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Everyday Ethics: Ethical Issues and Stress in Nursing Practice

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Abstract

Aim—This paper is a report of a study of the type, frequency, and level of stress of ethical issues encountered by nurses in their everyday practice.

Background—Everyday ethical issues in nursing practice attract little attention but can create stress for nurses. Nurses often feel uncomfortable in addressing the ethical issues they encounter in patient care.

Methods—A self-administered survey was sent in 2004 to 1000 nurses in four states in four different census regions of the United States of America. The adjusted response rate was 52%. Data were analyzed using descriptive statistics, cross-tabulations and Pearson correlations.

Results—A total of 422 questionnaires were used in the analysis. The five most frequently-occurring and most stressful ethical and patient care issues were protecting patients' rights; autonomy and informed consent to treatment; staffing patterns; advanced care planning; and surrogate decision-making. Other common occurrences were unethical practices of healthcare professionals; breaches of patient confidentiality or right to privacy; and end-of-life decision-making. Younger nurses and those with fewer years of experience encountered ethical issues more frequently and reported higher levels of stress. Nurses from different regions also experienced specific types of ethical problems more commonly.

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Conclusion—Nurses face daily ethical challenges in the provision of quality care. To retain nurses, targeted ethics-related interventions that address caring for an increasingly complex patient population are needed.

Keywords

Ethical issues; stress; nursing practice; patient rights; autonomy; informed consent; survey

INTRODUCTION

Nurses everywhere have long struggled with ethical challenges in patient care. In fact, in Florence Nightingale's *Notes on Nursing*, she discussed ethical duties of confidentiality, communication, and the centrality of meeting patients' needs (Nightingale, 1859; Ulrich & Zeitzer, 2009). Similarly, nurses today are bound to uphold the foundational moral virtues, duties and principles central to the nursing profession. However, it has become increasingly difficult for nurses in all parts of the world to practise with integrity amidst the complex moral choices and pressures that nurses confront.

Today's healthcare environment is demanding for nurses at a time when there is a critical shortage of staff to meet the multifaceted needs of patients. An ethical issue can occur in any healthcare situation where profound moral questions of “rightness” or “wrongness” underlie professional decision-making and the beneficent care of patients. For example, critical care nurses often face suffering head-on, and might question the balance between the value of attempts to preserve a patient's life and aggressive physiological measures that appear to prolong anguish and yield no fruitful outcome. Understandably, all members of the healthcare team, including nurses, can be affected by ethical decisions as they address the stressful and sometimes exhausting nature of working through ethical problems.

BACKGROUND

This study was guided by nursing, ethics, and health services theory and literature. Rest's (1986) four-component model of ethical decision-making identifies the importance of recognizing ethical issues that evolve from the social, cultural, and organizational environment in which one is embedded. The ethical issue or problem needs to be identified by the moral agent before moral decision-making processes can be activated. Thus, individuals may differ not only in their recognition of the moral or ethical issues they encounter but also in how they respond. This could vary by age, gender, ethnicity, years in practice or some other identified factors. Additionally, the intensity in which nurses experience these ethical issues or problems can influence the degree to which they engage in moral behavior (Jones 1991). Thus, it is essential to identify the ethical problems nurses face, the frequency with which they confront them, and the level of stress they produce.

Many of the studies that focus on ethical problems in nursing practice produce data unique to a particular specialty area. Such study topics include ethical issues in restraint use in mental health (Redman & Fry, 2003); providing care to high risk neonates (van Zuuren & van Manen, 2006; Janvier et al. 2007; Kain, 2007; Epstein, 2008); initiating, withholding, and withdrawing treatment and advance directives in acute and long-term care (Crego & Lipp 1998; Burns et al. 2001; Redman & Fry 2003); conflict resolution in parent-child-provider relationships in pediatric care (Butz et al. 1998); and physician collaboration, autonomy, and insurance constraints in advanced practice (Laabs 2005; Ulrich et al. 2007).

Studies have shown that nurses, more often than their physician colleagues, feel that end-of-life ethical issues are not thoroughly discussed within the care team or with families and

significant others (Levi et al. 2004). Preliminary studies (Corley et al. 2005) have explored professionals' experiences of ethical stress related to their inability to take moral action.

Redman and Fry (2003) published exploratory work on what is known about ethical conflicts among nurse leaders. Fry and Duffy (2001) developed and tested a tool (Ethical Issues Scale) to assess the full range of ethical issues experienced by nurses in current practice and the frequency of their occurrences. Seventy-nine percent of the 934 nurses surveyed by the American Nurses Association Center for Ethics and Human Rights at the ANA Convention in 1994 reported confronting ethical issues in practice daily (43%) or weekly (36%). Over 50% of these nurses identified the following four issues as the most frequent: cost-containment issues that jeopardized patient welfare; end-of-life decisions; breaches of patient confidentiality; and incompetent, unethical or illegal practices of colleagues. Pain management, use of advance directives, informed consent for procedures, access to healthcare, issues in the care of persons with HIV/AIDs, and providing “futile” treatment completed the list of 10 (Scanlon 1994). Previous researchers, however, have not explored the type, frequency, and level of stress that ethical problems engender in nurses across practice specialties.

THE STUDY

Aim

The aim of the study was to describe the type, frequency, and level of stress of ethical issues encountered by nurses in their everyday practice.

Design

In collaboration with the University of Virginia Center for Survey Research, we developed a cross-sectional descriptive survey and mailed a self-administered questionnaire to a sample of 1000 nurses in 2004. The data presented here are part of a larger survey on ethical issues, preparedness, and job satisfaction of nurses and social workers; the methods have been previously published (Ulrich et al, 2007). For purposes of this analysis, we include only responses from the nurse sample.

Participants

The sample was derived from state licensing lists from four states, one in each of the four census regions of the United States of America (USA) (California, Maryland, Massachusetts, and Ohio). In 2004, we randomly selected 250 nurses from each state list. Four mailings were sent to participants using Dillman's Tailored Design Method (TDM) (1978, 2000) as a guide for the data collection procedures. A total of 422 respondents returned usable questionnaires. The response rate of 52% was calculated according to the standards of the American Association of Public Opinion Research (2000) that adjusts for those who have not responded to the survey and are assumed to be disqualified. The disqualification rate was equal to that known from returned surveys and disqualifications/ refusal slips.

Data collection

Our procedures included: 1) A personalized signed cover letter with the complete survey packet; 2) A follow-up postcard 10 days after the original mailing encouraging completion of the questionnaire; 3) A cover letter and replacement questionnaire three weeks after the original mailing; and 4) A final postcard thanking the participants for completing the survey. Additionally, a small financial incentive (US$2) was included in the initial mailing, and both a paper and web-based format was made available.

Measures

Socio-demographic variables: Socio-demographic variables examined included age, gender, income, practice setting, years in practice, years in position, level of education, ethics education, and state of practice.

Ethical Issues Items: We adapted items developed by the American Society of Bioethics and Humanities (ASBH) to measure the frequency of respondents' direct involvement with ethical issues in their healthcare practice. The Ethical Issues Item Scale was composed of two sets of 16 listed items, designed to measure the frequency of ethical issues that the respondent encounters and the ethical stress associated with each issue. Items include issues such as protecting patient's rights, confidentiality, unethical practices, conflicts of interest, end-of-life concerns, among others. On a 5-point Likert scale from 1 (never) to 5 (daily), respondents were asked to indicate the frequency of their involvement with each of the specific issues over the previous year. Stress associated with each item was also measured on a 5-point Likert scale ranging from 1 (no stress) to 5 (very high stress). Higher scores indicated higher frequency of involvement with each specific ethical issue, as well as higher level of stress. Both scales were internally consistent (α = .82 and .89, respectively).

Ethics Stress Scale: In addition, we included a broader scale of ethics stress developed by Raines (2000) that was adapted to assess individual, organizational and societal effects of ethical decision-making in practice (e.g., powerlessness, fatigue, legal consequences, psychological effects). We used 30 of the original 52 items with good internal consistency reliability (α = .90).

Ethical Considerations

The appropriate institutional review board approved the study. Return of a completed questionnaire represented implied consent. Confidentiality was maintained by using unique identification numbers and all data were reported in the aggregate.

Data Analysis

Data were analyzed using SPSS version 15. Descriptive statistics included frequencies, means, standard deviations, and medians. We used cross-tabulations and Pearson correlations to examine whether ethical problems experienced by nurses varied by sociodemographic characteristics (i.e., geographical region, direct patient care, level of education, and level of ethics education). Missing responses on the scales were negligible, consisting of less than 3% on any one item. For all comparisons, a two-sided statistical significance level of α = .05 was used.

RESULTS

Participant demographics

The sample of 422 Registered Nurses (RNs) was predominantly female (95.1%), White (84.1%), and middle-aged [mean age 45.9 9SD 10.80 years]. The majority worked full-time (67.2%), and practised in various types of direct patient care facilities (e.g., acute, specialty, sub-acute, and long-term care). This cohort was experienced in their professional practice [mean 19.8 (SD 11.6) years], but had been in their current positions for less than 10 years [mean 7.7 (SD 7.95) years]. Less than half were prepared with an Associate degree or Diploma (43.9%), while more than one in three had a Baccalaureate degree (37.8%) and 18.3% were prepared at the Master's level or higher. The distribution of responses from the four states was fairly similar: Maryland (29.3%), Ohio (25.7%), California (23.3%), and Massachusetts (21.7%). Both Maryland and California had a smaller percentage of Whites

and a higher percentage of Blacks compared to the other two states [χ^2 = 34.19, df=9, p<. 001]. Massachusetts had a higher percentage of Baccalaureate-prepared nurses compared to the other three states [χ^2=24.19, df=12, p=.019].

Frequency and stress of ethical and patient care issues

The majority of respondents reported frequently or daily encountering issues related to protecting patients' rights (63.9%) and informed consent to treatment procedures (61.3%). Everyday encounters were also common with advanced care planning (41%), difficult staffing patterns (37.3%) surrogate decision-making (32.5%) and end-of life (26.2%) issues; respondents less frequently reported experiencing breaches of patient confidentiality and unethical practices (Table 1). More than one in every three respondents (37%) reported staffing patterns that negatively affected their work frequently or daily. This was more commonly-reported by nurses who worked for not-for-profit institutions than those who worked in for-profit institutions.

The majority of respondents reported no or low stress associated with each of the items encountered except for staffing patterns that negatively affected their work. Staffing patterns created the most stress (M= 3.20), followed by the stress associated with protecting patient rights (M = 2.41), and unethical practices of healthcare professionals (M = 2.37) (Tables 2, 3). Almost 80% felt confident that they could justify their ethical decisions, and nearly two-thirds (62.3%) felt prepared to deal with ethical issues. Nonetheless, many reported being tired (44%), frustrated (57.5%), and overwhelmed (37.7%) when dealing with ethical issues in practice. Almost three-quarters (71%) reported that there were some ethical issues about which they could do nothing, and one in three (36%) reported feeling powerless.

Interestingly, respondents in not-for-profit organizations were more likely to report greater frequency of encountering ethical issues associated with surrogate decision-making (p = . 004), provider rights and duties (p = .017), end-of-life care (p = .028) and staffing concerns (p = .025). Finally, more than 45% reported that ethics-related stress had at least some influence on their thinking about remaining in their position and about 38% their thinking about remaining in active practice. .

Bivariate Analysis

Bivariate analysis using Pearson correlations revealed that several ethical issues were statistically significantly related to age and years of experience (Table 4). Younger nurses were more likely to report increased frequency of encountering issues related to provider rights and duties (r=−.19, p < .01), medical research (r=−.12, p < .05), and staffing patterns (r= −.16, p < .01). Those with fewer years in practice also more frequently encountered issues related to provider rights and medical research (r=−.17, p<.01), issues related to end-of-life (r=−.16, p < .01), organ donation (r=−.10, p < .05), resource allocation (r=−.11, p < . 05), conflicting professional obligations (r=−.12, p < .05), conflicts of interest (r=−.15, p< . 01), and negative staffing patterns that affect care (r=−.22, p < .01) than their more experienced counterparts. Younger nurses and those with less experience also reported more stress from specific ethical and patient care issues. Indeed, end-of-life issues, advance care planning, provider rights and duties, conflicts of interest and staffing patters were statistically significantly more stressful for those who were younger (Table 7). Generally, younger nurses were more stressed overall (r=−.14, p < .01).

Nurses working in direct patient care were more likely to indicate high or very high stress [χ^2 = 5.84, df= 1, p=.016] associated with provider rights and duties (8%) as compared to only 1.7% of those not working in direct patient care. Additionally, 20.8% of those in direct

patient care reported high or very high stress (χ^2 = 13.67, df= 1, p < .001] associated with end-of-life concerns compared to 5.9% of those not in direct patient care.

Statistically significant regional variations were noted with respect to several ethical issues. First, more respondents practising in California (14.6%) reported frequent or daily encounters with end-of-life decision-making than those in Maryland (8.4%), Ohio (5.7%), and Massachusetts (3.3%) [χ^2= 9.04, df= 3, p=.029]. More California RNs (10.4%) also reported frequent or daily experiences with genetic testing and counseling compared to 3.4% of Maryland, 3.8% of Ohio, and 2.2% of Massachusetts nurses [χ^2 = 8.48, df=3, p=.037]. Nurses from all of the four regions of the U.S.A. reported encountering staffing problems that negatively affected their work, with nearly half of Maryland nurses (47.9%) indicating frequent or daily experience, 39.2% of Ohio RNs, 32.3% of Californians, and 29.7% of those in Massachusetts.

Most respondents (74%) indicated no or low stress from resource allocation. Nonetheless, Maryland nurses more frequently reported that resource allocation was stressful (16.8%) as compared to those in Ohio (7.5%), California (5.4%), and Massachusetts (6.7%) [χ^2= 10.45, df= 3, p=.015]. Stress associated with resource allocation also was more often reported as high by nurses with ethics training both in their educational programmes and continuing education(CE)/in-house training (22.1%), than by those with training through CE/in-house only (14.3%), those with no training (5.9%), and those with training in their educational programmes only(2.3%) [χ^2= 25.01, df=3, p<.001]. Finally, 60% of those with doctoral preparation reported frequent or daily issues with medical research, therapeutic innovation, or experimental treatment compared to 26.9% of those with a Master's degree, 9.9% of those with a Baccalaureate degree in nursing, 4.9% of Diploma-qualified nurses, and 3.4% with Associate Degrees [χ^2=24.19, df=12,p<.05].

DISCUSSION

Although the survey was administered in 2004, the data remain relevant to contemporary thought about the study topic. First, nurses continue to face challenging ethical issues in clinical practice and this will only increase with an aging, chronically-ill society. Second, these issues or problems are stressful and influence whether nurses want to remain in their positions. Third, given the current nursing shortage and the need for qualified, caring providers, understanding the ethical problems and how they influence the provision of beneficent care and the health and well-being of nurses is urgently needed. This is a concern for nurses everywhere

Study limitations

Our study has several limitations. First, although this survey represented nurses who practised in 4 different states and census regions of the U.S.A., differences in the type and frequency of ethical issues and the stress they create may exist in other locations—especially since we found some differences between the states included in our sample. Concerns specific to nurses in other countries also merit investigation. Second, the ethical issues list was not exhaustive. As the healthcare system continues to change, other issues of importance may need to be explored. Ethical issues may differ depending on the practice setting, patient population, and needs within a society, as well as the availability of sustainable resources to address the issues. For example, the swine flu pandemic and other threats of emerging and re-emerging infectious diseases may pose ethical stresses for nurses which are not reflected by the list. Third, although our response rate was slightly lower than hoped for, it is consistent with mean response rates among surveys using nurse respondents (61± 23) (Asch et al, 1997).

Ethical issues for nurses

Our findings underscore the importance of ethical issues that nurses frequently experience across a range of clinical practice settings and the amount of stress these issues engender in the nurses. Several important conclusions can be drawn from our findings. First, although more than two-thirds of our respondents cited protection of patient rights as their most frequent ethical issue, they identified staffing inadequacies as the most stressful issue. Without sufficient staffing it is difficult to meet the ethical standards of professional practice. Understaffing and other organizational and systematic barriers could preclude nurses from meeting many of their primary responsibilities, including protecting the rights of individual patients and families, alleviation of suffering, and preserving their own integrity. Today's healthcare environment is driven by discordant demands to provide high quality care and to manage costs with diminishing resources. Nurses seem to be doing more and more with these limited resources, but “Even when the provider does the best he or she can, it may not feel good enough” (Ulrich & Grady, 2009, p.5).

Nurses in each of the four regions cited frequent problems with staffing and resultant stress. In fact, more than twice as many respondents reported high or very high stress associated with staffing difficulties than with any other item. In 1999, the California legislature passed the first comprehensive minimum nurse staffing ratios for acute hospitals, yet 32% of California nurses in our sample reported regular occurrences of staffing patterns that negatively affected their work. Advancements in medical technology and research have made ordinary what was once considered extraordinary, making the needs of today's patients vastly more complex. Although California's nurse staffing ratios were meant to be protective for both patients and nurses, perhaps nurses perceive little qualitative differences. One patient with multifaceted needs could consume a large amount of a nurse's time and possibly exceed the demands of their skill set—for example, a patient with diabetes and a psychiatric illness who also has aggressive behavioral problems and emotional outbursts needs a great deal of attention. More research is needed to determine how staffing patterns negatively affect the ability of nurses to do their work. Research is also needed to tease out other important components that affect nursing care, such as patient acuity levels and treatment complexities, as well as the skill mix and educational needs of the professional staff on any given unit.

Not surprisingly, for the majority of nurses in our study the most frequent ethical concerns centered on protecting patients' rights as this is one of the basic tenets of the profession. Both national and international nursing codes of ethical conduct stress the importance of beneficence, professional advocacy, and serving patients' best interests. Unfortunately, anecdotal evidence suggests that when nurses attempt to advocate for patients they are often discouraged from doing so to the degree that some now say, “It's simply not worth it.” More research could elucidate which patients' rights are at stake and what helps nurses to feel successful in protecting them, as well as the factors that influence nurses' ability to act on their reasoned moral judgments. Qualitative interviews with nurses on the frontlines would provide us with more nuanced data about the process of and problems associated with advocating for patients' rights in different practice settings.

Our data also show that nurses identify concerns with informed consent, advance care planning, surrogate decision-making and end-of-life care. These concerns could possibly reflect the acute, chronic, and life-sustaining direct care needs of vulnerable populations, such as older people and those with Alzheimer disease and other cognitive ailments. Nurses need to engage in difficult ethical conversations, yet those with less experience reported greater stress and possibly were more uncomfortable and/or had received little training in broaching these subjects. Harrington and Smith (2008) note that “even clinicians who are well trained and skilled at giving bad news can find it burdensome and emotionally

difficult" (p 2674). Indeed, although a quarter of our cohort reported no ethics education (Ulrich et al. 2007), those who had in-house and educational ethics training reported higher levels of stress associated with allocating resources. The majority of respondents cited confidence in justifying their decisions about ethical issues and felt prepared to address them. Yet, paradoxically, many also reported a sense of powerlessness and little influence in dealing with others about ethical issues. This sense of powerlessness "fits" the classic definition of moral distress, where one knows the morally correct course of action but cannot carry it out due to situational and/or other internal and external constraints (Corley 2002; Corley et al. 2005). Moral distress can leave a person emotionally scarred and often hesitant to speak out against what is perceived as an impenetrable hierarchical system of care.

Rheaume (2009) noted that "The nursing profession offers innumerable rewards, but the work is demanding" (p. 1). Indeed, many of our respondents reported fatigue, feeling powerless, and frustration when dealing with ethical issues, and more than three-quarters felt that there were some ethical issues they can do nothing about. Levi and colleagues (2004) describe an occupational hazard known as "jading" that occurs in the clinical context of healthcare delivery when a person is basically "worn out" and exhausted from labor intensive work that is embroiled with the social dynamics associated with complex human caring relationships. Moral apathy can occur because the drive to make a difference and to care is compromised by repeated interactions that remain unresolved. For example, some nurses in our survey responded that it is often difficult to know what the options are when faced with an ethical dilemma, and that nurses are inadequately prepared to address them.

Interestingly, nurses with less experience encountered end-of-life and surrogate decision-making issues more frequently than those with more experience. Some research suggests that less experienced physicians and nurses are reluctant to withdraw life-sustaining treatments for critically ill patients, and have more difficulties associated with providing analgesic or sedative relief during treatment withdrawal (Burns et al. 2001). Additionally, end-of-life concerns were more prevalent for Californian nurses than for those in other regions. In fact, 1 in 5 Californians will be 60 years of age or older by 2010, and the state has also seen a rapid rise in the oldest old population (California Department of Aging, 2009). Older populations tend to suffer from multiple chronic diseases and disabilities, and their growing numbers in all U.S. states will require well-prepared practitioners to address the unprecedented ethical concerns related to their care needs.

More than one third of the nurses indicated that advanced care planning issues occurred frequently, and this was equally reflected in both for-profit and not-for-profit organizations. In a study of nurses' knowledge of advance directives at a large acute care hospital in the Midwest of the USA, Crego and Lipp (1998) found that a large majority of respondents thought that neither nurses nor patients had a good understanding of advance directives and that both needed more education. Although these conversations can be difficult, sensitive, and contentious, respect for persons is a cornerstone of the patient-provider relationship and allows individuals the right to determine their course of care. Further work is needed to understand how nurses, patients and families can best engage in advance care planning, the level of preparation that is needed to have these conversations, how well advance directives are honored by families and healthcare professionals and, finally, the factors that contribute to quality end-of-life care.

More than a decade ago, Scanlon (1994) identified important ethical problems in nursing practice that included issues of cost containment, futility, and informed consent. Our data show that these and other issues remain concerns for nurses in today's environment. "Acting for the good of the patient is the most ancient and universally acknowledged principle in

medical ethics" (Pellegrino & Thomasma, 1988, p. 73), but about a quarter of our respondents said that to some extent ethics stress influenced their current thinking about remaining in active practice.

CONCLUSION

An urgent need exists for both national and international strategies to retain a qualified workforce. Healthcare institutions should consider the range of ethical problems that nurses encounter in their work and how it impacts their level of stress and their ability to do good for their patients. Ethics support, including ethics committees, bioethicists and senior nurse mentors are all needed to mitigate the loss of providers that regrettably might occur due to these ethical challenges.

Summary Statement

What is already known about the topic

- Ethical issues in clinical practice are increasingly problematic for nurses in all parts of the world.
- Nurses often feel uncomfortable in addressing the ethical issues they encounter in patient care.
- Ethics-related stress may be linked to job satisfaction and retention of nurses.

What this paper adds

- Nurses cited frequent ethical problems associated with protecting patient rights, autonomy and informed consent, staffing patterns, advance planning and surrogate decision-making, among others.
- Younger nurses and those with less years of experience encountered ethical issues more frequently and reported higher levels of stress.
- Nurses in all regions of the United States of America reported high or very high levels of stress associated with staffing difficulties.

Implications for practice and/or policy

- Addressing ethical issues nurses encounter in healthcare is key to the delivery of quality patient care and retention of qualified staff.
- More dialogue is needed on the role of ethics education in reducing ethics stress and helping staff to feel comfortable in discussing ethical issues.
- National and international strategies are needed to address ethical issues in clinical practice and their effect on nurse- and patient-related outcomes.

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Table 1

Frequency and degree of stress related to ethical issues (n = 415).

Ethical and Patient Care Issue	Frequency			Degree of Stress		
	Frequently or Daily (%)	Sometimes (%)	Never or Seldom (%)	High or Very High (%)	Moderate (%)	None or Low (%)
Protecting patients' rights	63.9	21.5	14.5	12.3	28.7	58.9
Autonomy and informed consent to treatment	61.3	21.1	17.7	6.3	20.3	73.4
Breaches of patient confidentiality or right to privacy	23.2	26.4	50.4	10.9	24.5	64.6
Unethical practices of health professionals	6.8	21.3	72.0	18.7	22.1	59.2
Provider rights and duties	19.9	20.6	59.6	6.1	21.3	72.5
Advanced care planning	41.0	20.2	38.7	4.9	16.1	79.0
Surrogate decisionmaking	32.5	25.0	42.5	7.1	20.5	72.4
End-of-life decisionmaking	26.2	26.7	47.1	16.2	23.6	60.2
Beginning-of-life decision-making	8.0	7.5	84.5	2.9	7.3	89.7
Genetic testing and counseling	5.1	5.4	89.5	0.7	3.4	95.8
Conflicts of interest	13.3	29.3	57.4	12.7	25.5	61.8
Medical research, therapeutic innovation, or experimental treatment and related issues	10.5	17.8	71.7	3.7	13.3	83.0
Organ donation and transplantation	12.1	15.5	72.4	8.3	10.0	81.6
Resource allocation	10.4	19.3	70.4	9.8	16.5	73.7
Conflicting professional obligations to patient, institution, and/or profession	9.7	27.8	62.5	13.1	23.8	63.0
Staffing patterns that negatively affect work	37.3	31.8	30.8	43.0	27.5	29.5

Table 2

Mean frequency rating and degree of stress rating for ethical and patient care issues

Ethical and Patient Care Issue	Frequency[1]	Degree of Stress[2]
Protecting patients' rights	3.87	2.41
Autonomy and informed consent to treatment	3.69	2.11
Breaches of patient confidentiality or right to privacy	2.69	2.28
Unethical practices of health professionals	2.14	2.37
Provider rights and duties	2.43	2.00
Advanced care planning	3.03	1.84
Surrogate decision-making	2.77	1.92
End-of-life decision-making	2.56	2.26
Beginning-of-life decision-making	1.58	1.39
Genetic testing and counseling	1.39	1.28
Conflicts of interest	2.37	2.24
Medical research, therapeutic innovation, or experimental treatment and related issues	1.98	1.67
Organ donation and transplantation	1.92	1.66
Resource allocation	1.98	1.90
Conflicting professional obligations to patient, institution, and/or profession	2.23	2.22
Staffing patterns that negatively affect work	3.07	3.20

[Note: Correlation between mean frequency rating and mean stress rating is $r_S = .668$, $p<.01$. A total frequency rating and a total stress rating were computed for each respondent with mean frequency total 39.6 (SD=9.50) and mean stress total 32.7 (SD=9.73). Pearson correlation = .711, $p<.001$ between the two total "scores."]

[1] Frequency ratings: 1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Frequently, 5 = Daily

[2] Degree of Stress ratings: 1 = None, 2 = Low, 3 = Moderate, 4 = High, 5 = Very High

Table 3

Five most frequently occurring and most stressful ethical and patient care issues

Most Frequent
1 - Protecting patients' rights
2 - Autonomy and informed consent to treatment
3 - Staffing patterns that negatively affect work
4 - Advance care planning
5 - Surrogate decision-making
Most stressful
1 - Staffing patterns that negatively affect work
2 - Protecting patient's rights
3 - Unethical practices of healthcare professionals
4 - Breaches of confidentiality
5 - End-of-life decision-making

Note: Frequency ratings based on mean values.

Table 4

Statistically significant Pearson r correlations of ethical issues with age and years in practice.

Ethical and Patient Care Issue	Frequency		Degree of Stress	
	Age (n=399)	Years in Practice (n=405)	Age (n=399)	Years in Practice (n=405)
Protecting patients' rights				
Autonomy and informed consent to treatment				
Breaches of patient confidentiality or right to privacy				
Unethical practices of health professionals				
Provider rights and duties	–.19, p<.001	–.17, p= .001	–.14, p=.005	–.16, p= .001
Advanced care planning			–.17, p=.001	–.14, p=.005
Surrogate decision-making				–.14, p= .006
End-of-life decision-making		–.16, p= .001	–.21, p<.001	–.20, p<.001
Beginning-of-life decision-making				
Genetic testing and counseling				
Conflicts of interest		–.15, p=.003		–.12, p=.019
Medical research, therapeutic innovation, or experimental treatment and related issues	–.12, p=.022	–.10, p=.036		
Organ donation and transplantation		–.10, p=.048		
Resource allocation		–.11, p=.033		
Conflicting professional obligations to patient, institution, and/or profession		–.12, p=.015		
Staffing patterns that negatively affect work	–.16, p=.002	–.22, p<.001	–.13, p=.008	–.19, p<.001

Note: Negative correlation indicates younger respondents and those with fewer years in practice reported increased frequency and increased degree of stress.