards and Amy Haddad (1988) remarked that the specific and unique ethical concerns of nurses had also not been adequately addressed by these multidisciplinary committees. Their issues were not framed as ethical issues and therefore excluded. The nurse ethicist Dianne Bartels et al. (1994) who co-chaired a Hospital Ethics Committee in Minnesota in the 1980s is convinced: "I do not think hospital nurses have trouble speaking up, they just need a place to show up. (...) you need a place to convene, and then, once you are there, people don't have trouble ... representing their issues". She also thinks that the co-chair model equalizes power, expands interaction on the committees and increases the comfort of nurses to be able to speak up. "Moreover, nurses need to learn the language (spoken by ethicists)" (Kohlen 2009, p. 150).

Cheryl Holly (1986) found that nurses are forced to function at conventional levels in the bureaucratic organization of the hospital. It was seen as a failure when they were not able to define concerns related to their practice in terms of rights and justice. Nurses who attempted to operate from a base of caring and responsibility were relegated to a conventional role. Betty Sichel (1992) examined procedures, deliberations, goals and functions of Hospital Ethics Committees and realized that a model of rights and justice is not appropriate to describe ethical questions with regard to caring practices.

A study on the participation and perception of nurses in HECs gives a detailed overview that reveals changes compared to previous findings (Oddi and Cassidy 1990). The study was conducted in two phases. In the first phase, they determined the number of acute care hospitals in a Midwestern state that have HECs and obtained the names of the nurses who serve as members of these committees. In the second phase, they contacted individual nurses to assess the extent of their formal involvement in ethical decision-making as well as their perception of the role of the ethics committee within their institutions. Of the 148 responses from

hospitals, 45% said they have an ethics committee. All hospitals reported that nurses serve on those committees. The average number of nurses was said to be 2. Nurses were invited to participate in the study by anonymously completing a brief questionnaire about their perceptions "... of how the ethics committee is involved with selected aspects of practice" (Oddi and Cassidy 1990, p. 309). Members were predominantly female, hold a master's degree and served in administrative or management roles. The mean age was 42 years with a range of 25–65 years. The majority reported that they were either appointed or had volunteered to serve on the committee. They also indicated that they served on the committee from 1 to 7 years, with an average tenure of 2 years. Academic preparation, continuing education and self-directed learning were declared to be the main ways in which nurse members learn about ethics. Completion of an ethics course at either the graduate or the undergraduate level was reported by more than half of the respondents. Most of them indicated that they had attended continuing education programs, conferences or workshops on ethics. All respondents indicated that they contribute comments and ideas to the committee's discussions. Only a few indicated that they sometimes contribute, over 40% stated that they usually contribute and nearly half of them stated that they always contribute to the discussion. Only 1.4% indicated that their inputs were rarely sought (Oddi and Cassidi 1990).

The nurses interviewed in a study by Storch and Griener (1992) were generally positive regarding the perceived potential of a HEC, but only a few nurses were actually aware of the presence of the ethics committees (see also Pederson et al. 2009). For example, at one hospital, 20 nurses out of a total of 361 respondents were not aware of any ethics education being offered by the hospital. The study found that differences in ease of access to HECs by healthcare professionals were particularly pronounced between physicians and nurses. Physicians seemed to have greater access to the ethics committees and were perceived to have more support from them. In contrast, nurses did not perceive themselves as having direct access to the committees for consultation. They believed that access would be through their supervisor. Even though these gatekeepers posed no significant barrier, a few nurses interviewed stated that they would be too intimidated to go to the committee (Storch and Griener 1992, p. 23).

Cornelia Fleming (1997) found: "In institutions with established Hospital Ethics Committees, nurses are routinely included as members; however, the number of nurses able to participate at this level is small and not proportionally representative of nurses in clinical practice" (Fleming 1997, p. 7). A problem evolves: it is not bedside nurses as actors of caring practices who participate in HECs, but nursing managers. While nurses in management may bring a broader view, the perspective of staff nurses may be lost if they are not adequately represented. This is in fact a contradiction in the given role of nurses pointed out above, since nursing managers do not know patients by direct contact and have textual case knowledge, instead of a patient and person knowledge.

Although an occupation may have an adequate numerical representation, there could be differential participation in terms of communication exchange, as the study by Charlotte McDaniel (1998) reveals with regard to the nurses' communication exchange frequency as members in four sample HECs examined. Nurses proportionately represented the same or more membership numbers as physicians and the frequency of nurses' communication exchange was comparatively modest in proportion. The nurses had one of the smallest proportions of communication exchanges. Although most of the nurse members contributed communication exchanges to a topic, there were also nurses who did not participate at all. Nevertheless, nurses rated their participation effectiveness quite highly. Although nurses were moderately communicative on the committees, McDaniel suggests: "... nurses are engaged, active, and selectively participating in the committee deliberations. Nurses appear to be comfortable with a less overtly active, yet representative numerical membership on the committees" (McDaniel 1998, p. 50). Further exploration of the content of nurses' communication showed that they participate most in the discussions regarding patient care review and much less with regard to policy formation and education. McDaniel argues that nurses, representing the single largest group of healthcare personnel, need to be involved in the policies and decisions that surround and affect their administrative and clinical practice (McDaniel 1998, p. 48).

Sarah-Jane Dodd (2004) and her colleagues investigated the extent to which nurses engage with regard to "ethical activism" and "ethical assertiveness". Ethical activism they defined as "actions directed toward

reforming institutional policies and procedures, as well as attitudes of physicians and other medical staff, to create favourable climate for (nurses') participation in ethical deliberations" (Dodd et al. 2004, p. 17). Ethical assertiveness is defined as "actions to enter or facilitate ethics deliberations in which nurses have not been included, whether through personal initiative, coaching patients, advocating patients' wishes to others, or ethical case finding" (Dodd et al. 2004, p. 17). The researchers contend that these two kinds of involvement are vitally important if nurses want to expand their ethical roles. The results indicated that nurses are more likely to employ ethical assertiveness and ethical activism in settings that are already receptive to nursing participation. The authors recommend that nurses

need to try to change the hospital environment so that it promotes, rather than discourages, their participation. Even when not formally invited, (they) need to engage in ethical assertiveness when they advocate for patients, coach patients, act as ethical case finders, initiate ethics deliberations, and not withdraw from deliberations when not specifically asked to participate. (Dodd et al., 2004, p. 26)

The findings of the studies raise questions. First, why do the nurses know so little about ethics committees? Storch and Griener ask whether this goes back to a lack of knowledge that is induced by medical politics or whether it could be understood as a strategy of nursing administration maternalism that keeps staff nurses and head nurses removed from such information, or whether it might be simply a problem in communication within the hospital (Storch and Griener 1992, p. 25). In a study by Gaudine et al. (2011), nurses still report about a lack of knowledge about HECs as well as lack of experience.

A second question is whether ethics committees support existing structures and power relationships in the hospital rather than a shift to a democratic way of multi-professional discussion of ethical dilemmas and conflicts of care. The comments from physicians, nurses and administrators give credence to the view that HECs merely support the existing power structures.

The standards issued by the Joint Commission on Accreditation of Healthcare Organizations in 1992 required that structures be in place within institutions to enable nurses to participate in ethical deliberations (Erlen 1993). The standard is also included in the Standards of Clinical Nursing Practice developed by the American Nurses Association in 1991. But, having structures in place for nurses' participation does not necessarily mean that their voices are heard and that they bring in issues of care. The nurse ethicist and nursing manager Hans de Ruyter who has more than ten years of committee experiences in two different hospitals has gained a rather critical perspective and explains:

Nurses' issues get addressed if they present them the way that the people, the physicians and the kind of the leadership see it. So, you have to present it in a certain way, and if you go outside of that model, ... so, if you bring up an issue that they do not classify as being an ethical issue, you don't get listened to. But people and nurses, I think, we are very adaptable, so there is [sic] always nurses that will learn the language and you get listened to (...) But then, you cannot truly bring up the issues that you think are ethical issues because it's very much I think with ethical issues which issues are classified as ethical issues and which ones aren't. And, I think that the nurses who do that and I can't talk about ...their mind, but for me, the quandary is, do I want to be a part of the leadership and then I have to adapt, or do I speak what I think should be spoken, and that automatically makes me an outsider. (Kohlen 2009, p. 155)

Nursing Ethics Committees

Some nursing professionals established Nursing Ethics Committees (NECs) as entities separate from the multi-professional HECs. These committees are structured within the healthcare organization created specifically to assist nurses in resolving ethical dilemmas. They are comprised of nurses who represent different positions of nurses within the organization, such as nurse managers, nurse educators as well as staff nurses. They are supposed to assist nurses to identify, clarify and articulate the issues in their practice (Erlen 1993; Fleming 1997).

A forerunner of this idea dates back to the time when the institutionalization of HECs after the Quinlan decision first subsided. At that time, in many hospitals, some still rather small and unknown groups began to meet regularly to discuss clinical problems they were facing with their colleagues (Kohlen 2009). The nurse ethicist Ruth Purtilo at Massachusetts General Hospital (MGH) in Boston looks back to the mid-1970s and explains:

A group of nurses came to me telling ‘We need an informal committee’, ... what they needed, was a room and time to talk about daily conflicts and dilemmas in clinical practice. We established an informal forum to discuss nursing ethical issues. The goal was to get this forum more or less institutionalized. One effect of the forum was the reduction of moral distress. (Kohlen 2009, p. 156)

One of the first official NECs was established in a Catholic hospital in Omaha, Nebraska in 1984. The vice president of patient care took the initiative to establish a NEC at the hospital, because she could not get the multi-professional ethics committee get moving (Kohlen 2009, p. 156). Amy Haddad, professor and director of the Center of Health Policy and Ethics at Creighton University in Omaha, and at that time doctoral student of nursing, became a consultant. She explains in an interview:

... once the Nursing Ethics Committee was started and had a full day orientation to what ethics was, how decisions would be made, how to structure it (...) we had representatives from all the nursing areas in the hospital. This was before the hospital had governance structures, so there wasn’t anything else in place (...) we got the people who were most interested to do it. So, we probably met for six months, people on board for (...) physicians to establish the institutional ethics committee. So, I had to work as a consultant to that committee (...) both committees, the nursing committee and the committee for the whole institution. (Kohlen 2009, p. 157)

NECs are described as a way to empower nurses so that they can more fully participate in multidisciplinary ethical discussions and prepare nurses to become effectively involved in HECs (Zink and Titus 1994, p. 70). On the basis of the descriptions, establishing NECs seems to be

an adequate way to address ethical issues including the ones that refer to caring practices. But critical considerations are also expressed. Erlen argues that nurses who only discuss issues with other nurses might be limited in their focus. Perspectives given by other healthcare workers could challenge the analysis of the conflict and broaden the enquiry. "Although all nurses do not hold the same exact philosophy of nursing, there is a greater likelihood that there will be less divergence of perspectives and fewer alternatives presented when an ethics committee is comprised almost entirely of nurses" (Erlen 1997, p. 59). NECs might encourage division rather than collaboration with other disciplines (Fleming 1997, p. 8). The clinical ethicist, Mary Faith Marshall points out, that "nurses ... can be their best enemies, ... a democratic process should be learnt ... (and a) change in practices of local multi-disciplinary committees need to be supported by everyone" (Kohlen 2009, p. 157).

A closer look reveals that the question could be raised whether the functions of Nursing Ethics Committees are often the responsibility of other committees within the healthcare organizations. Moreover, while some nursing concerns are unique to nursing, most raise broader questions about human well-being that might be better addressed by the institution and the healthcare system at large (Taylor 1997, p. 69). A restricted discussion of these concerns to NECs may end up in their becoming trivialized or even marginalized. And, a separate nursing committee might communicate the image to the institution that these concerns are of lesser importance than those addressed by an interdisciplinary committee.

What happens if the committee actually serves to make nurses grow stronger in articulating their thoughts and put their issues of concern on the agenda? Haddad tells her piece of the story in an interview:

It created problems over the years because they stood up, collectively, you know, so you got now five people on the unit, and they are not only five people, they are five experienced people because usually people that volunteer for this had been there a while. And now we are going through years of running the committee, and learning a language and all that. Then you got five people who were saying, we are not going to put up with this. They started to present problems (and there came a new director). She was

unhappy with how they (the nurses) reacted to (...). I mean, they had learnt to ask questions. They had learnt to say that they would not agree on policies: We are not following it. Why are we not following it in this case, so what is happening? They had learnt to use tools of good arguments. (...) They had been taught to tell why (...) you cannot go up to somebody and say you are wrong, you have to have good arguments, and be able to say, here are my concerns and this is why (...) and they had been taught to do that, and they had learnt to link arms in how to do that, because nobody wants to be the one going forward. (Kohlen 2009, p. 158)

Bart Cusveller (2012) studied HECs and nurses' competency profiles. For future development, nurses ask for education in communication skills for all committee members, such as listening, speaking and writing. The ethics committee nurses were confronted with issues arising from constraints in the institutional context, such as budget issues and staff shortages.

In summary, the research findings about nurses' participation in HECs show that their participation does not necessarily mean that their issues are raised and their voices are heard. The following example taken from a field study in Germany (Kohlen 2009) can illustrate how caring issues are minimized and dismissed.

Voices of Care in a German Hospital Ethics Committee: A Petit Ethical Problem

A retrospective case consultation takes place in a committee meeting in a German hospital (Kohlen 2009, pp. 188–192):

A nurse had written down a concern in order to consult the committee. The female minister took the paper to the committee meeting and read it aloud. The nurse had experienced a situation two years ago that was still bothering her: An elderly female patient had been in need of a blood bottle. When the blood bottle arrived from the lab, it was still very cold, and the physician on shift asked the nurse to put the bottle on the old lady's belly, so that the blood bottle would warm up easily for her. The nurse, who did know the patient, could not imagine doing it. The patient had been sleeping and was not in an alert condition at all. The female

physician then told her to ask another nurse to do it, someone who would be more professional than her.

The discussion in the ethics committee developed as followed:

Female Minister:	"It is really uncomfortable to have something cold on your belly!"
Physician A:	"This is absurd from a medical perspective. There are, of course, other technical aids that can help to warm up blood bottles".
Nurse A:	"This nurse feels like an advocate for the patient, and wants to take care of her autonomy".
Physician A:	"This is really a mini ethical problem!"
Physician B:	"I think the problem emerged from hierarchy!"
Minister A:	"I think they have some communication problems on the ward".
Physician C:	"But this is really a petit ethical problem!"

The discussion ends after some minutes, declaring that this is really a minor problem. The minister explains that she will have to talk to the nurse who has revealed her concern.

Female Minister asks:	"What should I tell her?"
Physician A:	"You can tell her that she did not do anything wrong within the current knowledge of practice".
Physician B:	"And you can add that the problem had to do with hierarchy and failed communication".
Physician C adds:	"Well, the more I think about it, the more I feel instrumentalized by this nurse, because this is not an ethical problem at all!"
Nurse B:	"You can tell that she did not do anything wrong, and you can tell her about the possible hierarchy and communication problem behind it, but never tell her that this is not or is just a small ethical problem".

The meeting abruptly ends; people rose from their places and left the room. The minister remained there and took some notes.

Interpretation

First, the minister reacts and states, "It is really uncomfortable to have something cold on your belly". And this actually collides with a practice of care that does not allow one to put somebody into an uncomfortable

state for the use of something or somebody else. The lady who is ill and sleeping cannot defend herself and therefore needs protection. The physician explicitly speaks from a medical perspective, stating that “this is absurd” and that this is not the right way to warm up blood bottles, because there are technical aids. He clarifies that this is obviously not a medical dilemma in which physicians do not know how to make an adequate decision.

Nurse A shows empathy for the nurse who has revealed her concern. She identifies the role of the nurse who cared for the old lady as an “advocate for the patient” who wanted to take care of her autonomy. Caring for her autonomy from a nursing understanding could mean that the patient cannot articulate herself and therefore needs protection, here given by the nurse. This is a mandate of nurses. It is different from the physician’s, who is interested in getting a warm blood bottle for a medical intervention. Nursing care for patients who are sleeping implies keeping her or him in a state as comfortable as possible while protecting them from disturbing noises, interventions that can be postponed like “taking the blood pressure”, as well as disturbing and uncomfortable interventions like putting a cold blood bottle on their warm belly. Although, in the patient’s current state of not being able to verbally interact, the nurse sees that her autonomy still belongs to her and cannot be taken away, she uses the principle of autonomy to justify her nursing care, namely, her responsibility to take care of the patient’s sleep.

When the physician defines the situation as “a mini ethical problem” without giving any reason, no questions or controversial points are raised. Why this is only a small ethical problem is left open. The physician does not feel a need for explanation, and nobody else asks for it. Then the commentaries that lack explanation move on: Physician B declares it as a problem that has to do with hierarchy, and Minister A remarks that the problem might be linked to “some communication problems on the ward”. Since the exclamations that follow the non-rejected definition of a “mini ethical problem”, one could ask whether hierarchy and communication are categories that can be put under the umbrella of small ethical problems or whether they are indicators for difficult situations that cannot simply be framed as ethical. Framing them in the context of small ethical problems minimizes their potential for conflicts and understand-

ing the situation in its complexity which, of course, can harm not only patients but also disrupt professional identities, here nursing care.

When Physician C repeats the remark of Physician A that this is a “petit ethical problem”, the conversation is closed down. There seems to be a hidden consensus about how much time should be spent on what kind of issues. That the discussion of the concern does not deserve much time could have been evoked by the minimization of the problem. The minister, realizing that the discussion is ending, asks the rather pragmatic question: “What should I tell her?” and the first answer is given by Physician A who started to comment on the concern. “You can tell her that she did not do anything wrong...”, he authorizes the minister to tell. Does this mean that the nurse acted correctly according to a medical perspective? What are the criteria to distinguish between wrong and right in this situation? And who has the power to define it?

Physician B adds that the nurse should be told that “the problem had to do with hierarchy and failed communication”. What is the message of this information? What can the nurse take out of this kind of analysis? This is difficult to tell, because there is no explanation. With regard to inter-relationships, especially between different professions, you can narrow down and contextualize nearly everything with hierarchy and communication problems in a hospital. Physician C “feels instrumentalized” by the concern of the nurse. This is a strong reproach. “This is not an ethical problem at all!” is the explanation for his feeling. Does a talk of problems which are not defined as ethical ones, instrumentalize disputants? Again, it is not clear what counts as a “real ethical problem” in comparison to a “petit” ethical problem, or a different kind of a problem, for example, of competence and communication. Criteria are not given. What is the legitimization to minimize the nursing concern at all?

It is the physician who has the power to declare what counts as a “real ethical problem” and what counts as a petit ethical problem. Nobody in the group asked for an explanation why the problem is declared to be a petit ethical problem. Nobody talks about the physician who told the nurse to use the warmth of a patient’s body to warm up a blood bottle. What is her part in the story? What can be said about her clinical expertise and responsibility? Did she behave in a correct manner? Did she possibly think that this might be a “petit ethical problem” that counts less

than the outcome, respectively, having a warm blood bottle for another patient in need?

The nurses' professional role is to take care of the patient's sleep. The nurse theorist Nancy Roper has developed a conceptual framework for nursing practice. One component of the model is called the "Activities of Daily Life" (ADL). Relaxing and being able to sleep is one element of these daily activities nurses have to care for. This involves having an eye on the duration of sleep, times of sleep, day and night rhythm, sleeping quality, rituals of falling asleep, habits and aids to fall asleep. Knowing the patient involves knowing his or her sleeping habits and knowing what this special patient needs to get the kind and duration of sleep that helps her to recover and gives comfort to her, especially when she is in pain and dying. The more dependent the patient is due to his situation of illness or disease, the more *comfort* the patient needs. For nurses, comfort implies a moral stance, clinical knowledge and the tangible, practical skills in which they have developed expertise.

Conclusion

The experiences of three decades caring about care in the hospital arena from an ethical perspective and trying to bring in nurses' voices into the discursive space of HECs point to structural shortcomings (resources), attention needing to be paid to power relationships and to the use of the ethical language being bound to a traditional institutional hierarchy in hospitals. Are structural shortcomings and the power-relationships expounded a problem in the first place? Is the language of ethics reflected to see whether issues of care can be described in depth? What are the theories and frameworks of ethics that rule the committee debates and how can they be broadened to capture issues of care?

Although the findings of my field study in Germany that investigated nurses' participation in HECs as illustrated above cannot be generalized, they support the assumption that ethical conflicts of delivering caring practices are not listened to as such. As a result, when framing a conflict of care as an ethical one, it is framed as a "petit ethical problem" and its importance for attention and consideration is therefore minimized.

Writing and talking about care mean that we need to take care of our care language and adapt it. It is difficult dealing with the limits of using words that do not represent patient knowledge, but only case knowledge that is textual and disembodied. Therefore, nurses who do bedside nursing and face-to-face body care need to be taken seriously whenever they articulate a concern about care.

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