

ETHICAL ISSUES OF AIR FORCE NURSE PRACTITIONERS
IN CLINICAL PRACTICE

by

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DEDICATION AND ACKNOWLEDGEMENT

To my mother, Yvonne Procunier Smith-Cahoon, I dedicate this paper. You taught me that hard work, perseverance, honesty, and a big smile could overcome any obstacle. I know you are looking down on me now smiling.

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Thank you Jim, you're ability to make me laugh kept me going. Now I have arrived.

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PRACTICE

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ABSTRACT

What are the ethical issues or situations **Air Force Nurse Practitioners** (AFNPs) experience in clinical practice? Which moral or **ethical** principles are reflected? Little has been written about the ethical issues faced by AFNPs in clinical practice. The description and exploration of these issues was accomplished in this study through the use of **qualitative research** methodology. Seven active duty AFNPs provided narrative accounts of ethical issues and situations encountered in their clinical practice. The individual narratives were analyzed and findings were presented using four basic principles of biomedical ethics: respect for autonomy, nonmaleficence, beneficence, and justice. Implications of this study illustrate the need for some type of ethics education in **advanced practice nursing** curricula. Further implications for use in clinical practice include time management, resource utilization, template creation, and training. More research is needed to determine if the experiences of AFNPs are universal to the profession of advanced practice nursing. Patient and healthcare provider satisfaction, and retention of personnel in military service may all be impacted by further research in ethical issues in clinical practice.

Key Words: **Air Force Nurse Practitioners, ethical, qualitative research, phenomenology, advanced practice nursing**

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CHAPTER I: INTRODUCTION

Background

Ethical issues confound the ever-present challenges of being a health care provider. As novice nurse practitioners, being aware of the issues and concerns of our more experienced colleagues may make us better prepared to face those challenges in practice. Little has been written about the ethical issues faced by nurse practitioners. This study explored some of the ethical issues faced by experienced nurse practitioners in clinical practice.

“As independent providers of health care, as members of health care teams, and in their various roles in a variety of settings, nurses are caught in the midst of the complicated ethical debates of our time. There is no special brand of ethical reasoning or moral intuition for nurses only” (White, 1992, p. xiii). Nurses confront ethical issues in clinical practice that have been difficult to resolve partially because of the complex nature of our relationships with patients, families, physicians, administrators, and other nurses. Nurse practitioners (NPs), as independent providers of health care, are faced with ethical issues as the advocate of the patient and the protector of community health

Some of these ethical issues are a product of the advances in technology. Technology has opened the doors to ethical issues concerning the social implications of disease and health. Examples of these issues are acquired immunodeficiency syndrome (AIDS), genetic counseling, fertility and selective reduction of fetuses (Bunting & Webb, 1988). More and more often, the NP is faced with these issues as the provider, the protector, and a member of society.

The Air Force nurse practitioner (AFNP) has all these roles in the Air Force community. Studying the ethical situations AFNPs experience in clinical practice furthers the knowledge base of professional nursing. This exploration of thoughts and descriptions recounted by AFNPs has given insight into the ethical situations facing military practitioners. The central themes revealed by the ethical situations AFNPs confront also serve to encourage a dialogue between civilian and military nurse practitioners.

Purpose of the Study

The purpose of this research is to describe and interpret the ethical issues AFNPs encounter in clinical practice. This study is an adaptation of the research done by O'Connor (1991), using the written stories by oncology nurses of ethical issues and situations they faced in clinical practice (O'Connor, 1996).

Research Questions

The research questions were:

1. What are the ethical issues or situations AFNPs experience in clinical practice?
2. Which moral or ethical principles are reflected?

Participants were asked to respond in an unstructured essay or telephone interview to the request: Describe a situation in your nurse practitioner role in which you experienced ethical questions. Share all thoughts, perceptions, and feelings you can recall until you have no more to say about the situation (O'Connor, 1996). From the responses of the AFNPs more has been learned about the ethical issues facing them in practice.

Theoretical Framework

“Nurses must learn from the struggles of other nurses...” (David, 1999, p. 188). To learn, we must first understand. To understand, meaning must be given to the experience. The phenomenological method illuminates the experience through reflective insight and interpretation, creativity, and description. Phenomenology is the study of the lived experience (Ray, 1994).

Phenomenology is Greek in origin, from the root *phanomenologie*, meaning “the description of ...awareness and of awareness itself” (Woolf, 1974, p. 860).

Phenomenology is both descriptive and reflective. Understanding the lived experience of the AFNP requires thoughtful reflection on the description of the experience to gain the meaning of the experience.

The research question was designed to elicit a description of an ethical issue or situation experienced in clinical practice and a description of the feelings associated with that experience. The phenomenological approach allows for reflecting upon these experiences. Exploration through reflection has brought an understanding of the experiences faced by the AFNP.

Definitions

Air Force Nurse Practitioners (AFNPs)

Nurse practitioners are defined as registered nurses with an advanced academic degree and/or clinical expertise, enabling him or her to diagnose and manage most common and chronic illnesses, either independently or as part of a health care team. Nurse practitioners in most states have prescriptive authority (American College of Nurse Practitioners, 1998). For the purpose of this study, also included is the

stipulation that they are members of the active duty population of the United States Air Force, practicing as providers in a clinical setting.

Ethical

This term may be used interchangeably with moral, to describe human behavior in a right or wrong context as it pertains to good or evil (Bunting & Webb, 1988).

Ethical situations/issues

Are situations or conflicts where the decision options are choices between two desirable or undesirable outcomes that are equal in nature (Bunting & Webb, 1988).

Assumptions and Limitations

Several assumptions were inherent in the study.

1. AFNPs experience ethical situations/issues in their clinical practice and were willing to share their experiences about those situations/issues.

2. AFNPs had time to respond to a written request to describe the ethical issues/situations they encounter in clinical practice, or were willing to participate in a telephone interview.

3. AFNPs had an interest in participating in this research study.
Limitations inherent in the study are:

1. AFNPs may have lacked the time to respond in a written format or participate in a telephone interview.

2. Interpretation of the meaning of the experience may have been limited by the lack of advanced practice experience of the researcher.

Summary

Nurses confront ethical issues in daily practice. The advances in technology

have widened the scope of ethical issues nurses are confronted with, as patient advocates and protectors of the community health and moral values of society.

AFNPs are faced with ethical issues in the Air Force health care community. The examination of these situations furthers the base of nursing knowledge and encourages dialogue between the civilian and military health care communities.

The phenomenological approach has been used to obtain the descriptions and to interpret the meaning of the experience, revealing useful knowledge. These descriptions have advanced the body of nursing knowledge and are beneficial to the future of AFNP clinical practice.

CHAPTER II: REVIEW OF THE LITERATURE

INTRODUCTION

A review of the current literature was undertaken to illustrate the need to explore the ethical issues and situations faced by AFNPs. Topic areas explored were; cognitive development and education, moral reasoning, and care and justice principles. It was revealed the ethical issues and situations experienced by NPs have not been widely studied.

The Air Force, concerned with ethical behavior, published a set of Air Force Core Values in 1997. These values addressed the three key principles of ethical Air Force conduct, integrity, service, and excellence. Limited Air Force research about ethical issues in nursing was available.

Recent studies stress the role of caring in ethics, as well as the pressures identified by registered nurses, but do not address the issues unique to NPs or AFNPs. This purpose of this study was to explore the ethical issues/situations experienced by the AFNP.

Cognitive and Moral Reasoning Development

According to Crisham (1981), early research in nursing ethics reflected primarily the cognitive theory of moral development as set forth by Kohlberg. Crisham explained building on the works of Piaget in the early 30's, Kohlberg (1976) proposed that development of moral reasoning is directly related to cognitive development. Kohlberg utilized the responses from children of different ages to draw a parallel between the cognitive development and moral development of the human mind. Kohlberg's theory of moral development reflects the idea that there is a genetic

component in each of us to develop the principle of social justice (Crisham, 1981). Social justice guides us to be fair with one another in human relations because of the inherent belief that all human beings are equal in value (Flake-Hobson, Robinson, & Skeen 1983). In addition to a genetic component, education seems to also play a role in the development of moral judgment.

Crisham's 1981 study to measure the moral judgment in nursing dilemmas was based on Kohlberg's 1976 theory. Her results, gleaned from a sample of 225 nurses and non-nurses verified that scores on the nursing dilemma test and levels of education were positively correlated. The higher the level of education, the higher the score achieved on the dilemma test. Experience was also demonstrated to be a factor in moral development in her study.

Additionally, Crisham (1981) found novice nurses chose the ideal solution more frequently than their more experienced counterparts. The more experienced nurses answered the questions based on reality not the ideal solution. Crisham concluded that further research needed to be done to illuminate reality versus ideality in making ethical decisions.

Justice

In 1979, Mahon and Fowler recognized that perhaps it was not only the stage of moral development of the nurse, but also the personal values and beliefs of the individual that play a role in clinical decision making. They found that Kohlberg's 1976 theory provides a useful tool to establish a correlation between moral development and education in nurses. Researchers subsequently wondered whether

there was a relationship between moral reasoning and a nurse's perception of realistic moral behavior in nursing dilemmas (Ketefian, 1981).

Ketefian (1981) disclosed in her study of 79 practicing nurses, there might be more than situational justifications to the ethical decisions nurses made. Using Kohlberg's 1976 theory, Ketefian found there were differences between ideal and realistic moral behavior, and cultural differences in moral behavior as well. Nurses with less than one year of experience held higher ideals than their more experienced counterparts. Ketefian (1981) concurred with Crisham (1981) that nurses' knowledge and values were not translated into practice. An example of this is nurses held high ideals from their education; however, once they had acquired more experience their behavior was affected by factors other than their ideals. Ketefian's (1981) results agreed with Crisham's (1981) that experience and practice effected ethical decisions. Personal values influenced the difference in responses between real and ideal situations in practice. Ketefian (1981) concluded this area needed further research.

Caring

Gilligan (1982) expanded her exploration of Kohlberg's theory of moral development to female subjects. Gilligan felt Kohlberg's original results negated the role that gender plays in moral development and that the results could not be translated to the general population. This criticism of Kohlberg evolved into her study that concluded that there were other issues besides justice, fairness, and rights of others that shape the way women frame moral conflicts and choices. Gilligan found that women were more concerned with connecting and the relationship attachments between people. This translated into care as a concept. Gilligan proposed that

Kohlberg's 1976 theory lacked the human element of caring perhaps the highest form of moral development. Nurse educators, recognizing care as basic to nursing, incorporated it into the moral curricula of nursing schools (Bevis & Watson, 1989; Moccia, 1990).

Kelly (1992) expounded on the ethics discussion stimulated by Gilligan 1981, and interviewed 23 senior baccalaureate-nursing students to explore their perceptions about professional ethics. She discovered that these students linked professionalism with good nursing, identified values consistent with the professional code of ethics, and believed that caring was a part of good nursing. Kelly found that nursing students felt respect and caring were integral to nursing and nursing ethics.

Since the late 1980s, nursing research has addressed caring as a central theme to nursing. In 1989, Jean Watson's philosophy and theory of human caring in nursing addressed human love and caring as it related to the nursing profession (Bevis & Watson, 1989). In 1990 she addressed another aspect to caring in the relationships of nurses and their patients; her feeling that the male-oriented view of the world influenced not only the way nurses thought, but also it indirectly affected the lives of their patients because of these thoughts. Watson addressed the patriarchal nature of the health care system, although many women were now primary care providers there did not seem to be an impact on the system as a whole. Watson believes there is an invisible care morality that has been largely ignored because it is linked to feminism. She also believes we do not have to justify our caring, it is our moral worldview, it becomes our politics, our policy, and our underlying consciousness. Her fear is if we do not use our caring morality, we will accept the following value assumptions; that

there is a naturalness to unequal access to healthcare; that destroying disease is done separately from the human body and soul, and that the treatment of illness is done at all costs, without respect to the holistic nature of the human being. This is the framework of the male oriented view of the medical world (Watson, 1990). Watson believes that it is not necessary for nurses to justify caring about their patients. Caring is a part of human emotion, it influences every facet of our lives, caring is simply what nurses do.

Caring is part of our social, professional, and political identities, it is not a separate entity. Watson is concerned that if we concentrate on quantifying our care, we will lose the perspective of care and default to the assumption that it is acceptable for there to be unequal access to healthcare. Watson is apprehensive that in the future of health care we will consider the mind and body as two separate entities, rather than the holistic being nursing has come to define and know (Watson, 1990).

Clarke and Wheeler, (1992), agree with Watson's concerns. They studied the quality of care given by six practicing registered nurses in a British hospital by asking them to describe what constituted caring for them in their clinical practice. The insight the researchers gained was nurses approached their patients with caring and love in response to the needs and problems the patients presented. Pressures in the workplace influenced nurses caring and the quality of that care. Lack of time, doctors withholding information, lack of support, inexperienced staff, fatigue, and frustration all effected the quality of care given to their patients. Nurses in this study felt they gave lower quality care because of the situations described above. Nurses were forced by outside influences to alter the care to their patients and the nurses felt this alteration

became less than optimal care. This study allowed nurses to describe what care was to them and helped them gain more insight into what effected their care of patients.

O'Connor (1996) examined the narrative responses of 70 oncology nurses regarding ethical situations in their clinical practice. The nurses emphasized and described attributes of a caring perspective, rather than a justice perspective, when discussing dilemmas in their clinical practice. The responses were analyzed using the moral principles of autonomy, beneficence, non-maleficence, and justice, as set forth by Beauchamp and Childress (1984). O'Connor's conclusions led to reinforcement of the caring principles in ethical decision making by oncology nurses. This study described the principles used by oncology nurses to make ethical-moral decisions. Further studies are needed to address if the terminal nature of the patient affected the feelings of the nurse.

Air Force Values

Scannell-Desch (1996) explored the lived experience of military nurses in Vietnam, and the difficulties they faced during war time operations. In 1998, Turner published her study of 13 Air Force chief nurses and their deployment experiences during military operations. Turner's study revealed five "essential themes: paradox, leadership, caring, knowing, and the true military" (p. iii). This study of military nursing experience illustrated some of the ethical issues of Air Force nurses, including caring, but did not investigate the ethical issues experienced by AFNPs in clinical practice. The Air Force had adopted a set of core values to help guide ethical behavior in the Air Force previous to Turner's 1998 study.

The United States Air Force (1997) are a set of organizational ethics all Air Force members are expected to internalize and follow in their personal and professional lives. These core values reflect many of the principles of caring and justice:

1. Integrity first.
2. Service before self
3. Excellence in all we do

Integrity is a character trait. It is the willingness to do what is right even when no one is looking. Integrity is the ability to hold together and properly regulate all of the elements of a personality. Integrity also covers several other moral traits indispensable to national service: courage, honesty, responsibility, accountability, justice, openness, and self-respect.

Service before self tells us that professional duties take precedence over personal desires. At the very least it includes the following behaviors: rule following, respect for others, discipline and self-control, including controlling anger, appetites, and religious intolerance, and faith in the system.

Excellence in all we do directs us to develop a sustained passion for continuous improvement and innovation that will propel the Air Force into a long-term, upward spiral of accomplishment and performance including, product/service excellence, personal excellence, community excellence, inclusive of mutual respect and benefit of the doubt, resources excellence, both material and human, and lastly operational excellence, internal and external operations (United States Air Force, 1997).

Summary of the Literature

The dual role as officers and healthcare providers places AFNPs in unique situations. The Air Force has established a set of organizational values, ethical-moral standards to encourage good moral character and professionalism in all its members. This set of values emphasizes the importance the Air Force has placed on ethical behavior. Air Force Nurse Practitioners have not been studied to determine how they describe the ethical situations they experience in clinical practice. Researchers have studied nursing students, staff nurses, and oncology nurses with respect to their ethical orientation and decision making processes, however the research to date has not focused on the unique experience of AFNP.

Describing the ethical situations encountered in the clinical practice of Air Force nurse practitioners illustrates some of the same frustrations, pressures, or philosophies identified by other nurses. Previous ethical research has dealt minimally with nurse practitioners. No research to date was found that examined the ethical issues and situations military nurse practitioners encounter. The present study provides a beginning point to examine how Air Force nurse practitioners describe and deal with the ethical issues they confront in their clinical practice.

CHAPTER III: METHODOLOGY

Introduction

A descriptive, exploratory approach has been used to answer the questions:

1. What are the ethical issues or situations AFNPs experience in clinical practice?
2. Which moral or ethical principles are reflected?

In this chapter the philosophy and method of phenomenology are discussed. Procedures for the sample selection, data collection, and data interpretation are described.

Protection of human subjects and trustworthiness are presented and discussed.

Methods of the Study

Phenomenology

Phenomenology is the philosophy of being and the method of knowing (Ray, 1994). Human beings are complex. They shape their existence and change according to their own experiences (Polit & Hungler, 1993). Phenomenology is the best suited approach for this study as it emphasizes the description and meaning of lived experiences, and encompasses the philosophy that life is ever changing and there is meaning within each lived experience.

Accepting phenomenology as a philosophy is based on the acceptance of being in the world, a part of the ever-changing dynamics of life and lived experiences. The philosophy of phenomenology is apropos to discovering meaning in lived experience (Ray, 1994).

As a method, phenomenology takes several forms. One form, according to Ray, (1994) is based on the works of Husserl, concerned primarily with description of the experience, and eliminating presuppositions from the recounting of the experience.

This form seeks to describe lived experience, but not to interpret the meaning of the experience. Ray further explains Husserlian phenomenology as it relates to being *of* the world as opposed to Heideggerian phenomenology being *in* the world. Heidegger, according to Ray (1994) believed that human experience and understanding are necessary to elicit meaning in lived experiences. AFNPs descriptions of their lived ethical issue experiences were examined for themes and meanings using the Heideggerian method, searching to understand the meaning of the experience.

Design

Qualitative and Quantitative

There is room in nursing research for both qualitative and quantitative research methods. Quantitative methodology assumes events to be static, replicable and constant. It also assumes that variables are dependent or independent (Hasse & Myers, 1988). Quantitative research focuses on preconceived ideas and the study of a small number of specific concepts through the use of a formal instrument. Subjects are usually under some condition of control and the results are analyzed as numeric information through the use of statistical procedures. Quantitative methods seek not to explain or give meaning to, but to measure the outcome in relationship to the research question (Polit & Hungler, 1993). Quantitative methods are based on measurement and are excellent for descriptions or examining questions. Because the meaning of lived experience is not readily measured, a qualitative method was chosen.

Qualitative methodology views variables as interdependent and ever changing. This method also validates the meaning of the experience for the individual. Qualitative study accepts the reality of an individual as it is given without objective

proof. Qualitative study reflects the sum is greater than its parts, a holistic view of the world (Hasse & Myers, 1988).

According to Polit and Hungler (1993) it is possible to combine both methods, but in doing so, some of the context is lost. The meaning of the experience may not be adequately reflected in data, and data reflects a static place in time and space. It is appropriate to choose the method that best reflects the intent of the study (Hasse & Myers, 1988). This research study describes the meaning of lived ethical experiences of AFNPs. The choice of the qualitative method of research to describe the meaning was the most appropriate.

Research Approach

Sample Selection Procedure

The sample was seven active duty AFNPs with a minimum of one year of clinical experience as an active duty AFNP. Permission to access the participants was requested and granted through the offices of the Air Force Surgeon General.

Snowball sampling was used. This process was begun by inviting an AFNP known to the researcher to participate in this study. This AFNP provided two additional names to the researcher. One of the referred AFNPs suggested contacting the utilization review nurse at her base for additional names of AFNPs that may be willing to participate. Through a process of professional networking referral, the remainder of the participants were identified and invited to participate. This sampling method as described by Patton (1987) builds upon locating knowledgeable individuals and asking for their referrals to other participants that met the criteria to participate in the study.

Experiencing an ethical issue or situation in clinical practice, and the ability to articulate the feelings associated with that experience were necessary to participate in this research project. In addition the participants met the following criteria:

1. Participants were able to recall their ethical experiences.
2. Participants were willing to write about those experiences, or communicate the experience during a recorded telephone interview.
3. Participants were willing to participate in the study.
4. Participants had a minimum of one-year experience as an AFNP in clinical practice.

Description of the Sample

There were seven participants in the study, all women. Three were Air Force captains, three were majors, and one was a lieutenant colonel, all currently on active duty. The average time on active duty was 13 years, with a range of 7.5 to 18.5 years. The average number of years practicing as a nurse practitioner was 7.5, with a range of 1.5 to 15 years. The average number of years in nursing of the participants was 16.2 with a range of 12 to 20 years. Four of the participants held master's degrees, three held master's in nursing degrees, one held a master's in another field, and one nurse held a dual master's in nursing and another field. Three nurses did not hold master's degrees.

Two of the participants were Family Nurse Practitioners; five were Women's Health Nurse Practitioners. Three of the participants identified themselves as managers in addition to their role as practitioners.

Data Collection Procedures

Each participant was mailed materials consisting of an explanation of the

research project, an invitation to participate in the research project, a demographic sheet, a consent form, two addressed stamped envelopes, and a sheet of lined paper. They were asked to respond to the statement: Describe a situation in your nurse practitioner role in which you experienced ethical questions. Share all thoughts, perceptions, and feelings you can recall until you have no more to say about the situation.

Participants were also informed they could respond electronically or request a recorded telephone interview. Demographic sheets were mailed to the researcher in separate envelopes from the mailed narrative responses. There was no link between the response and the demographic information returned in the study.

Data Analysis Procedures

Written responses were transcribed into a typed format. Original responses were kept in a locked file in the researcher's office. There were no electronically submitted responses. No participants requested a telephone interview.

Data analysis procedures were adapted from Colaizzi (1978), O'Connor (1991), Ray (1994), and Turner (1998). The phenomenological approach was best suited for interpreting the lived human experience through analysis of those experiences. Analysis was not one-dimensional and was an ongoing process. The steps of analysis are listed.

1. Each of transcripts was read uninterrupted; to gain a sense of the situation described and the feelings associated with it.
2. Each transcript was read a second time, highlighting significant statements.

3. The research advisor and a nurse expert reviewed a duplicate set of transcripts and highlighted significant statements. The three sets of transcripts were then compared to insure that no statements of significance were missed.
4. Creative insight was used to reveal the meaning of the transcript. Care was taken to preserve the connection with the statements.
5. These steps were repeated with each transcript, organizing the formulated meanings into interpretive clusters. A chart of basic ethical principles according to Beauchamp and Childress (1994) was drawn on paper and each transcript was reviewed and statement clusters were entered on the grid.
6. The field grid was used to organize the principles and situations into themes. Referring back to the original transcripts validated the themes.
7. The themes were then integrated into a comprehensive description of the phenomenon.

Trustworthiness

According to Polit and Hungler (1993), trustworthiness is an evaluation of qualitative data according to the criteria of credibility, dependability, transferability, and confirmability. Credibility is the accuracy and precision of the data. In this study the data was transcribed from the original responses in their entirety. An advisor viewed the original and transcribed responses ensuring an accurate copy of the original response. This review insured the transcripts had no omissions.

Polit and Hungler (1993) stated “the dependability of qualitative data refers to the

stability of data over time and conditions” (p. 255). In this study dependability was achieved by having the advisor review a duplicate set of the transcripts and highlight the significant statements in each transcript. The advisor’s transcripts were then compared to the researchers highlighted transcripts to insure the dependability of the researcher’s interpretation. Dependability was further insured by a nurse expert’s review of the transcripts and the interpretations of the ethical themes, ensuring the consistency of the researchers interpretation.

Transferability is parallel to generalization in the quantitative research realm. The responsibility of the researcher is to provide descriptive data in the research report so that others may determine the value and applicability of the data to other circumstances (Polit & Hungler, 1993). In this study, transferability was achieved through the use of rich descriptions in the text of the findings.

Confirmability is the accurate and accountable management of the data. For data to be confirmable, it must be presented objectively and with neutrality (Polit & Hungler, 1993). In this study, the review and agreement of the nurse expert and advisor with the researcher’s transcription and interpretation of the original narratives ensured confirmability.

Trustworthiness in this study was demonstrated through careful evaluation of the data. Credibility, dependability, transferability and confirmability were achieved though accurate transcription, thoughtful analysis, interpretation, with advisor and nurse expert reviews of the data.

Human Subject Consideration

Approval was obtained from the Uniformed Services University of the Health

Sciences Institutional Review Board and the United States Air Force, Office of the Surgeon General prior to data collection. Human subject considerations included limited anonymity in the presentation of the findings by eliminating references to clinics where the issue or situation occurred, confidentiality and security of the materials in a locked file in the office of the researcher, and a written statement of informed consent.

Summary

This chapter discussed the selection of the qualitative research approach of Phenomenology for examining the ethical issues encountered by Air Force nurse practitioners. Selection criteria and a description of the sample demographics as well as data collection procedures were furnished. The data analysis procedure steps were outlined and trustworthiness criteria and fulfillment in this study were presented. The next chapter will present the findings of the study.

CHAPTER IV: DATA ANALYSIS

Introduction

This chapter presents a description of the data. The findings are presented using the four basic principles of biomedical ethics as outlined by Beauchamp and Childress (1994). These four basic principles are respect for autonomy, nonmaleficence, beneficence, and justice. Although Beauchamp and Childress define nonmaleficence and beneficence as separate principles, for the purpose of this study, they will be presented on a continuum as described by Frankena (1973).

Respect for Autonomy

Beauchamp and Childress (1994) define respect for autonomy as an obligation “to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision making” (p. 127). Respect for autonomy differs from autonomy itself in several ways. Respect requires more than an attitude, it requires an action. It is not enough to state that a person has a right to act and make decisions independently. Respect for autonomy directs the lessening of fears or other circumstances that interfere with a person’s ability to take action or make choices based on their personal beliefs. According to Beauchamp and Childress, respect for autonomy is exhibited by the five following examples of moral rules.

1. “Tell the truth.”
2. “Respect the privacy of others.”
3. “Protect confidential information.”
4. “Obtain consent for interventions with patients.”
5. “When asked, help others make important decisions.” (p. 127)

How each AFNP demonstrated respect for autonomy was illustrated in excerpts from the responses. One practitioner addressed an ethical situation where truth telling could have affected the autonomy of the patient. Out of respect for her autonomy, the AFNP declined to disclose confidential information about her patient.

After the initial interview with the patient and mother, I excuse the mom to speak privately. If upon ensuring confidentiality, the patient reveals that she is sexually active and seeking contraception but is not ready to inform her parents, I will not document this in the chart. I usually document a diagnosis of menstrual irregularity which is a catchall phrase and can mean anything you want as opposed to true diagnoses as metorrhagia, polymenorrhea, menorrhagia which have precise definitions. I am very careful to document the menstrual interval, flow (pads/day), and length in days. I do not disclose this sexual activity, because I feel very strongly about keeping the confidentiality of my patients, and open access to records does not allow me that confidentiality.

This situation resulted in the AFNP documenting the clinical data in the record. Respect for the patient's privacy and protection of her confidentiality was given as justification for not providing the complete truth.

Telling the truth, protection of confidentiality, and privacy as a respect for the autonomy of the patient were illustrated in the following example. There was a question if the adolescent had participated in consensual sexual intercourse or had she been raped.

My dilemma was whether she had been “raped” or had consensual sex with a young classmate. I was unsure which had transpired, so went to my supervisor. We, together, called the hospital legal consultant who advised me to report this to Family Advocacy. In the end, the social workers concluded this was teenaged experimentation and her parents were not notified. All the while, of course, this young 14 year old was terrified her parents would find out, and we would all be violating her confidentiality. Oh I forgot to mention that because a possible rape occurred, they sent over an OSI (Office of Special Investigations) agent to take my statement.

This was a difficult situation, requiring the AFNP to enlist the supervisors involvement, and subsequently reporting to Family Advocacy and OSI, potentially jeopardizing the patient’s privacy and confidentiality. In this situation the AFNP had to weigh respect for the patient’s autonomy with nonmaleficence, doing no harm.

Two important aspects of autonomy are illustrated in the following examples; telling the truth and helping others make important decisions. In these examples both AFNPs set aside their personal beliefs and convictions to provide their patients the necessary information to make informed decisions in their care, illustrating their respect for the patient’s autonomy, while making clear the conflict within themselves.

I have a patient who had unprotected sex and requested emergency contraception, I do not recall if she was married or not and I’m not sure if those circumstances matter. I wrote the prescription for high dose OCPs to be taken 12 hours apart to prevent possible implantation of a

fertilized egg. I struggled with this issue because I am not really sure if the medication would be considered to cause an abortion. I believe life starts with fertilization and therefore it conflicts with my beliefs.

Another expressed her feelings about the same issue.

I am personally a pro-life advocate, but approach the patients of elective abortions with a nonjudgmental attitude. It is a very difficult situation. Separation of religious beliefs and clinical practice proves challenging. It is a personal struggle for me to do follow up elective abortions. Emergency contraception and abortion counseling are areas I struggle with. I make a conscious effort not to impose my beliefs/thoughts to the patient while discussing all the options.

These situations illustrated respect for autonomy and also under scored the AFNPs personal beliefs that abortion or harming a fetus is wrong. Preventing harm and doing good represent the opposite ends of the continuum of nonmaleficence and beneficence.

Nonmaleficence and Beneficence

The principle of nonmaleficence according to Beauchamp and Childress is “one ought not to inflict evil or harm” (1994, p. 192). Nonmaleficence is the act of consciously not inflicting harm to another. It is not enough to do the right thing but one must actively be preventing harmful or evil acts.

“Morality requires not only that we treat persons autonomously and refrain from harming them, but also that we contribute to their welfare” (Beauchamp & Childress, 1994, p. 259). Beneficence requires more than not intentionally harming patients.

Beneficence directs the positive action of assisting others to achieve their goals and is the principle behind the Good Samaritan laws.

As with respect for autonomy, there are moral rules that define some of the activities of beneficence.

1. "Protect and defend the rights of others."
2. "Prevent harm from occurring to others."
3. "Remove conditions that will cause harm to others".
4. "Help persons with disabilities."
5. "Rescue persons in danger." (Beauchamp & Childress 1994, p. 262)

Nonmaleficence and beneficence are at times such subtle differences in language that for the purposes of this study, they are presented together as conception on a continuum. That continuum ranges from not inflicting harm, nonmaleficence, to actions taken to benefit others, beneficence (Frankena, 1973).

Nonmaleficence was exhibited in several different situations as described by AFNPs. First were the thoughts of not doing harm through conscious omission of assessment questions.

Sometimes I avoid a question that perhaps I should ask because I don't want the answer because then I have to address it, and don't have the time for it. Or then I have to chart it and do more of a physical exam to support it. Ethically this is probably wrong. Ethically, when you have been educated and you know what should be done, what should be addressed and you withhold, it's probably wrong, even though you

haven't inflicted harm. You could potentially be inflicting harm down the road.

In this example the AFNP also expressed the difficulty of providing health care when time becomes a constraint. Then she went on to discuss how she provided optimal care that benefited patients within the time constraint.

Sometimes when I am pushed for time, behind with patients, and tired, I stick to the basics knowing that the patient needs more medical care such as prevention.

I don't address it. I rationalize that I'll have more time next visit.

Ordinary versus extraordinary care are two examples this AFNP described on the continuum of nonmaleficence and beneficence. Providing the patient with adequate and appropriate care in the available time opposed to being able to provide all the teaching and prevention assessment that would transpire during the perfect health care encounter.

Nonmaleficence can take another form. Managed care issues are cited as causing harm to patients in a third set of examples illustrated by AFNPs. The feelings of abandoning patients, forcing patients to pay out of pocket health care costs, and providers spending hours in administrative duties rather than patient care were examples of potential harm to patients.

A man in his forties on terminal leave had recently made his home in our area. He had been diagnosed with Hepatitis C prior to his terminal leave at his last duty station over 1500 miles from us. He was told our base would take over his evaluation and treatment. At his prior base he had

not received a liver biopsy necessary to his care. I referred him to a specialist in our area for the biopsy. The patient was informed that his liver biopsy was cancelled by TRICARE (the military managed care agency) because he was considered outside of his catchments area. He now belonged to TRICARE remote and TRICARE remote would not authorize the biopsy because it should have been done at his last duty station. Neither the patient nor the providers had been notified of this change between the time of his specialist visit and the scheduled liver biopsy. We had to tell the patient his options were to pay for his biopsy or return to his former duty station (1500 miles away) and have the biopsy scheduled there. I felt that we had abandoned care in this case and perhaps patients with difficult problems are pushed off on someone else too quickly. I also feel that the changing rules of HMO's (Health Maintenance Organizations) seem to benefit only the company and have completely lost sight of the person.

This provider clearly felt she had abandoned the patient in his need. Paying for necessary health care out of pocket was briefly mentioned as one of his options, but what of those who are left with few options? In the following example, this AFNP addressed the hardship to older patients and the feeling that we owe our older veterans something better than the options they were given in this case. Not only does this example illustrate nonmaleficence, but also the principle of justice to be discussed later in this chapter.

The over 65 retiree population was prohibited from access to the medical

clinics. Many of them on limited budgets were suddenly forced to seek medical care elsewhere or pay back deductibles to Medicare. Many of these patients had been my best patients in the system. They always kept appointments and were appreciative of our services. I remember the inner conflict and resentment I had toward the military for this decision. I believed as many do that medical care benefits should exist for life as they had been promised many years ago. Many of my patients and their husbands had served our country in past wars and I think they deserve better treatment.

Sometimes it is not the options available, but the system itself that causes the AFNP to be concerned that patients may be harmed as this AFNP describes staffing shortages and her attempts to ensure the available staff was properly trained.

Due to the lack of planning and support staff, the care we delivered our patients became very challenging. Also due to decreased manning and other additional duties there were numerous times I had no help at all. I repeatedly went to my Nurse Manager and Element Chief about ways to improve the care and services provided to our patients. I requested that the support staff be trained in ways to assist us in providing optimal services. I continued to bring these issues to the management.

Properly trained staff helps ensure patient safety and assist AFNPs in providing optimal care. Accurate measurement and documentation of vital signs, competent assistance with procedures, and recognizing ominous symptoms in patients are all illustrations of duties performed by properly trained staff. Without properly trained

staff there is an increased risk of harm to patients. This AFNP expressed her duty to speak up and prevent harm from occurring to patients by requesting support staff be properly trained demonstrating the principle of beneficence.

An excerpt below draws attention to the choices one must make on the continuum of nonmaleficence and beneficence. In this narrative the AFNP described a case in which a mother requested her daughter be tested for HIV (human immunodeficiency virus). The mother refused to bring the daughter in for an examination and interview or counseling that is required by law in many states. In this case the AFNP had to decide which was better, to test the daughter for HIV without knowing if she had any risks for contracting the disease, or refuse to test the daughter, knowing she may be HIV positive.

I was asked to draw an HIV test on a teenage girl by her mother, but the mother would not allow me to speak with the girl or examine her. I refused her request because what if it is positive? I tried but I could not convince the mother that there were appropriate medical reasons for me to know more.

The AFNP chose not to test the daughter knowing that she may be HIV positive, yet, knowing it may be a greater harm to be unable to counsel the girl that HIV is not a death sentence and there are treatment options. This example also highlighted the need to protect persons who are vulnerable, such as adolescents.

Many other populations besides youth are vulnerable; homosexual, mentally retarded, physically disabled, and minority populations are also vulnerable. There is a need to safeguard these populations beyond the routine protection afforded by law

occasionally to ensure they are not discriminated against. One AFNP highlighted this protection by her practice of documenting only clinically relevant material in the medical record to prevent chance discovery and potential adverse reactions to the lesbian population.

With lesbians, and admittedly I have not had many who have disclosed, I will not document this in the chart for this can have serious ramifications for them. Again I am put in a bad position because of access to medical records. In this case command access to medical records.

Not documenting sexual orientation may offer some protection from inadvertent discovery and potential discrimination.

Nonmaleficence and beneficence were often difficult to separate as frequently they were interwoven in situations that AFNPs encountered. The principle of justice was more clearly stated in terms of the AFNPs feeling limited in their ability to provide equal treatment for all patients.

Justice

The theories and definitions of justice are broad and loosely defined. Justice is “fair, equitable, and appropriate treatment in light of what is due or owed to persons”(Beauchamp & Childress, 1994, p. 327). This description defines justice as a right, an entitlement, or something that is owed to a person. Persons need to be treated equally and fairly according to the principle of justice. The AFNPs in this study also expressed this sentiment in the following excerpts. They spoke to the fairness in the managed care system.

My biggest ethical issue as a NP came in the last few years when the

military changed to TRICARE in our region. The over 65 retiree population was prohibited from access to the medical clinics. Many of my patients and their husbands had served our country in past wars and I think they deserve better treatment.

This AFNP addressed the fairness of managed care and the unequal allocation of resources. Retired veterans were excluded for the health care system. Another AFNP spoke of the frustration of managed care's changing rules and the feeling that the policies of the system are for the benefit of the organization, not the patient.

HMO rules and changes are an endless source of frustration in my practice. I feel that the changing rules of HMO's seem to benefit only the company and have lost sight of the person and the families.

One reason AFNPs felt limited in their ability to provide equal treatment to their patients was because of organizational policies excluding patients. Another issue AFNPs encounter is being asked to see patients not entitled to care in the military system.

I was asked by my boss to see her family member, who was ill and not authorized care in the military. This placed me in an awkward position. I did not see her family member, but put a lot of effort into finding an appropriate referral for her in the civilian community. I'm pretty good about correcting a wrong, speaking out when is something is clearly wrong or someone will get hurt by it.

This AFNP also exhibited beneficence in finding an appropriate civilian provider for her supervisor's relative. This was one situation that demonstrated the attempt to improperly use resources and the AFNPs conviction to act on her ethical decision. She

knew the relative needed healthcare, but they were not entitled to that care in the military system. She went to the extra length of securing appropriate care in the civilian system.

Summary

In this chapter the findings of the study have been presented using the four biomedical principles outlined by Beauchamp and Childress; respect for autonomy, nonmaleficence, beneficence, and justice. In the AFNPs own words, the ethical dilemmas they face in clinical practice invoke a variety of emotions, frustrations, disappointments, and yet a sense of pride in their ability to be advocates for their patients. In chapter five, the findings are discussed in light of O'Connor's (1991) study of oncology nurses and the implications of these findings in education, practice, and research.

CHAPTER V: SUMMARY

Introduction

The purpose of this study was to describe and interpret the ethical issues AFNPs encounter in clinical practice. This study was based on the work of O'Connor, who studied the ethical/moral language of 70 oncology nurses through the use of written narratives. This chapter discusses the conclusions, implications for nursing, and recommendations for further research derived from this study.

Conclusions

A description of the ethical issues experienced by seven AFNPs was presented in Chapter Four. Like O'Connor's(1991) study of oncology nurses, AFNPs described ethical situations in clinical practice that illustrated the principles of respect for autonomy, nonmaleficence and beneficence, and justice. These findings support the earlier work of O'Connor.

Similar to the nurses in O'Connor's study, AFNPs described situations and issues that pertained to more than one ethical principle. Respect for autonomy was cited in a majority of the responses in both studies. Respect for "autonomy in patients has central import in the practice of nursing and pervades our ethical language." (Liaschenko, 1993, p. 78)

Findings of beneficence and nonmaleficence in O'Connor's 1991 study were reported separately. AFNPs in this study reported both beneficence and nonmaleficence as did the nurses in O'Connor's study.

AFNPs in this study described ethical issues and situations more often illustrating

the principle of justice than the oncology nurses studied by O'Connor (1991). This phenomena may be a reflection of the difference in roles between the groups, the number of years of experience, increased exposure to the managed care system, or may be a result of military culture. This study supports and broadens the findings of O'Connor's 1991 study.

Implications

Education

Nurses experience ethical issues and situations. The AFNPs in this study articulated situations they encountered in clinical practice. Implications of this study illustrate the need for some type of ethics education in advanced practice nursing curricula. The AFNPs made no mention of being prepared to resolve these issues and situations they were confronted with through their own personal experience or education. "The ultimate goal of nursing ethics education in nursing is ethical practice by professional nurses" (Duckett, et al. 1992, p. 324). "Professional moral values may be internalized via education or socialization." (Omery, 1989, p. 502)

The implication for education rests in providing formal ethics classes, or fostering discussions of ethical situations in clinical practice in graduate schools of nursing. Nurses should have the opportunity to explore their feelings about cases that "choose between two mutually incompatible choices related to right or wrong" before they experience them first hand in practice. (Omery, 1989, p. 502) Implications for ethics education research in practice are clearly evident.

Practice

Issues of training, time management, and resource utilization were depicted in the

narratives. The current trend in Air Force clinics is to focus on illness prevention, health maintenance, and seeing more patients in shorter appointments to improve access to care. AFNPs feel pressed for time under the current system to see patients and provide safe care without providing prevention education at each visit. The findings of this study indicate increasing the number of patients per day may result in less opportunity for prevention education during clinic visits. Further research should be done to determine if shortening the appointment time is in the best interest of the patient, provider and organization.

Properly trained staff are key to providing optimal patient care. In this study, the lack of trained staff and lack of numbers of sufficient staff were addressed by AFNPs. Nonavailability of support staff impact the numbers of patients that can be seen per day, as well as compromise the safety of the clinic environment. Implications for practice range from training, safety, and scheduling to opening a dialog between different types of health care providers.

Recommendations for Research

AFNPs written responses were studied to reveal the ethical situations they encountered in clinical practice. The ethical situations of civilian nurse practitioners should be examined to explore the similarities or differences in situations and feelings encountered.

Studying the ethical issues of physician assistants and physicians in the military community may provide information necessary to implement policy changes insuring optimal health care for beneficiaries. Including data from these groups would give a more complete picture of the ethical issues in clinical practice. Information gathered may be

key to effectively creating patient templates may be consistent with the philosophy; the right patient in the right appointment with the right provider.

Further study is needed to reveal ethical issues experienced in a variety of clinical practice situations. Exploration of the ethical issues experienced in small clinics, medical centers, and geographically separated clinics will add to the foundation of ethical knowledge and may impact policy decisions.

In this study, all participants were female with a range in years of AFNP experience. Male AFNPs should be studied examining what ethical issues they experience to increase the knowledge base in nursing. Further exploration of ethical issues AFNPs at different experience levels should be done determining if there are different ethical issues or ways of thinking about ethical issues based on experience levels.

Readiness is our mission. We are physically prepared at a moments notice to depart to anywhere in the world. Examining ethical issues experienced during operations other than war and during conflict may better assist the military in preparing health care providers for the psychological challenges of deployment.

Research on effective ethics education, and efficient use of ethics education would likely have a positive impact on patient satisfaction. Patients want to be treated justly, with respect for their autonomy and with nonmaleficence and beneficence by their health care providers. With the effective use of ethics education, patients would be more satisfied, and provider satisfaction should rise. The rise in professional satisfaction could positively impact the retention of professional medical and nursing providers the military.

Summary

This study found similarities and differences compared with O'Connors' (1991) study of 70 oncology nurses. These findings support the need to establish formal ethics classes in the nursing curriculum. Implications for use in clinical practice include time management, resource utilization, and training. More research is needed to determine if the experiences of AFNPs are universal to the profession of advanced practice nursing. All types of military health care providers in varied physical settings should be studied to aid in policy and practice implementation of the TRICARE managed care system. Examining the ethical issues they encounter may also enhance the effectiveness of health care providers during deployment. Patient and provider satisfaction, and increased retention in military service may all be impacted by further research in ethical issues in clinical practice.

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APPENDICES

Letter of Invitation to Participants

Informed Consent Form

Appendix A

Letter of Invitation to Participants

Date:

To:

From: Carol L. Gilchrist, Captain, USAF, NC

Subject: Participation in Research Study

1. You are invited to participate in a study of the ethical issues experienced by Air Force nurse practitioners in clinical practice. I hope to learn what ethical issues are confronted in clinical practice and what thoughts you may have about these issues. You were selected as a possible participant because you are a nurse practitioner in the Air Force.
2. The purpose of this study is to further the body of nursing knowledge by studying the ethical issues experienced by Air Force nurse practitioners in clinical practice. I hope to learn what ethical issues are confronted in clinical practice and what thoughts and concerns you have about these issues.
3. If you choose to participate, I ask that you fill out the enclosed demographic form, sign the consent form and return it to me via the materials provided. Please fill out the narrative sheet about your ethical issue or situation you encountered in your clinical practice and return to me in the second stamped envelope provided, or via my electronic mail addresses: <cgilchrist@usuhs.mil>, <smile4u2day@erols.com>. If you would prefer to talk to me about the issue you encountered in clinical

- practice, a recorded telephone interview will be arranged at your convenience, by providing me with a telephone number to contact you. There are no risks or benefits to being in this study other than your contribution to the body of nursing knowledge.
4. The records of this study will be kept private. In any report to be published there will not be included any information that will make it possible to identify you as a participant. Records will be kept in a locked file, with limited access to this file. Confidentiality will be insured by separating the narrative from the informed consent and demographic sheets immediately upon receipt of the returned materials.
 5. Your decision whether or not to participate will not effect your status or relationship with the USAF. If you decide to participate, you are free to withdraw at any time without affecting that relationship or status.
 6. Contacts and Questions. I am the researcher conducting this study; my name is Capt. Carol L. Gilchrist. You may ask me any questions you may have now or later by contacting me at (301) 545-0267. You may contact my advisor Dr. (Col.) Martha Turner at (301) 295-1009.

Carol L. Gilchrist

Captain, USAF, NC

Appendix B

Informed Consent Form

Research Study

Ethical Issues of Air Force Nurse Practitioners in Clinical Practice

You are invited to participate in a study of the ethical issues experienced by Air Force nurse practitioners in clinical practice. I hope to learn what ethical issues are confronted in clinical practice and what thoughts and concerns you have about these issues. You were selected as one of a possible 30 participants because you are assigned as a nurse practitioner. You are being asked to take part in a research study. Before you decide to be a part of this study, you need to understand the risks and benefits so that you can make an informed decision. This is known as informed consent.

This consent form provides information about the research study, which has been explained to you. Once you understand the study and tasks it requires, you will be asked to sign this form if you want to take part in the study. Your decision to take part in the study is voluntary. This means you are free to choose if you will take part in the study.

Description, Purpose and Procedures.

This study is being conducted by myself, Capt. Carol L. Gilchrist, USAF, NC;
Graduate Student, Masters of Science of Nursing Program, Uniformed Services

Date_____ Initials_____

University of the Health Sciences, Bethesda, MD. My advisor is Dr. (Col.) Martha Turner. I hope to learn what ethical issues are confronted in clinical practice and what thoughts and concerns you have about these issues.

If you choose to participate, I ask that you fill out the enclosed demographic form, sign the consent form and return it to me via the materials provided. Please fill out the narrative sheet about your ethical issue or situation you encountered in your clinical practice and return to me in the second stamped envelope provided, or via electronic mail addresses: <cgilchrist@usuhs.mil> or smile4u2day@erols.com >. If you would prefer to tell me about the issue you encountered in clinical practice, a recorded telephone interview will be arranged at your convenience, by providing me with a telephone number to contact you.

Possible Risks and Benefits.

There are no risks or benefits to being in this study other than your contribution to the body of nursing knowledge.

Privacy and Confidentiality. All information that you provide as a part of this study will be confidential and will be protected to the fullest extent of the law. Information that you provide and other records related to this study will be kept private, accessible only to those persons directly involved in conducting this study and members of the Uniformed Services University of the Health Science's Institutional Review Board and other Federal agencies who provide oversight for human use protection. All

Date _____ Initials _____

questionnaires and forms will be kept in a restricted access, locked cabinet while not in use. However, please be advised that under Federal Law, a military member's confidentiality cannot be strictly guaranteed. To enhance your privacy of the answers that you provide, data from your responses will be entered into a database in which individual responses are not identified. After verification of the data base information, the hard copy of the responses containing identifiers will be shredded.

Right to Withdraw from the Study. Your decision whether or not to participate will not effect your status or relationship with the University or the USAF. If you decide to participate, you are free to withdraw at any time without affecting those relationships or status.

Contacts and Questions. The researcher conducting this study is Capt. Carol L. Gilchrist. You may ask me any questions you may have now or later by contacting me at (301) 545-0267 during evening or weekend hours. You may contact my advisor Dr. (Col.) Martha Turner at (301) 295-1009 during business hours.

Statement of Consent.

I have read the above information. I have asked questions and received answers. I

consent to

participate in the study. By signing this consent form you are agreeing that the study

has been explained to you and that you understand the study. You are signing that you

Date_____ Initials_____

agree to take part in this study. You will be given a copy of the consent form.

I would/would not like a summary of the final results.

SIGNATURE:

DATE:

I certify that the research study has been explained to the above individual by me and the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.

SIGNATURE OF THE INVESTIGATOR:

DATE: