Ethical dilemmas experienced by Health Care Professionals working in Intensive Care Unit Tshilidzini hospital, Vhembe district in Limpopo Province

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DECLARATION

I, **Malelelo H,** hereby declare that the research proposal titled “Ethical dilemmas experienced by Health Care Professionals working in Intensive Care Unit Tshilidzini hospital, Vhembe district, in Limpopo Province” is my own work and is being submitted in partial fulfillment of the degree Masters in Nursing in the department of Advanced Nursing Science at the University of Venda. All the sources that I have used or quoted have been indicated and acknowledged by means of references, and this work has not been submitted previously for any other degree at this university.

Signature: Date:

DEDICATION

For Thuso - you will always be in my mind, in my heart and in your grave.”

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ABSTRACT

Background: Doctors and nurses working in ICU are always confronted with ethical dilemmas when caring for critically ill patients no matter where they practice. The ethical dilemmas experienced by ICU nurses and doctors include amongst other: freedom of choice, truth telling, distribution of resources and confidentiality.

Purpose: The study sought to explore the ethical dilemmas experienced by healthcare professionals working in ICU, Vhembe district in Limpopo province.

Setting: The setting of the study was Tshilidzini hospital, Vhembe district in Limpopo Province

Methodology: A qualitative, explorative, descriptive design was used. The population was nurses and doctors working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province. A purposive sampling was used to select the study sample, and the study hospital. Data was collected by means of Semi-structured, in-depth interviews. Data was analyzed using Tesch`s method. Ethical considerations were adhered to.

Findings: Participants expressed ethical dilemmas related to lack of resources, unsuitable infrastructure, hospital policies and patient`s decision making**.**

Recommendations: The study recommends better policies by government and critical care societies to help guide resource allocation for ICU services. The number of ICU beds must be allocated according to the population it serves, in-service trainings to be conducted on regular bases in order to equip ICU health care professionals with knowledge of ethics and skills of decision-making, an active ethics committee to be elected to assist ICU practitioners when they encounter ethically challenging situation.

Keywords: Ethical dilemma, Health care professionals, Intensive Care Unit

ABBREVIATIONS AND ACRONMYS

BP	Blood Pressure
CCUs	Critical Care Units
CPR	Cardiopulmonary resuscitation
DENOSA	Democratic Nursing Organisation of South Africa
EMS	Emergency medical services
EOL	End of Life
ESICM	European Society of Intensive Care Medicine
GCS	Glasgow coma scale
HC	High Care
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HPCSA	Health Professional Council of South Africa
ICU	Intensive Care Unit
IV	intravenous
LST	Life sustaining therapy
RENs	Registered Enrolled Nurses
RPNs	Registered Professional Nurses
SA	South Africa
SANC	South African Nursing Council
US:	United State of America

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Intensive Care Unit (ICU) has existed in the early 50s in most developing countries. The unit has helped many patients from the specialized care rendered in that unit (Luce & White 2009). ICU admits patients that are critically ill, those recovering from surgery and trauma patients. These patients need close monitoring achieved by specialized equipment. Life support is the focal point of Intensive Care Units, and advanced technology makes this possible. The use of life-sustaining technology in ICU, the helplessness of the patient together with the relatives who are anxious create ethical problems in ICU. An ethical dilemma is when one has to decide between two options and, the choice may have wanted and unwanted results (Pacsi 2008). Scanlon and Murphy (2014) also assert that, ethical dilemmas are situations that led to solutions that will never be satisfactory. Every solution that is taken results is conflict. Whenever there is a clash between the ethical principles, ethical dilemma arises.

Ethical dilemmas confront even the most experienced professionals. Health care professionals working at ICU, Tshilidzini hospital, Vhembe district, in Limpopo Province are not immune from these dilemmas particularly considering that, it is a public hospital having the only ICU in the district. The ICU admits patients from various backgrounds with the health care professionals coming with different cultural concerns. Nevertheless, their perception and extent of ethical dilemmas they experience while working in these areas have not been studied.

The Nurses' Pledge of Service is the ethical foundation of the nursing profession in South Africa. This pledge was developed from the Nightingale Pledge. This pledge is used in nursing training institutions all over South Africa. Nurses enter into an agreement with the community when they pledge. Nevertheless, there is a question as to whether the views of all nurses are indicated in this pledge (Muller 2009).

Most of the health problems experienced by many patients resulted in the widespread use of the very advanced technology. This form of technologies and their accessibility have created new forms of treatment in many countries. It has also provided hope for dealing with many problems and making it possible to sustain life. Hence, the hospitals have become the only place where this technology can be used. Many people are visiting the hospitals every day for treatment and diagnosis. Amongst the admissions, there are those that need specialized care and life support measures. These life support technologies and the need for trained staff resulted in the establishment of the Intensive Care Units (ICUs) (Chaves & Massarollo 2009).

In the United States (US) and other developed countries, ICUs are a usual place in the hospitals. Three major medical branches activated the development of the ICUs. First was the postoperative recovery unit in Johns Hopkins Hospital in Baltimore, which was established in 1923 for neurosurgical patients. This led to the development of surgical ICUs. In 1952, a medical ICU was opened in Denmark to focus on patients with breathing difficulties and neuromuscular diseases and this became the forerunner of medical ICUs. The first coronary ICU was established in 1962 to care for patients with heart diseases (Luce & White 2009).

In South Africa, single function units such as the post-operative ventilation of cardiothoracic patients, ventilation of patients with respiratory problems in pulmonary units was established in the 1960s in Cape Town. In Durban, King Edward VIII Hospital established the first neonatal tetanus unit. In October 1970, the first general ICU was opened in the Addington Hospital in Durban (Scribante, Schmollgruber & Nel 2008). In 1993, March, a general ICU was established at Tshilidzini Hospital.

According to Haq (2012), the ethical principles are pleasing, attractive and ethically sound if they are taken alone. On the contrary, some circumstances result in the clash between ethical principles and, when this happens, ethical dilemma result. End of life decisions are the major cause of clashes in ethical principles. The end of life decisions such as the withholding or withdrawal of treatment involves issues such as religious and cultural beliefs and these results in ethical dilemmas. Many other issues are involved in the development of conflicts between ethical principles in ICU and, this includes, communication issues, admission and discharges,

multidisciplinary team conflicts, withdrawal or withholding life supporting therapies, advance directives and surrogate decision maker.

Searle, Human, and Mogotlane (2009) indicate that ethical principles are frameworks for deciding what is good or bad in a given situation. Medical practice is guided by set of principles for ethical principles and they are as follows: principle of autonomy, principle of non-maleficence and beneficence and the principle of justice.

Autonomy means that the patient is able to make his own decision. Moreover, this decision must not be made under duress. In order to respect the principle of autonomy, the decision needs be made by a patient who is fully conscious and not under the influence of any medication. This requirement is always compromised in ICU. Patients in ICU are either unconscious or sedated and this makes them not to be aware of their surroundings, have difficulties in making decision hence they are likely to make poor judgment. This status quo led to a clash between the principle of autonomy and the principle of beneficence. In respect of patient`s autonomy, no procedure must be performed without the patient`s consent and the patient`s decision is always right. Beneficence requires that only the decisions that will benefit the patients be considered even if it is not the patient`s choice The difference between what the patient thinks is best for him and what the health professionals think is best for the patient results in ethical dilemma (Haq 2012).

According to Lind (2012), the principle of non-maleficence implies that the health care professional must not harm the patient. Any procedure or decision considered to can do more harm than good to the patient must not be performed. In medical practice, a clash between the principle of autonomy and non-maleficence always occurs. Ethical dilemma occurs when relatives or patients opt for procedures that are not going to benefit the patient and are harmful. Even the health care professionals can arrive to different decision regarding the patient`s treatment. The health care professional may not abandon the patient because they have differences regarding the treatment choice. Nevertheless, the request of the patient must always be considered (Haq 2012).

Another study conducted by Fant (2012) also indicates that ethical dilemmas result when there is clash of moral principles. This study indicates that ethical dilemma

occurs when then the health care professionals have to decide whether the decision that is to be taken is going to make the patient to live a productive life against the number of people who are to be affected by the decision. According to Fant (2012), the health care professionals values and believes can also be a source of ethical dilemma when caring for the patient with different values. Ethical dilemma results when patient or relatives ask for euthanasia from a health care professional from a Christian background. The medical knowledge that a health care professional has is sometimes contrary to patient`s culture and or religion. The patient may need blood in order to be saved but there are religious practices which do not allow the patient to receive blood from donors. This creates a dilemma. Conflicts also occur when limited resources are distributed between patients. This occurs when there are those patients who can benefit from the resource and those that even if they get the resources, they will not benefit because their prognosis is poor.

Soderberg and Gilje (1996) reported that the ethical problems experienced by different health care professionals are not the same. The different categories of doctors experience different ethical dilemmas. The dilemmas encountered by doctors are also different from those encountered by nurses. In addition, different categories of nurses also experience different types of ethical dilemmas. The ethical dilemma experienced by doctors involves what to and what not to do. This may involve continuing with giving of futile treatment or not. The registered enrolled nurse's (RENs) ethical problems involve relationships with colleagues, patients and relatives. Their problem is specifically on communication. The registered professional nurse (RPNS) dilemma includes those experienced by doctors and those experienced by RENs. According to McMillen (2008) the junior nurses are unable to communicate their views because only the views of the RPNs are considered and this creates a dilemma when they have to make a decision.

A study conducted in Croatia by Sorta-Bilajac, Bazdaric, Zagrovic, Jancic, Brozovic, Cengic, Corluka and Agich (2011) assert that poor communication creates an ethical dilemma. Poor communication between doctor and patients occurs when patients are misinformed. Poor communications between health care professionals occurs when the instructions are not clear.

However, Mutinda (2015) indicates that the way in which the health care professionals experience ethical dilemma is related to some personal factors. These include age of the health care professional, the experience and the educational level of the health care professional. This study also indicates that some organizational factors also relate to the way in which health care professionals perceive ethical dilemmas. These include organizational culture, physical environment and setting of the institution in which they are working.

Furthermore, Goethals, Gastmans and de Casterle´B (2010) indicated that health care professionals in USA and Canada reported that apart from knowledge and the experience of the doctors and nurses, risk taking, problem solving skills and the courage influence the way in which ethical dilemmas are encountered. The study also indicates that contextual factor influence the way in which ethical dilemma will be addressed.

Nevertheless, Fernandez and Moreira (2012) stated that globally, ethical dilemmas in ICU are the results of the use of specialized equipment. The nature of the patients that are admitted in ICU and the urgency in which decisions are made in ICU result in ICU nurses and doctor encountering a lot of dilemmas than any other health care professionals in a hospital. The dilemmas experienced include, deciding whether to resuscitate or not, unequal distribution of resources, bad communication between family, patient and management.

In one of the Sub Saharan countries, Tanzania, a study conducted by Häggström, Mbusa and Wadensten (2008), indicated that respect of the patient`s autonomy is the main ethical dilemma experienced. Patients are discriminated according to their economic and social standing and this creates a dilemma for the admitting doctor. The study indicates that limited resources are first allocated to rich patients. In Kenya, apart from the Do Not Resuscitate order, the withholding or withdrawal of treatment and patient`s religious beliefs create an ethical dilemma. The study also found out that there are dilemmas resulting from how to deal with incompetent colleagues, shortage of staff, unfair discrimination of patients and bad communication with the patients (Mutinda 2015).

In South Africa, unfair distribution of resources is among the ethical dilemmas that the doctors and nurses are facing. There is limited number of ICU beds in South Africa both in public and in private sector. Because of the limited number of beds in ICUs, some criteria are put in place to help in determining the patients who are suitable for ICU. The following are the criteria for admission in ICU as stated by Naidoo, Singh and Lalloo (2013), the availability of ICU bed, previous health status of the patient, the present condition of the patient and if there is a need to discharge any patient in ICU in order to admit the patient. All these create ethical dilemma for health care professionals when there is a need to admit a patient in ICU. The table below, Table 1 indicates the limited number of ICU beds in South Africa in both public and in private sector and this creates ethical dilemmas to those working in ICUs (Naidoo, Singh & Lalloo 2013).

Table 1 Public sector ICU/HC bed: population ratio in South Africa: 2008 – 2009 (Naidoo et al 2013)

Province	**Population (millions)**	**Public sector ICU/HC beds**	**Public sector ICU/HC bed:population ratio**
EC	6.648	90	1:75 000
FS	2.902	103	1:30 000
GT	10.531	397	1:25 000
KZN	10.449	224	1:45 000
LP	5.227	35	1:150 000
MP	3.606	40	1:90 000
NC	1.147	21	1:55 000
NW	3.450	32	1:110 000
WC	5.356	244	1:20 000
Total	49.320	1 186	

EC = Eastern Cape; FS = Free State; GT = Gauteng; KZN = KwaZulu-Natal; LP = Limpopo; MP = Mpumalanga; NC = Northern Cape; NW = North West; WC = Western Cape (Naidoo et al 2013).

Limpopo Province is not an exception when it comes to ethical dilemmas. Despite the fact that there is no literature that has been found regarding ethical dilemmas in Limpopo Province, shortage of beds reported in the study of Naidoo et al (2013) also included Limpopo Province.

However, Rushton and Penticuff (2007) indicate some other minor issues that cause ethical dilemmas such as the realization that the situation at hand involves ethical dilemma. Therefore, the researcher is prompted to investigate the ethical dilemma experienced by health care professionals working in ICU, Vhembe district, in Limpopo Province.

1.2 PROBLEM STATEMENT

The researcher is a trained ICU registered professional nurse working in Tshilidzini Hospital. Although there are criteria for admission in this ICU, it is difficult to adhere to them because the patient cannot be left to die just because he does not meet the admission criteria. Patients with no hope of recovery occupy the beds waiting for death process to occur, preventing admission of patient who will benefit from ICU. Cultural beliefs, which are always in contrary with scientific medicine, makes patient`s decision making very difficult often delaying the treatment or even resulting in death. It is against this background, that the researcher is interested in investigating the ethical dilemmas experienced by health professional working in ICU, Tshilidzini Hospital, Vhembe district, in Limpopo Province.

1.3 PURPOSE OF THE STUDY

In this study the purpose of the study was: To investigate the ethical dilemmas experienced by health care professionals working in ICU, Tshilidzini hospital, Vhembe district in Limpopo Province.

1.4 RESEARCH OBJECTIVES

The objectives of this study were to:

To explore and describe the ethical dilemma experienced by health care professionals working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

1.5 RESEARCH QUESTION

The following question guided the study:

“What are the ethical dilemmas experienced by health care professionals working at ICU in Tshilidzini hospital”?

1.6 SIGNIFICANCE OF THE STUDY

The study offered some insights into the ethical dilemmas experienced by healthcare professionals working in ICU Tshilidzini hospital. Contributory factors to the ethical dilemmas may also be identified and measures to assist healthcare professionals to deal with the dilemmas can be identified. Better policies by government and critical care societies can be established to help guide resource allocation for ICU services.

An alternative to ICU admission can be introduced in a form of a high care unit. In-service trainings can be conducted on regular bases in order to equip ICU health care professionals with knowledge of ethics and skills of decision-making. An active ethics committee can be elected to assist ICU practitioners when they encounter ethically challenging situation. Appropriate support systems may be in place to assist health care professionals through any personal difficulties when they are experiencing ethically challenging situations. The study may add to the already existing body of knowledge about ethical dilemmas experienced by healthcare professionals working in ICU. The study may also form a basis for further research on ethical dilemmas that healthcare professionals experience

1.7 THEORETICAL FRAMEWORK

1.7.1 Paradigmatic perspective

Burns and Groove (2009) view paradigm as a particular way of viewing a phenomenon in the world. The paradigms for human inquiry are often characterized in terms of the way in which they respond to basic philosophical questions. In this study participants responded to the following question:

What are the ethical dilemmas that you experience while working in ICU, Tshilidzini hospital, Vhembe district?

1.7.2 Meta- theoretical

The researcher believes that patients should be treated with respect and dignity. According to the Constitution of the Republic of South Africa, 1996 (Act No. 109 of 1996), everyone has inherent dignity and the right to have their dignity respected and protected. The researcher also believes that all nursing professionals have the "responsibilities towards individuals, families, groups and communities, namely to protect, promote and restore health, to prevent illness, preserve life and alleviate suffering. These responsibilities will be carried out with the required respect for human rights, which include cultural rights, the right to life, choice and dignity without consideration of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status" (SANC 2013).

1.7.3 Ethical analysis framework

Health care professionals are confronted regularly with dilemmas and during this time they need a certain way of solving the problems. James Rest develops a 4-components model that assists the health care professionals from the realization of the dilemma until the dilemma is resolved. The theory was applied in Chapter 4 of this study. This model consists of moral sensitivity, moral judgment, moral motivation, and moral action (Rushton & Penticuff 2007).

1.7.3.1 Moral Sensitivity

To be morally sensitive means that the health care professional is able to feel the pain that the patient or a family member is having. It involves viewing the situation from the patient`s perspective. Moral sensitivity also means that the health care professional is aware of the potential benefits and harm of his or her action. Being morally sensitive means that an ICU doctor will realize that a dyspnoeic patient is in pain and that using Morphine Sulphate to alleviate the pain will cause respiratory distress to the patient (Chambers 2011).

1.7.3.2 Moral Judgement

Moral judgement is a process in which the health care professional decides on the best action to be taken on a given situation; balance the potential benefits and the potential harm of the decision; check all the available options and take the most ethically justifiable solution. When deciding the best option, several other factors must be considered such as, patient`s wishes, cultural background and patient`s religion. Moral judgment also means that the health care professional is respecting the ethical principles in his decisions. The patient must be protected from harm and autonomy must be respected. The doctor must judge which action is most ethically appropriate, to let the patient suffer of pain or to give sedatives and alleviate pain but hasten the patient`s death (Rushton & Penticuff 2007).

1.7.3.3 Moral Motivation

Moral motivation implies that the health care professional will choose the solution that is ethically right over all possible solutions. The essence of moral motivation is to put the moral values above all other interests, with the aim of bringing more good than harm in a situation. A health care professional with high level of moral motivation will intubate the patient against the patient`s directives because is going to benefit the patient. Although the doctor cannot promise good outcome after intubation, the aim is to do what is ethically justifiable. Some external and internal factors such as organizational policies and lack of resources and skill can lower person`s moral motivation (Lachman 2007).

1.7.3.4 Moral Character

Rest added the moral character on the 4-components model. Moral character is the courage to do what is ethically right despite all odds. It implies that the health care professional is aware of organizational factors that can support or be against the decision. “In ICU the use of ethics committee, climate meeting, multidisciplinary team word rounds and family conference enhances one`s moral character” (Chambers 2011).

1.7.3.5 Moral Action

Moral action is when the most ethically justifiable decision is implemented. This is when a doctor decides to stop medication because it is futile (Robichaux 2012).

1.8 DEFINITION OF CONCEPTS

Ethical dilemma can be defined 'as a problem involving a choice between two or more alternatives to the competitive assignment of priorities and responsibilities, or to a problem without a satisfactory solution' (Shapira-Lishchinsky 2009).In this study, an ethical dilemma shall mean a situation in which health care professionals have to choose between two options both of which will bring a negative result based on society and personal guidelines.

Experience is knowledge or skills over time (Saudi 2014). In this study experience shall mean what the process of doing and seeing things and of having things happen to you.

Intensive Care Unit (ICU) Adam and Osborne (2004) define an ICU as a "clearly defined area within a hospital where the skills of specialist personnel and technology can be combined in the management and care of the critically ill patients". In this study, an ICU shall mean a ward in the hospital where seriously ill patients are cared for by specially trained staff.

Health care professionals Healthcare professional is a "qualified person who directly provides, or helps in providing healthcare to patients, whether in the form of diagnostic, curative, or rehabilitative services that affect health condition. This includes doctors, dentists, pharmacists, nurses, and healthcare technicians in: radiology, nursing, anaesthesia, laboratories, pharmacies, optometry, epidemiology, prosthetics, physiotherapy, dental care and fixation, diagnostic imaging, nuclear medicine, laser equipment, surgical operations, etc (Saudi 2014). In this study, health care practitioner shall mean any person licensed to practice by the Health Professionals Council of South Africa (HPCSA) or the South African Nursing Council (SANC)

Patient is a person who is receiving, or registered to receive medical treatment (Chiaranai 2011). In this study, a patient shall mean anyone admitted in ICU.

1.9 SUMMARY OF THE RESEARCH METHOD

In this study a qualitative research method, an exploratory, and a descriptive research design was used to describe the ethical dilemmas experienced by healthcare professionals working in ICU Tshilidzini hospital, Vhembe district in Limpopo Province. The descriptive research design enabled the researcher to describe in depth the ethical dilemmas experienced by healthcare professionals working in ICU Tshilidzini hospital, Vhembe district in Limpopo Province.

Purposive sampling was used to sample seventeen (17) participants and ethical considerations of informed consent, confidentiality and anonymity were observed. Data was collected from participants by means of semi-structured interview sessions. Tesch's open-coding method of data analysis was used to analyze data. Measures to ensure trustworthiness included credibility, transferability, conformability and dependability. Details of the research methodology are discussed in Chapter 3.

1.10 CONCLUSION

This chapter introduced the reader to the study. The problem statement, the research questions, the purpose and objectives of the study have been stated. Paradigmatic perspectives including relevant definitions have also been described. In addition, an overview of the research methodology including the plan of research action has been provided. The following chapter will cover literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

According to Burns and Grove in (Brink et al, 2012) a literature review is “an organized written presentation of what has been published on the topic by scholars”. The aim of the literature review is to indicate that which is already known regarding the topic. It also helps the researcher to decide whether the topic can and should be researched.

In this study, the researcher conducted literature review to explore and describe ethical dilemmas experienced by ICU professionals working in ICU, Tshilidzini Hospital, Vhembe district in Limpopo Province.

2.2 WHAT CONSTITUTE AN ETHICAL DILEMMA?

Shapira-Lishchinsky (2009) defines ethical dilemmas as the conflict between “two equally desirable or two equally undesirable choices”

An ethical dilemma involves conflict that occurs when there is contradicting personal values, ideas and philosophy. There is difference between ethical and non-ethical dilemmas. Non-ethical dilemmas are conflicting decisions that do not concern ethics. They are decisions that mostly affect personal values. This decision does not need to be justified and no one will be harmed by the decision. Non-ethical dilemma differs from ethical dilemma because ethical principles such as not inflicting harm are involved in ethical dilemmas. Ethical dilemmas also need to be justified. Therefore, ethical dilemma results when any choice available is contrary to the ethical principles. According to Shapira-Lishchinsky (2009)”ethical dilemmas can occur between interpersonal relationships such as nurse–patient, nurse–colleague, and nurse–family”.

Ethical dilemmas are not clear-cut. Before any decision is applied, it must be determined whether a true dilemma exists. Criteria for defining ethical dilemma in a clinical practice are threefold: (1)" an awareness of various options (2) an issue that has options, and (3) two or more issue with true or good aspects, with the choice of one option compromising the option not chosen" (Urden, Lough, Thelan & Stacy 2010).

Furthermore, Chiaranai (2011) indicated that there are five characteristics of an ethical dilemma:

- Involvement, engagement or commitment: This involves engaging in solving problems that create ethical dilemmas. There must be direct involvement to the situation. When one is not directly involved, he may not even realize that there is an ethical dilemma.
- Equally unattractive alternatives: For a situation to be regarded as an ethical dilemma, two or more solutions must be applicable to the problem. There need to be or greater alternative concerning solution to the problem. All available options are undesirable, equally unfavorable or unattractive, with the choice being desired and the outcomes unwanted.
- Need for a choice: At the end a choice has to be made from the available alternatives.
- Awareness of alternatives: In order to see a situation as a dilemma, the professional agent must be aware of alternatives. If he/she lacks the knowledge and/or experience of differentiating alternatives, the dilemma most likely will not recognized.
- Uncertainty of action: The choice is difficult because one does not know the real consequences of the choice or the consequences are unwanted, but unavoidable. As a result, one does not know, precisely, the right thing to do (Chiaranai 2011).

In addition, ethical dilemmas were found to be linked to diversity of values; presence of terminal patients at the ICU; uncertainties about terminality and the limits of intervention to prolong the patients' lives; disagreements in decision-making; non-acceptance of the process of dying by the patients' families and the lack of clarifications for the patient and the family (Chaves & Masarollo 2009).

2.3 ETHICAL DILEMMAS EXPERIENCE BY BOTH DOCTORS AND NURSES WORKING IN ICU

Soderberg and Gilje (1996) reported that the ethical problems experienced by different health care professionals are not the same. The different categories of doctors experience different ethical dilemmas. The dilemmas encountered by doctors are also different from those encountered by nurses and different categories of nurses experience different types of ethical dilemmas. The ethical dilemma experienced doctor involves what to and what not to do such as continuing with giving of futile treatment. The registered enrolled nurse's ethical problems involve relationships with colleagues, patients and relatives. The problem is specifically on communication. The registered professional nurse dilemma includes those experienced by doctors and those experienced by RENs

In addition, Lee and Hawkins (2015) indicated that health care professionals experience ethical dilemma when they want to give reasonable treatment and they do not know what reasonable treatment is. Most of the dilemmas experienced by doctors include, knowing when to make decision, lack of resources, which treatment to give and respect of patient, family and colleagues. The registered professional nurses started to be in dilemma immediately when the treatment is no longer having any effects on the patient. For the registered enrolled nurses ethical dilemma occurs since they just have to give medication when they are not included in treatment choice and they do not even understand why the treatment was ordered.

Furthermore, Fernandes and Moreira (2012) posit that, most of the ethical dilemmas experienced by health care professionals in ICU involve end-of-life decisions, communication, hierarchical problems, and social problems. As part of end-of-life decisions, the ethical dilemma experienced by nurses are the do-not-resuscitate (DNR) orders and the patient`s wishes to die. They also experience conflict when they communicate with the management, patients and their families. Lack of resources such as limited ICU beds and lack of staff as well as other economic constraints also created a dilemma. Ethical dilemma occurs when there are conflicts between ethical principles, these principles are: autonomy, which is an individual's right to self-determination, non-maleficence which means, do no harm, beneficence which is attempt to do good, justice which means the just and equitable provision of

finite healthcare. Dilemmas involving the ethical principles affect both doctors and nurses.

2.3.1 End of life decision

Health care professionals have realized that despite the life support system in ICU, some patients must be left to die peacefully (Sprung, Cohen, Sjokvist, Baras, Bulow, Hovilehto, Ledoux, Lippert, Maia, Phelan, Schobersberger, Wennberg, & Woodcock 2015). 'Death is end‐of‐life (EOL) process and dying is the end process of the life' (Sharma, Jagdish, Anusha& Bharti 2013). Although ICU uses specially trained staff and life support machines, at some stage, end of life care must be practiced (Langley, Schmollgruber, Fulbrook & Albarran 2013).

According to Kisorio (2013) end of life care is the care given to the patient when there is no longer hope for recovery. The aim is to relieve pain and suffering and to treat the disease symptomatically. The treatment of patients at the EOL is focused on ensuring that that the patient and family needs are met. In ICU decisions such as withdrawal and withholding of life support and do not resuscitate orders are made and this makes the end of life decision very difficult hence and ethical dilemma (Adams et al, 2011). End of life practices differ according to units and the health care professional who is to decide (Sprung et al, 2015).

In most ICUs end of life decisions always create ethical dilemmas because of lack of guidelines. 'In 2001, the American College of Critical Care Medicine published a set of guidelines for end-of-life care in the intensive care unit. These guidelines were updated in 2008'.Although there are guidelines in place, health care professionals are still inexperienced and fear to implement the end of life decisions (Beukes 2011).

"End-of-life practices vary on the basis of geography, religion, culture, law, religiosity, patient, doctor, and institutional characteristics, different attitudes between doctors and nurses, patients, and families", (Sprung et al, 2015), ethics, ethnicity and legislature (Ryu, Choi, Lee, Koh, Bae & Heo 2013).Societies also have a greater influence in end of life decisions (Ryu et al, 2013).

Decisions regarding withholding and withdrawal of treatment varies greatly throughout the world. The differences also reflect on the way in which families are

engaged in decision-making. Most end of life decision are taken by doctors discussing amongst themselves, not involving the patient, family or other health team members. Family members are only informed when their consent is needed (Sprung et al, 2014) and nurses only become aware of the decision when they have to carry out the doctor's orders (Langley et al, 2013). Several factors relate to the difference in the end of life practices in ICUs. "These may include, legal and regulatory issues and legal precedents within the country, the religious and cultural beliefs, practices of both the health care professionals, the patients and their families, the speciality of the attending doctor, the patient profile, which may include the medical condition itself as well as race/ethnicity and socioeconomic factors"(Sprung et al 2014).

2.3.2 Autonomy vs Beneficence

Autonomy is from a Greek word "auto" which means self and "nomos" meaning rule. Autonomy means self-governing. Patients autonomy is expressed by the respect of patient`s dignity. Autonomy means that the patient has the right to make decisions and in health care practices, this right is expressed through an informed consent (Beukes 2011).Informed consent entails an "autonomous choice " and "personal autonomy." Autonomous choice is the ability of the patient to make choice freely and personal autonomy is the person`s ability to make choice. Three conditions make up an autonomous choice. "A person must act with intention, with understanding, and without controlling influences" (Van Norman 2012). Autonomous choice is a choice that is made after desired and the undesired effects of the decision has been fully explained to the patient or family. The patient or relatives must understand the explanation, and the patient must not be forced to take a certain decision. Hence misinformed patients cannot make autonomous choices (Van Norman 2012).

Health care professionals are ethically obliged to create an environment that promotes both autonomous choice and personal autonomy. In respect of personal autonomy, the patient must have the capacity to decide. Capacity to make decisions means that the patient understands his treatment, is able to compare the medical information and is able indicate his choices (Jeffrey, Lanken, Taichman 2004).

However, patients in ICU are either confused due to disease process, disorientated due to sedation and pain and all these alter their ability to be an autonomous person.

This creates ethical dilemma when there are some procedures like insertion of naso-gastric tube that need to be done. Heath care professionals choose what will benefit the patient over patient`s choice and procedures are done without patient`s consent (Tejwani, Fan Wu Serrano, Segura, Bannon & Qian 2013). The autonomy model indicates that the duty of the health care professional is to enlighten the patient about the treatment options and the patient makes the choice (Azoulay, Chaize & Kentish-Barnes 2014). According to Fant (2012), in other states it has been agreed that patient`s respect is superior to other principles therefore, patient`s wishes must be granted.

2.3.2.1 Refusing consent

Consent also means that after been given all the information about the treatment options, the patient has the right to refuse treatment. Patient might refuse treatment or choose another option regardless of the outcomes. The doctor has a duty to respect the patient`s choice even if it means that the choice will lead to death. “The practice of beneficence is challenged by the respect for autonomy” (Medical Protection Society 2013). What patient perceives as good might be different from what the health care professional perceives as good for the patient and this results in a dilemma (Medical Protection Society 2013).

2.3.1.2 Therapeutic Privilege and Waiver of Informed Consent

Respect for autonomy requires that the doctor must first explore the patient`s preferences before giving some information about his condition. Just giving information that the patient doesn’t want is overriding patient`s autonomy. The patient may waive his right to information. There are some factors that influence patient`s preference of information and these include familial, personal and cultural background (Billings & Krakauer 2011). However, the doctor may also decide not to give some information to the patient that is deemed harmful and this is called therapeutic privilege. Therapeutic privilege is against the principle of autonomy.“If unacceptable harm is defined as harm that causes the patient to become emotionally, psychologically or intellectually incapable of making a decision, then therapeutic privilege does not technically violate the principle of respect for

autonomy because full disclosure would render the patient non-autonomous anyway" (Van Norman 2012).

2.3.3 To tell or not to tell the truth

Veracity or truth telling is one of the ethical principles that underline the medical and the nursing profession. Truth telling forms the basis doctor-patient, and nurse-patient relationship. This principle requires that both the nurse and the patient tell the truth. In ICU, situations arise in which the health care professionals are caught between telling and not telling the truth, hence an ethical dilemma. This principle is necessary in order to get an informed consent. The patient must be aware of all the risks and the benefits of a specific treatment or procedure. Pera and Van Tonder (2009) question the fixedness of this principle because they indicated that there is "benevolent deception". This is when not all the necessary information about a situation is given. Sometimes the information can be correctly given, but in a way that is misleading. Veracity must guide all the areas of practice of a health professionals including, colleagues, families, patient, and employer relationship (Urden et al 2010).

Relatives of patients in the intensive care unit often always have questions that they need to be answered in a way they can understand. Information about patient condition is what they need the most. They also want information about anything happening to the patients as soon as possible. Family members become stressed if they got inadequate information about the condition of the patient.

Researchers also asserted that the uncertainty and inadequate information given to family members is the most common cause of their depression and anxiety. In contrast, because patients are very ill and relatives are anxious, health care professionals just give non-specific information about the patients' condition to protect their families against anxiety and stress. In most instances, health care professionals should choose whether to be truthful or to give hope, and that is when giving information becomes an ethical challenge (Farahani, Gaeeni, Mohammadi & Seyedfatemi 2014).

Truth telling is about breaking the bad news to the patient or relatives like to confirm brain death or a poor prognosis. That is why the many health care professionals

have trouble during truth telling, creating a dilemma as to whether to tell the truth or not.

Truth telling in critically ill patients is the hardest tasks for health-care professionals. Research has shown that health-care professionals are not at ease telling the patient about their bad prognosis. To them is like confirming that there is nothing they can do about the patient`s situation and this will impact negatively on their doctor-patient relationship. Despite all that, not telling the truth can also damage the relationship between the patient and the health care professionals (Lee & Hawkins 2015).

Truth telling is associated with the principles of beneficence and non-maleficence. Although there is evidence supporting that telling the truth does not result in any emotional distress, it is still believed that not telling the truth about the patient`s bad condition is protecting the patient from harm (Zahedi 2011).

There are some factors that are closely related to truth telling. There are some patients who do not want to be told about their conditions and there are some health care professionals who do not want to tell the patient about their bad prognosis.Studies indicate that many patients, who are critically ill, do not want bad news (Sarafis, Tsounis, Malliarou & Lahana 2014). Female health care professionals relate well with the relatives than the patients and may not tell the truth to protect the family from emotional stress. However, younger health care professionals can disclose anything because of their professional immaturity (Locatelli et al, 2012).

Truth telling differs according to countries. These differences are related to cultural background of that society. In European countries, there is no problem in telling the truth; no matter how bad the situation is, whereas it is not acceptable to tell the bad news in the Asian countries. However, not telling the truth to a westerner is disrespecting the patient (O`Kelly, Urch, & Brown 2011).

Some differences occur between the patient and their relatives with regard to information preference. Family members want to hear more about the patient`s condition than the patient (Lee & Hawkins 2015). However, the patient is the only person who can give permission to share information with the family (Zahedi 2011). This creates a challenge when the family want to know about the patient`s condition and the patient doesn’t want them to know.

2.3.4 Fidelity

The principle of fidelity implies being faithful to the patient and fulfilling the patient`s promise. It can also be defined as an" obligation to live up to patient `s expectation and trust" (Robinson 2003). Fidelity also means notifying the family when the patient`s condition changes (Urden et al, 2010). Fidelity is divided into confidentiality and privacy.

2.3.4.1 Confidentiality

Confidentiality is the right to keep patient`s personal information private unless the patient gives consent that the information be shared and unless not sharing the information is risky to others (Urden et al 2010).

The medical profession obliges the health care professionals to respect confidentiality in the following ways. In the Hippocratic oath, the doctors vowed to respect confidentiality in these words: ''What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.'' The World Medical Association's Declaration of Geneva, indicate that ''I will respect the secrets which are confided in me, even after the patient has died" (Lockwood 2007). "Nurses by taking the Nightingale Pledge promised to do all in their power to maintain and elevate the standard of their profession, and hold in confidence all personal matters committed to their keeping and all family affairs coming to their knowledge in the practice of their calling''(McGowan 2012).

Despite being ethical conscious, it is sometimes very difficult for health care professionals to manage confidentiality hence ethical dilemma (Petronio DiCorcia, & Duggan 2012). Health care professionals are likely to breach confidentiality purposely or not on purpose. Health care professionals can deliberately discuss the patient with an unauthorized person or intentionally when an unauthorized person overhears the conversation about the patient (Moskop, Marco, Larkin, Geiderman & Derse 2005).Ethical dilemma arises when relatives request for patient`s information without patient`s consent.

The Privacy Rule accommodates the fact that some patient information can be accidentally disclosed. This disclosure happens when visitors overhear the patient information during discussions, or when the patient`s information is written on the board. Accidental disclosure is allowed if some measures are taken to protect the patient information. These include “talking quietly when discussing a patient’s condition in a waiting room, avoiding the use of patients’ names when in public areas, and posting signs to remind employees to protect patients’ confidentiality” (McGowan 2012).

2.3.4.2 Privacy

Privacy is also an element of the principle of fidelity, This principle is closely associated with privacy of patient`s information and of his/her person (Urden et al, 2010). Privacy implies that the patient is not exposed. Privacy is enhanced by dressing the patient and screening the bed during procedures. Privacy is categorized into “physical privacy, informational privacy, and decisional privacy”. Physical privacy implies that the patient`s body is not exposed and is prevented from unnecessary contact with other people. However, the layout of the ICUs becomes a barrier for physical privacy. Informational privacy means that patient`s personal information is not shared. However, the need by staff to share the patient`s information for continuity of care compromises the informational privacy. Decisional privacy is the patient`s right to make choices without being coerced and this is prevented by the decreased level of consciousness of ICU patients (Budimir, Cerjan-Letica, Budimir, & Macan. 2013).

According to Fernandez and Moreira (2012), the physical structures of ICUs are in such a way that patient`s privacy is invaded. The ward is just an open space usually divided by curtains. In case of emergency, health care professionals tend to forget to draw the curtain first or rather see it as inappropriate to go for a curtain instead of saving the patient`s life. The general ICU admits both adults and children, male and female and they are usually covered with sheets. The study conducted by Barlas, Sama, Mary and Ward (2001) indicated that the privacy provided by the curtains is not the same as the privacy provided by walls. In ICU, visual privacy is prevented by not pulling the curtains completely during the emergency. The nurses stations are just an open spaces and the curtain cannot provide auditory privacy. Patient`s

information is revealed during report giving and during telephonic conversation with other team members. Nonetheless, the auditory privacy that a curtain can provide depends on the following: the material of the curtain, loudness of the voices and how far people are from each other.

Most of the patients in ICU are unaware of their surroundings. In some instances, we find that some patients are fully conscious. The health professionals tend to forget that at times they admit some patients who are fully awake and discuss the patient`s condition in front of other patients and the confidentiality of patient information is invaded. The prognosis of those patients who are unconscious are always discussed with the relatives without the patient`s consent. Due to limited space, counseling and every procedure is done on the patient`s bed. This makes it possible for other patients to hear and see the other patient. Due to the decreased level of consciousness of the patients in ICU, patients are unable to protect their privacy and the health care professionals must protect the patient`s privacy (Olsen, Cutcliffe & O'Brien 2008).

2.3.5 Resource Allocation

Resource allocation refers to the allocation of limited resources amongst people. Because some health care resources cannot be accessible for all the patients that need them, a strategy must be devised to decide the allocation of the resources. This resulted in triage, rationing and prioritizing of health care resources. Decisions for allocation of resources are done on two levels; the macro allocation and micro allocation. Macro allocation is done at national level and it allocates number of resources to be used at micro level. At macro level, resources are allocated to the whole country. The number of resources allocated at macro level will determine how scarce the resource will be at micro level. The macro allocation decides the number of ICU that each hospital will have. Micro allocation occurs within the hospital. It is when a decision has to be made as to who amongst the two patients must get the remaining bed in ICU (Enck 2011).

Allocation of resources involves the admission and discharge of patients in ICU. Due to limited number of ICU beds, the principle of justice must be respected during their distribution. It is imperative to realize that the allocation of resources in ICU involves

the life of others. The allocation of resources becomes difficult because of factors involved that are not related to the patient. Political factors, economic factors and the personal values of the health care professional involved influence the resource allocation (Ersoy & Akpinar 2010).

Due to limited number of beds in ICU and the effects that ICU has on the hospital economy, ICU beds must be used profitably. Although there are criteria for admission and discharge in ICU, the authority of the management also plays a role. “Particularly when medical criteria alone are insufficient in deciding what is the right thing to do, healthcare professionals can be faced with an ethical dilemma; a conflict of values can occur which makes every possible decision less than optimal on moral grounds”. For example, deciding whether to discharge a seventy nine years old patient in order to admit a twenty- five years old patient (Oerlemans, van Sluisveld, van Leeuwen, Wollersheim, Dekkers & Zegers 2015).

It is always difficult for health care professionals to decide on how health care resources can be distributed equitably. This is caused by the fact that they do not have to admit the patient in ICU because of the patient`s condition, the availability of ICU beds is the dictator of patient`s admission. The same applies to the discharge of the ICU patients, not all of them are discharged because they no longer need ICU, and most of them are discharged to create beds for other patients. Admission and discharge in ICU is based on the patient`s needs, maximizing the health of the patient and egalitarian theories, all of which benefit the young and those who have been healthy previously (Booth 2006).

According to Naidoo et al (2013), because the need for ICU beds is more than the available beds, beds must be reserved for patient whom there is hope for recovery. In South Africa, there is high demand of ICU beds resulting in ethical dilemma as to who must get a bed in ICU.

2.4 ETHICAL DILEMMAS EXPERIENCED BY DOCTORS

2.4.1 Withdrawal and withholding of treatment

Although the main aim of developing the ICU was to help patient through specialized machine until they fully recover, treatment can be withdrawn when it is seen that the patient can no longer recover. However, this act creates an ethical dilemma (Bunch 2001). Withdrawal of treatment implies that the treatment that was ordered is stopped .Withholding of treatment means that treatments that can sustain life are not given. Withdrawal of treatment is regarded as an active process whereas withholding is seen as a passive process. Hence, health care professionals are more likely to withhold than to withdraw treatment (Buekes 2011).

The fact that in ICU patients cannot be placed on life sustaining treatment forever makes the withdrawal of treatment a controversial issue. Treatment can be withdrawn so that the process of natural death can occur and this is not killing the patient. There is difference between allowing the disease to progress until the patient dies and killing the patient deliberately. When it has been established that the preferred treatment is no longer doing good to the patient, the treatment can be withdrawn or withheld. Treatment withdrawal or withholding must be aimed at reliving the patient from suffering. This makes the withdrawal of treatment a controversial issue. The withdrawal of treatment is limited to the following patient: “patients whose illness is judged irreversible, who are moribund, and who need to be protected from needlessly burdensome treatments” (Brendel, Wei, Epstein and Cassem 2011:559).

According to Haq (2012), ethical dilemma occurs when ethical principles are in conflict. Withdrawal and withholding of treatment violate all the ethical principles. Nonmaleficence is in conflict with autonomy when it comes to withdrawal of treatment. Beneficence is violated because withdrawal of treatment will not benefit the patient. Autonomy is affected as patients will not be informed about the decision and patients will not choose to get treatment that will lengthen their suffering. Distributive justice is violated as the treatment that is being given to the patient without benefit can be given to benefit others. The principle of non-maleficence implies the health care professionals must not give any treatment that will harm the patient. Conflicts with autonomy occur when the patient requires treatment that will

not benefit him. However, the health care professionals have the right not to provide treatment that is harmful to the patient.

In addition, Hov (2012) indicated that, a competent patient can request for withdrawal of treatment and this request must be respected after the results of such request has been discussed with the patient. The decision to withdraw or withhold treatment is influenced by the age of the patient, poor outcomes, expected quality of life, decision-making capacity, the wish of the patient and the pre-existing conditions. Patients, families, health care professionals, hospitals and the state may have conflicts over the withdrawal of treatment.

2.4.2 Principle of double effect

The main focus of intensive care units is to relieve pain and to maximize comfort. For this reason, the patient continues with sedation although other treatment are withdrawn or withheld. In spite of relieving pains, many opioids depress the respiratory centre, which results in death. “Provided the intention for using opioids is to relieve pain or distress, and the dose is titrated to this end, then their use hastens death. Equally important is the obligation to provide a sufficient dose of the drug to achieve the beneficial effect and this creates an ethical dilemma. If the intent is to relieve suffering and not to accelerate death, the treatment would be both legally and ethically acceptable” (Beukes 2011).

2.4.3 Euthanasia

Euthanasia’ or ‘mercy killing’ is allowing a patient to die without pain by either withholding or withdrawal of life support treatment. The use of life support technologies that extend life without the hope recovery has incorporated withdrawal and withhold of treatment in defining euthanasia (Taqi 2012).

Euthanasia can be voluntary or involuntary. Voluntary euthanasia is when the patient gives permission to the act. When euthanasia is performed without the patient`s consent, the act is an involuntary euthanasia. There is active and passive euthanasia. Passive euthanasia is when life support measures are withheld or withdrawn. Active euthanasia is when the health care professional gives something to deliberately end the patient`s life. Although punishable in South Africa, in some

states some criteria make euthanasia acceptable. Euthanasia is in conflict with the principle of non-maleficence, which creates an ethical dilemma. Not withholding or withdrawing life support treatment in some patient will prolong the suffering of the patient (Buekes 2011). Autonomy implies that a competent patient has the right to choose euthanasia and according to non-maleficence, health care provider has the right not to carry a procedure that in his opinion is detrimental to patients health

2.4.4 Non-abandonment vs Non -maleficence

Sometimes the patient and health care professionals does not agree on the necessary treatment. The health care professional has a duty to explain to the patient until he understands. If it fails, the doctor must ask another doctor to explain the importance of the preferred treatment. The health care professional must refer the patient to another doctor who prefers to continue with the treatment needed by the patient. The doctor cannot abandon the patient because of the disagreement on treatment modalities. However, the doctor has a duty not to provide inappropriate treatment (Haq 2012).

2.4.5 Do not resuscitate order

Cardiopulmonary resuscitation (CPR) “is an emergency procedure performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest”. However, it becomes meaningless when performed to every patient despite of the outcomes. The DNR order creates conflict between all parties involved; the patient, relatives, doctors and nurses. “Some of the conflict around the use of DNR orders stems from the phrase itself. A decision not to do something suggests abandoning and not caring for the patient, when the intention is the opposite”. Instead of using DNR, the doctor must indicate that death process must be allowed to take place naturally (Langley, Schmollgruber, Fulbrook & Albarran 2013).

Several factors influence the decision for family to agree on DNR order. These include patient`s age, medical condition and severity of the disease. “Older age, unmarried status, poor prognosis, and longer length of ICU stay are associated DNR decisions”. Family members who are old, females and professionals are more likely to sign for DNR orders (Cheng, Wang, Wu, Huang, & Su 2015).

2.4.6 Futile medication

The word futility comes from the word “leaky” which means a fruitless action. Medical futility is the treatments that will not produce fruitful results. However, no one can guarantee that the treatment will produce the desired results (Scanlon & Murphy 2014).Futility also implies “using considerable resources without a reasonable hope for recovery to a state of relative independence and interaction with the environment” (Chow 2014).

Several terms are used to describe various forms of futility. Qualitative futility and value futility means that although the treatment is effective on the patient, the quality of life will be very poor afterwards. Patient may remain unconscious. Quantitative futility means that the treatment fails to produce the desired outcomes. Continuous giving of medication is not helping the patient in anyway. In spite of this treatment, the patient will not survive. Several terms are used to indicate quantitative futility. These are; physiologic futility, which means that treatment, is unable to make the required physiologic changes to the patient. Imminent demise futility, which means that death is inevitable regardless of the treatment, lethal condition futility meaning that the patient is going to die due to illness despite treatment and goal futility, which means that the treatment is unable to produce the desired goal (Scanlon & Murphy 2014).

In addition, Vincent (2014) indicated that the term “medically inappropriate” is sometimes preferred to “futile” This is because ‘medically inappropriate’ indicates that judgement was done and the treatment was found to be inappropriate for the patients` condition. The indication of the intervention must first be established.

The medical data and professional experience is the ones that dictate that the intervention is futile. Because of their difference in experiences, health care providers can have different views as to when the intervention is considered futile. Therefore, the doctor needs to consult with different stakeholders before considering the treatment as futile (Jecker 2014, Chow 2014).

Since the aim of treatment is to benefit the patient, futile treatment does not benefit the patients but prolongs the suffering. In addition, the family thinks that because the patient is getting treatment there is hope. Giving futile treatment is just a way of

wasting the resources. The problem with futile treatment is that, what the health care professionals see as futile the family can see as helpful. This results in doctors making decision without informing the family members about the treatment. “Religious belief, cultural background, personal values, local legislation can influence one’s interpretation of futility” (Vincent 2014).

In an effort to prescribe reasonable medication, where there is no clear definition of what reasonable medication is in a given situation doctors become stressed. The decisions they must take regarding which treatment to give, the financial burden of giving such medication, loyalty to their patients, colleagues and profession create an ethical dilemma The moment the treatment is no longer beneficial to the patient, these creates an ethical dilemma to the registered professional nurses. For registered enrolled nurses, not being involved in treatment decision making is their greatest dilemma. This occurs when they are compelled to give medication that they do not even aware of its intention. (Sprung et al 2015).

There is always a problem when family members are involved in deciding the treatment. Due to lack of medical knowledge, they even choose the treatments that are not producing any effects to the patient. In such cases if attending doctors agree that the treatment is futile it can be withdrawn. Family members may choose futile care because they need more time with the patient (Chow 2014).

Although there is agreement that the treatment is futile, the family wishes my influence the doctors` decision to continue with futile treatment. “The family’s feelings of helplessness, belief in the possibility of an incorrect diagnosis and prognosis, an attitude of not giving up and not abandoning the patient, placing trust in God, and belief that medicine can work miracles may force the family to request futile treatment” .In spite of the family involvement the ultimate decision remains with the doctor (Scanlon & Murphy 2014).

Professional standards, empirical studies and clinical experience must guide the doctor when deciding the futility of the treatment. In respect of autonomy, patients have the right to choose treatment but not whatever they ask for. The ultimate decision is with the doctor who must make sure that the patient benefits from the treatment and adhere to his professional code of conduct (Jecker 2014).

Some other people are also affected by the use of futile treatment. These include family members who have to witness the patient suffering and other patients who could not receive ICU care because there is another patient in ICU receiving treatment that will not help him (Wilkinson & Savulescu 2011).

Futile treatments create ethical dilemma because it is against the ethical principles. The principle of beneficence requires that the action must benefit all people. The patient does not benefit from futile medication and so are the other patients waiting for a bed in ICU. Non-maleficence obliged the doctor to do no harm. Continuation of life sustaining therapies provides more harm than good to the patient. They prolong the suffering of the patient and patient may remain in dependent state forever. For example, repeated cardiopulmonary resuscitation can result in brain damage (Shapira-Lishchinsky 2009). Distributive justice implies that limited resources are shared fairly. Medical futility is against distributive justice, because they are the resources, and expenses that might have been used to patients with better prognosis than the ones who will not cured and have good quality of life.(Buekes 2011). The principle of autonomy is violated because most of the patients receiving futile treatment are unable to make choices. The decision by doctors to continue with treatment that has been rendered futile without the consent of the patient, violate the respect of patients` autonomy (Aacharya & Maharjan 2014).

2.4.7 The use of antibiotics as an ethical dilemma

The use of antibiotics creates a dilemma because it provides both benefit and harm to ICU patients. Antibiotics help to fight microbes on the patient that is receiving them, and prolong use can cause resistance. The same antibiotic that is benefiting one patient can cause resistance to the entire unit. Unlike other resource, the dilemma in the use of antibiotics is not about scarcity of resource, but rather the harm that it will cause to other patients (Michael, Niederman, Jeffrey & Berger 2010).

2.5 ETHICAL DILEMMAS EXPERIENCED BY NURSES

Bunch (2001), reported that the principle of nursing creates dilemma for nurses working in ICU. Although there are machines that help in patient care, these

machines are never in the interest of nurses, the main interest of the nurses is the patients. The principle of caring, that teaches nurses never to give up on a patient creates a dilemma in ICU (Shapira-Lishchinsky 2009).

Furthermore, Chaves and Massarollo (2009) highlighted that the action performed in ICU are in contrast with the nurse's values and beliefs. The values of their professional class, their religious principles, the certainty that critically ill patients should die in a room surrounded by the family and not in the ICU, the determination itself about when patients become terminal, and the doubt about how much should be invested generate deep personal conflicts and bring out the dilemmatic sense to the situation. The activities that performed in ICU are in conflicts with their professional responsibilities. Nurses have good relationship with patients` family. This relationship creates dilemma as the family can never accept that the patient has to die and does not understand the treatment modalities in ICU.

However, Wilkinson & Savulescu (2011) contends that, ethical dilemmas are associated with factors such as; organizational structure and nurses` value believe pattern. The type of patients cared for will determine the frequency in which dilemma will be encountered. However, Mutinda (2015) indicated, "age, professional qualification and level of knowledge of ethical issues" as socio-demographic factors related the experience of ethical dilemma by nurses. Furthermore, Chaves and Massarollo, (2009) indicated Physical and relational setting as closely related to ethical dilemma experienced by nurses in ICU.

ICU nurses experience ethical dilemmas more often than any nurses in the hospital do. The use of health care technology in patient management and the severity of patients` illness results in ethical dilemma. The use of technology provides nurses with new responsibility. They have to make decisions regarding life-sustaining treatments. These decisions involve the misuse of futile treatment, enteral feeding, DNR order and mechanical ventilation (Erlen & Sereika 1997).

Fernandes and Moreira (2012) argue that teamwork between different health care professionals create dilemma for nurses. This is because nurses are not involved in decisions regarding patient care and they must implement the decision that the doctors take although they are against their principles.

Mutinda (2015) identified the following ethical dilemmas“. End-of-life decision, (prolonging the dying process, withholding treatment, DNR orders and patients' religious values). Patient care issues (unsafe nurse- patient ratios, allocation of scarce medical resources, breaches of patients' privacy, ignoring patients' autonomy dealing with incompetent colleagues, discriminatory treatment of patients, patient/ relatives uninformed about the patient's prognosis) and human rights issues (advance directives, informed consent, rights of paediatric patients and nursing of critically ill patients posing a risk to nurses)".

Furthermore, Bunch (2001) identified other ethical dilemmas experienced by nurses in Norway. These include, (1) Patients remaining on the same condition for long, not getting better and not dying. (2) Unexpected development of multiple organ failure. (3) Premature discharge due to shortage of beds. (4) The use of age as a criterion for some operations. (5) Shortage of staff and beds. (6) Patient improving and dying later. The patients who remained ill for long time, not recovering and not dying are considered to be lingering. Lingering becomes a dilemma because despite the outcomes, nurses have to provide quality care (Bunch 2001).The following are some of the ethical dilemmas experienced by critical care nurses as indicated by Shapira-Lishchinsky (2009).

2.5.1 Caring for Others vs. Following Formal Codes

Almost every workplace has rules and regulations that govern the conduct of its personnel. Rules and regulations are put in place to ensure safety. Allegiances and loyalties among the employees improve the atmosphere at the workplace, and make it a more pleasant and efficient unit. Sometimes, however, a clash arises between the social aspects of the workplace and the rules that guide it. This category illustrates the tension between caring for either patient or colleague and maintaining proper behaviour that is in keeping with the rules and norms of the health organization.

2.5.2 Patient-centered care vs. keeping the rules

The patient-centered care implies that patients are involved in every aspects of their care. They have to be given information regarding their treatment upon which they

can make informed choices. However, in ICU most patients are unconscious making it impossible to make decisions and this creates a dilemma.

2.5.3 Collegial loyalty vs. reporting misbehavior

This occurs when a nurse finds out that the actions of a colleague are not ethical. When someone's` actions are against the rules and standards, patient care becomes compromised and the patients suffer the consequences. Dilemma results when a nurse wants to be loyal and not report the colleague on the other hand knowing that the patients are the ones that are bearing the consequences of her silence.

2.5.4 Guarding Secrecy vs. Duty to Report

ICU patients are dependent on the nurses for basic nursing care. These include bathing, changing of positions and even covering themselves. In the course of doing all these, the patient can lose her right to privacy. However, there is difference between exposing the patient because you want to see something and because you want to help him. Therefore, dilemmas result between "the desire to respect a patient's wishes for privacy regarding personal details, and the nurse's professional duty to report his medical condition".

2.5.5 Fair Process vs. Fair Outcome

Sometimes in hospitals, conflicts occur between what is best for the patient and what is best for the hospital. Fair distribution of resources implies that resources are available for the care of the greater society. An intervention needed by an individual patient may not be available for the patient because its cost will deprive other patient of the basic care. The rules regarding this are made by people whose focus is the health of all the patients in an organisation. This process creates a dilemma for nurses who are in direct contact with the patients, the rules become the stumbling blocks for patient`s recovery.

2.5.6 Autonomy vs. Deference to Higher Authority

Autonomy vs. Deference to Higher Authority is an ethical dilemma experienced by nurses, as they have to follow the organizational policy. Although nurses are capable of making their own decision regarding patient care, policies must be followed. Dilemma occurs when nurses do not agree with the policy that they must follow (Shapira-Lishchinsky 2009).

2.5.7 Organizational Standards vs. Family Agenda

When organizational standards are in conflict with what family wants then ethical dilemma results. In the performance of patient care, nurses have a set of organizational standards they must follow. They also have to cater for patient and family needs. Sometimes these standards are against the family or patient`s wishes. Nurses are caught in the middle, not knowing whether to alter the rules and please the patient and family or to ignore the family and follow the standards (Shapira-Lishchinsky 2009).

2.5.8 Perfidy

Perfidy is an ethical dilemma experienced by nurses when they wish to be true to the patients and conditions make them not to do so. Different categories of nurses experience different types of perfidy. RPNs experience perfidy during treatment trials and when treatments are withheld, patients think they are getting the best treatment and nurses are aware that some treatment has been withheld. The feel they are not faithful to their patients' hence ethical dilemma results. For RENs perfidy occurs when patients are subjected to life sustaining treatment only to complicate and die later instead of letting them die before suffering (Soderberg et al 1996).

2.5.9 Lack of time / staff

Lack of time requisite for procedural attention may result in nurses doing less than they are supposed to do to the patient. Although they want to provide quality care, time does not allow them and this creates a dilemma for them. If they spend enough time with one patient, they will be neglecting the other. Shortage of staff creates a dilemma because there will be no suitable trained staff to provide quality care to the

patients. Dilemma occurs when patient cannot be left unattended because there are no qualified staffs. The available personnel must take care for the patients even though it is against the standards.

Mostly, administrative nurses are having ethical dilemmas experienced by nurse managers include Performance Management and Development System, distribution of resources, reporting of medical error and doctors` misbehaviours. Furthermore, the following was identified as the ethical dilemmas experienced by nurse managers:(1) protecting patients' rights, (2) care of patients' quality of life; (3) providing care with possible risks to own health and safety; (4) respecting informed consent by patients to treatment; (5) use of physical or chemical restraints on patients; (6) determining when death occurs; (7) prolonging dying process without appropriate reason; (8) hiding information regarding patients' actual condition from patients or family; (9) working with unethical or incompetent colleague (10) problems of staffing that limit patients' access to nursing care; and (11) problems of medical resource management that limit patients' access to nursing care" (Musa, Rashid & Sakamoto 2011).

2.6 CONCLUSION

Literature review indicates that ethical dilemmas are the hallmark of every ICU. It indicated what constitute a dilemma. Furthermore, it covered several dilemmas experienced in various ICUs. It also highlighted some of the best practices in resolving these dilemmas.

I

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter describes in details the research design and the methods that were used in the study. These included the research setting, research design, population, sampling method, data collection, data analysis and ethical considerations. Research limitation and debriefing of participants were highlighted.

3.2 RESEARCH DESIGN AND METHOD

3.2.1 Qualitative Research

The researcher adopted a qualitative research method to answer the research question and achieve objectives of the study.

According to Polit and Beck (2012), qualitative research is the investigation of the phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design. However, Brink, Van der Walt and van Rensburg (2012) indicated that this type of research attempts to understand the phenomenon in its entirety, rather than focusing on specific concepts. It is a type of research that produces findings not arrived at by statistical procedures or other means of quantification. It has few preconceived ideas, and stresses the importance of people`s interpretation of events and circumstances, rather than researcher`s interpretation (Brink et al, 2012).

Qualitative approach was used to answer questions on ethical dilemmas experienced by health care professionals working in ICU, with the purpose of exploring, describing and understanding the experiences from the nurses and doctor's point of view and collecting extensive verbal data from a small number of participants. That data is then organized to give coherence and use verbal descriptions to portray the situation studied (Leedy & Ormrod in de Vos 2012).

This is a systemic, subjective approach which was used to describe life experiences of ethical dilemmas experienced by health care professionals working in ICU and

give them meaning (Burns & Grove 2009:22). The researcher had a sustained interaction (in a form of an interview) with the health care professionals in their own language and on their own work place (Brink et al 2012). Furthermore, the researcher borrowed ideas from the health care professionals about the ethical dilemmas they experience while working in ICU and place them within the context of natural settings, examine motifs, themes, distinctions and ideas instead of variables (Neumann 2011). The emphasis was on the health care professional`s interpretation of the ethical dilemmas they experience while working in ICU rather than the researcher's interpretations.

3.2.2 Research design

In this study, the researcher adopted a qualitative, descriptive and exploratory design to answer the research question and achieve objectives of the study

The design of the study is the end results of a series of decision made concerning how best to implement the study. It is closely related to the framework of the study (Burns & Grove 2009).

Polit and Beck (2012) define it as the overall plan for obtaining answers to the research question. It indicates how data will be collected, what type of comparisons will be made, and where the study will take place. It is also defined as the overall plan for addressing a research question, including specifications for enhancing the study`s integrity (Polit & Beck 2012).

3 2.2.1 Descriptive design

According to Polit and Beck (2012) a descriptive research is a research that typically has as its main objectives the accurate portrayal of people`s characteristics or circumstances and/or the frequency with which certain phenomena occur.

In this study, a qualitative descriptive design was used to obtain complete and accurate information about the lived experience of ethical dilemmas by health care professionals while working in ICU in Tshilidzini hospital, Vhembe district in Limpopo Province. This design allowed health care professionals to describe their experience of ethical dilemmas while working in ICU, Tshilidzini hospital, Vhembe district in

Limpopo Province. In addition, a descriptive research allowed the researcher to observe, describe, and document aspects of situations as they naturally occur (Polit & Beck 2012).

Furthermore, the data that materialized from this study was descriptive because the researcher was interested in processing the meaning of and understanding the ethical dilemmas as described by the health care professionals.

3.2.2.2 The exploratory design

Polit and Beck (2012) define an exploratory research as a study that explores the dimension of a phenomenon. It is a study that is designed to increase the knowledge of a field of studies and is not intended for generalization (Burns & Groves 2009). Polit and Beck (2012) added that an exploratory research begins with a phenomenon of interest, but rather than simply observing and describing it, exploratory research investigates the full nature of the phenomenon, the manner in which it is manifested, and the other factor to which it is related.

In this study, the exploratory design was used because little is known about the ethical dilemmas experienced by health care professionals working in ICU (Brink et al, 2012). The aim of this exploratory research was to establish the facts about the ethical dilemmas experienced by health care professionals working in ICU, to gather new data from health care professionals, to determine whether there are new patterns in the ethical dilemmas experienced by health care professionals and, to gain new insights into the experiences of health care professionals of ethical dilemmas while working in ICU (Mouton 1996, De Vos et al 1998).

Furthermore, the exploratory design has assisted the researcher to ask probing questions based on the interview guide questions set prior the interview sessions to explore the ethical dilemmas experienced by health care professionals while working in ICU, Tshilidzini hospital, Vhembe district in Limpopo Province

3.2.3 Population

Population is a particular type of individual or elements who are the focus of the research (Burns & Grove 2009). Brink et al (2012) added that population is the entire group of persons or objects that is of interest to the researcher, in other words that meet the criteria that the researcher is interested in studying. The accessible population was registered health care professionals working in ICU, Vhembe district. There are seventeen registered nurses including registered enrolled nurses and ten medical doctors.

The inclusion criteria:

- All nurses and doctors working in ICU
- Have at least one year experience in ICU of Tshilidzini hospital.

Exclusion criteria:

- The intern doctors
- Nurses and doctors with less than one year experience in ICU of Tshilidzini hospital

3.2.4 Sampling

Sampling is a process of selecting subjects, events, behaviour, or elements for participation in the study (Burns & Grove 2009:35). According to Brink et al (2012), Sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. There are two types of sampling, namely probability and non- probability sampling.

In this study, non-probability purposive sampling was used to obtain seventeen (17) participants. A purposive sampling was used to select seventeen (17) participants. Purposive sampling is a type of nonprobability sampling in which the units to be observed are selected on the basis of researcher's judgement about which ones will be the most useful or representative (Babbie 2010). However, in purposive sampling, researcher selects information rich cases, or those cases that can teach them a great deal about the central focus or purpose of the study (Burns & Grove 2009).

The study focused on all nurses and doctors working in ICU, Vhembe district of Limpopo Province because they are the ones rich in information about caring of patients in ICU. The researcher has purposefully selected ICU, Tshilidzini hospital, because it is the only ICU in Vhembe district.

3.2.5 Sample size

According to Polit and Beck (2012), sample size is the number of people in a study. There are no fixed rules for sample size in qualitative research. In qualitative studies, sample size should be based on informational needs. Hence, a guiding principle in sampling is data saturation that is, sampling to the point at which no new information is obtained redundancy is achieved (Polit & Beck 2012).

In qualitative research, the focus is on the quality of information obtained from the person, situation or event or documents sampled versus the size of the sample. The number of participants in qualitative study is adequate when saturation of information is achieved in the study area (Burns & Grove 2009).

In this study, the sample size was seventeen (17). Data was collected until data saturation was achieved. Data saturation occurs when additional sample provides no new information, only redundant or previously collected information (Burns & Grove 2009).

3.3 RESEARCH SETTING

Brink et al (2012) refer to research setting as a specific place or places where the data will be collected and where the participants live and have these experiences. It is the location for conducting research such as natural, partially controlled or highly controlled setting (Burns & Grove 2009). Qualitative studies are conducted in a natural setting. A natural setting is an uncontrolled, real life situation or environment. The researcher does not manipulate or change this environment for the study (Brink et al, 2012). The setting of the study was ICU, Tshilidzini hospital in Vhembe district.

Tshilidzini Hospital is a regional health facility in the Limpopo Province. It is located in the Vhembe district, about 5 km from Thohoyandou and it is easily accessed from

the main road between Makhado and Thohoyandou. The Dutch Reformed Church initially opened Tshilidzini Hospital in 1958 as a missionary hospital. Later it was taken over by the former Bantustan of Venda in 1979 and re-integrated into South Africa in 1994.

Tshilidzini Hospital serves a catchment population of 1.3 million people; this includes twenty-four (24) clinics, two (2) community health centres and six (6) district hospitals. It refers patients to the Polokwane-Mankweng Hospital Complex for tertiary care and all higher-level radiological examinations, such as CT scan and screening. The hospital has access to an air ambulance from Polokwane in the event of serious poly-trauma. It seems, therefore, that access to tertiary care for all citizens in the Vhembe district is possible within the prescribed three-hour limit. The facility also has a gateway clinic and provides primary health care services despite its designation as a regional hospital. This is necessary because there is no district hospital nearby. The researcher purposively selected Tshilidzini hospital ICU because it is the only ICU in Vhembe district.

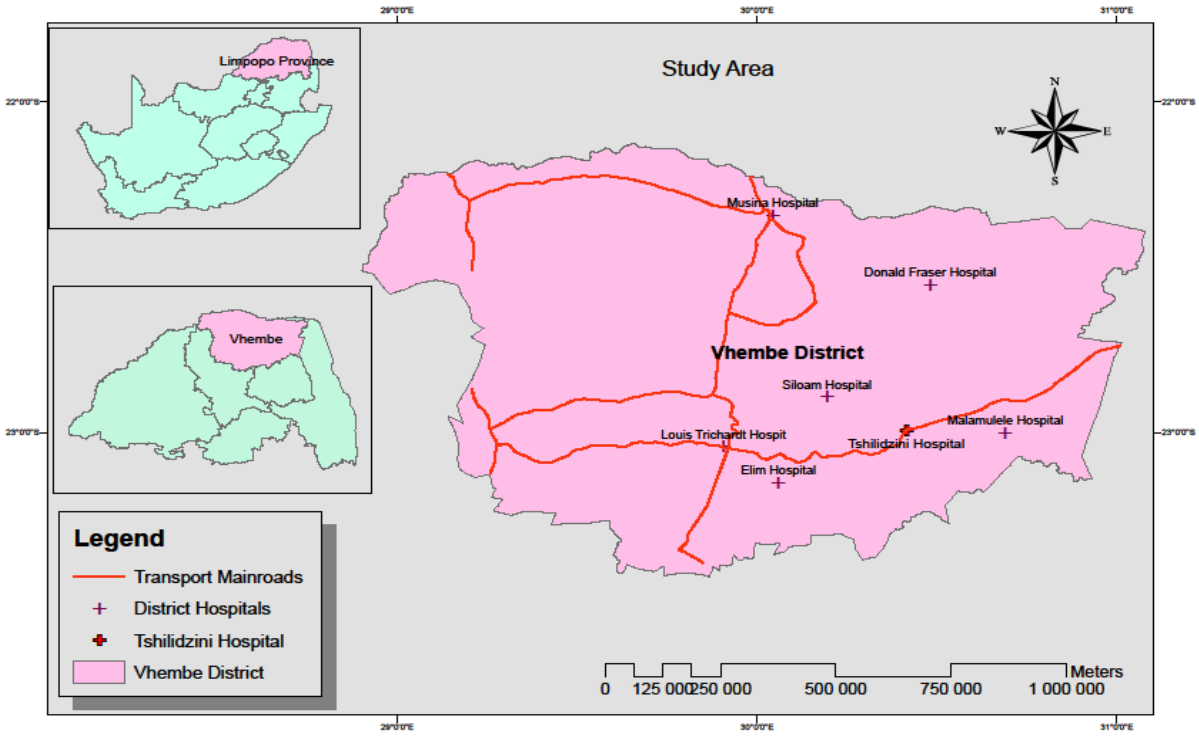

Figure 1 Map indicating Tshilidzini Hospital

3.4 DATA COLLECTION

Data collection is the gathering of information to address a research problem (Polit & Beck 2012). According to Burns and Grove, (2009) data collection is a precise, systemic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of the study. Furthermore, qualitative researcher uses unstructured observation and interview to collect data. The data includes shared interpretations of the researcher and participants, and no attempts are made to control the interaction (Brink et al, 2012).

The researcher sought permission to conduct research from the management Tshilidzini hospital after getting approval from the Province. Permission to collect data was also sought from the operational manager of ICU. The researcher made appointments with the participants before the date of data collection. Data was collected in ICU, Tshilidzini hospital in the side ward and at the participant's homes. Data was collected during their lunchtime and at their residential area if the participant was off duty or on leave during data collection. A semi-structured, one-to-one, in-depth interview was conducted, to explore and describe the ethical dilemmas experienced by health care professionals while working in ICU. Each interview began with one central open-ended question that focused on the research question. In this study the central question was:

"What are the ethical dilemmas experienced by health care professionals at ICU in Tshilidzini hospital"?

Several communication techniques according to de Vos et al (2007) were used during an interview.

Minimal verbal response, a verbal response that correlates with occasional nodding, e.g. 'mm-mm' I see, showed the participants that the researcher is listening. Paraphrasing, this involves a verbal response in which the researcher enhanced meaning by stating the participant`s words in another form with the same meaning. Clarification, this embraces a technique that was used to get clarity on the unclear statement, e.g. could you tell me more about...? Reflection, involves reflecting back

on something important that the participant has just said in order to get him to expand on that idea.

This was followed up by probing questions, which depended on the responses of the participants. Probing is when the researcher elicits more useful or detailed information from the participants during an interview than was volunteered in the first reply (Polit & Beck 2008).

The interview lasted for forty-five minutes to an hour. The interview was conducted in English and in the local ethnic languages used in the region to enhance greater self-expression. The respondents were interviewed during their spare time.

Observation notes were also taken. Observational note are the who, what, where and how of human activity (de Vos 2010). Observational and personal notes were written on the pad to note verbal and nonverbal cues of the participants that were observed. A voice recorder was used to capture all the individual interviews conducted. The interview was voice recorded with the permission of the participants. Data was collected continuously to the point of saturation of information, when no more new data was obtained or when there was repetition of data (de Vos et al, 2008).

3.5 BIAS

In this study bias was minimized as follows:

- The researcher suspended all her preconceived ideas about the dilemma experienced by healthcare professionals working in ICU Tshilidzini hospital.
- Purposive sampling was used to sample participants who had one years of experience in Tshilidzini ICU.
- No leading questions were asked during data collection, but probing was also done for clarification of vague answers.
- During data collection, field notes that helped the researcher to reflect on the research process and verbatim reports from the participants were written.

- Observation of the participants was done to register any important reaction during data collection.
- An audio tape was also used during data collection.
- During data analysis, transcripts were carefully read and coded using themes and sub-themes, and an independent coder verified the themes and sub-themes that emerged from the data.

3.6 DATA ANALYSIS

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (de Vos *et al,* 2008).Data analysis entails categorising, ordering, manipulating and summarising the data , and describing them in a meaningful way (Brink et al, 2012).

In this study, qualitative data analysis was conducted; this involved an examination of text rather than numbers. Data-analysis was done simultaneously with and after data collection, this assisted the researcher to refine the questions, and assist the researcher to remember what has been said or observed.

In this study, Tech's method (Brink et al 2012) of qualitative data analysis was followed as in table 2.

Table 2: Tech's method of qualitative data analysis

Getting sense of the data	The researcher read through all the transcription several times carefully in order to understand the information provided by participants. The researcher immersed into the topic in detail, trying to understand interview before breaking them down into parts. Some ideas were jotted down as they come to mind. At this stage, the researcher organized data,

	transcribed data verbatim and translated data
Pick one document	The researcher picked the most interesting, shortest transcription or the one at the top and goes through them, read and re-read them, analysing their underlying meaning. Thoughts were written in the margin.
Compiling this task for several participants	After compiling this task for several participants, the researcher made a list of all topics and cluster together similar topics. Topics were formed in the columns. Notes and headings were written in the text while reading it. Data was treated as answers to open ended questions or as data specific questions.
Topics that relate to each other must be grouped together	The researcher analyzed the topics and then groups those that relate to each other. The list of categories was be grouped under headings. The aim was to reduce the number of categories by collapsing those with similarities or differences in broader categories.
Take list of topics	The researcher took the list of topics from the data. Topics were abbreviated as codes, and those were written next to the appropriate segment or margins.
Abbreviate each category	The researcher made decisions on the abbreviations for each category. Then the researcher made and alphabetize topics as codes.
Assemble categories	Data material belonging to each category was transcribed

Record	Records of existing data were created. The findings was then be presented in writing and the information gained from the findings was counter checked

(Brink et al 2012).

3.7 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is a way of ensuring data quality or rigour in qualitative research, based on the model of Lincoln & Guba (1985). Researchers adopt various strategies to ensure trustworthiness of data as suggested by Lincoln and Guba (1985) and Krefting (1991), the models concentrate on the following criteria: credibility, dependability, confirmability and transferability.

3.7.1 Credibility

Credibility also referred to as truth-value, establishes how confident the researcher is with the truth of the findings based on the research design, informants and context (Brink et al, 2012).Credibility in qualitative research is like internal validity in quantitative research.

In this study, credibility was enhanced by ensuring the following:

3.7.1.1 Prolonged engagement

In this study, the researcher ensured that the study is credible by spending more time with the participants to establish rapport, to explain the aim of the study. The researcher spent at least an hour gathering data. Data was collected until data saturation occurred.

3.7.1.2 Persistent observation

The interview was conducted in English and in the local ethnic languages used in the region to enhance greater self-expression. The researcher confirmed responses and non-verbal cues from participants by paraphrasing, comments and asking further probing questions. The researcher once again returned for data control and follow-up

information to establish truth-value. The researcher shared her interpretations with the study participants and asks them to confirm that their life-words have been captured accurately; comparing the researchers' interpretations with the participants' accounts.

3.7.1.3 Triangulation

Furthermore, the researcher ensured data triangulation by using various methods of data collection. The voice recorder, observational notes and interview was used to collect data. Different questions in line with the central question were also asked.

3.7.1.4 Peer- debriefing

In addition, peer debriefing enhanced credibility of the study. Peer debriefing was enhanced by seeking the views of the peer and consulting those with similar statues and colleagues. The researcher also kept a constant consultation with her supervisor and co-supervisor regarding the findings of the study. The researcher also consulted experts who are not part of the study. The experts who were consulted guided the researcher throughout the research process and had knowledge about the research topic, (Brink et al 2012).

3.7.2 Transferability

"Transferability refers to the extent to which the findings of the study can be applied in other contexts or with other respondents" (Babbie & Mouton 2001). "Transferability also refers to the ability to apply the findings in other context or other participants" (Brink et al 2012). Qualitative research meets this criterion when the findings fit into contexts outside the study situation. The researcher selected information-rich participants through purposive theoretical sampling. Data was collected until data saturation occurred. The researcher proved dense descriptions of the research data; including verbatim quotations.

3.7.3 Dependability

According to de Vos et al. (2008), dependability is another word for reliability. It is when "the researcher attempted to account for changing conditions in the phenomenon chosen for the study as well as changes in the design created by

increasingly refined understanding of the setting''. In addition, Creswell (2009:190) argues that "qualitative reliability is determined by the researchers approach being consistent across different researchers and different projects''. According to Brink et al, (2012) dependability is when the researcher's peers follow the steps followed by the researcher to determine whether they are acceptable. It is more about auditing.

In this study, the researcher learnt from informants rather than to control them. Furthermore, the researcher ensured that the research focus is kept in mind and that the research problem was addressed. The researcher kept copies of the research methods, audiotapes, the transcribed data, the coding system and the reports containing the coded data. Dependability was achieved by the researcher allowing cross-checking of codes also known as inter coder agreement by other research experts to see whether these experts would code the data in the same way as the researcher (Creswell 2009).

3.7.4 Confirmability

Confirmability is when several people or informants view the general findings as similar with the researchers' findings (de Vos et al, 2008). Confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between investigators interpretation and the actual evidence (Brink et al 2012). Data neutrality but not investigator neutrality is the criterion to be considered. This can be achieved when the truth-value and applicability are established.

The researchers ensured confirmability of the study results by becoming closely involved on the informants' life-worlds, which they revealed during a study. In addition, the researcher ensured that she is open to the perceptions of the participants rather than attaching her own meanings to it; setting aside preconceived ideas. The researcher also sent the findings to experts, and supervisors to read the findings and confirm. Throughout the study, data checking was done and continuous discussion between experts and the supervisors ensured the truth value of the data (Creswell 2009).

3.8 ETHICAL CONSIDERATION

Ethical measures as set out by the Democratic Nurses Association of South Africa (DENOSA) was adhered to during the research process and included informed consent, confidentiality and anonymity, and protection from psychological harm (DENOSA 1998).The researcher was guided by the following ethical principles: permission to conduct research, autonomy, privacy, confidentiality, anonymity and informed consent (Burns & Grove 2007).

3.8.1 Permission to conduct research

Proposal was submitted to school of Health Higher degree Committee and to the University Higher Degree Committee for quality and control. Ethical clearance to conduct the study was obtained from the University of Venda Research and Ethics Committee. The researcher obtained approval from Limpopo provincial and district Department of Health and the Tshilidzini hospital Ethics Committee.

3.8.2 Right to self-determination or autonomy

The purpose of the study was explained to each participant before choosing whether to participate in the study or not. It was explained to the participants that they have the rights to voluntarily participate in the research and the rights to withdraw from the study.

3.8.3 Right to confidentiality

According to Burns and Grove (2007), confidentiality in a participant's information is the "management of private data in research in such a way that only the researcher knows the subject's identities and can link them with their responses". According to Brink et al (2012), confidentiality means, the identity of study participants is only known to the investigator. In this study, participants were assured that any information they will provide will not be published or reported in any manner that will identify them. There will also be no publication of participant's and research setting. No information will be shared without authorisation from the study participants .All raw data will be kept confidentially in a secure place. The participants were informed

that field notes will be written and that a tape recorder will be used during interviews to capture the proceedings of the interview sessions.

3.8.4 Informed consent

Informed consent means that participants have adequate information regarding the study, comprehend the information, and have the power of free choice, enabling them to consent voluntarily to participate in the study or decline participation. In this study, the researcher explained the purpose of the study, the procedures that will be involved, how confidentiality will be maintained and the right to withdraw from the participation. The participants were informed that the study will be conducted humanely and that the researcher will not probe any information that would harm them. Arrangements were made with the staff in ICU to provide supplementary psychosocial support for the participants, if the interviews should cause emotional reactions not anticipated by the researcher. Participants were also informed that there will be no financial gain or other rewards for participating in the study. The participants were given the researchers' contact particulars in order to contact her if they need any clarity. The participants also gave the written and oral consent to conduct research. Participants also gave permission to use the voice-recorder.

3.8.5 Anonymity

Anonymity literally means namelessness. According to Brink (2012), even the researcher should be unable to link a participant with his/her data. The participants were allocated numbers and their real names were not be used to ensure confidentiality and anonymity in the entire research project. No report was made on the long quote of participants on responses to question to avoid identifying participants by linking quotes to the participants. The researcher kept the results of the study under lock and key and with no identities.

3.8.6 Privacy

Privacy can be defined as freedom from exposure to or intrusion by others (Moskop et al 2005). Interviews were conducted in a private room away from destructions. The participants were made aware that they are not forced to answer any question if

they feel the questions violate their privacy. Participants were not coerced into sharing private information.

3.09 CONCLUSION

This chapter described in details the qualitative, exploratory and descriptive research design that was used in this study. Semi-structured, in-depth interviews with an interview guide were used to collect data until data saturation was reached. Field notes and a voice recorder were also used during data collection. Data were analysed according to Tesch's open coding method as outlined by de Vos et al (2012). Furthermore, the researcher showed how ethical issues and measures to ensure trustworthiness were observed. The following chapter is the discussion of the study findings.

CHAPTER 4

RESEARCH FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

This chapter presents the analysis of data collected from seventeen (17) participants, seven (7) doctors and ten (10) nurses who were purposively selected to describe their experiences with regard to ethical dilemmas in ICU Tshilidzini Hospital. The participant's verbatim statements are presented in italics and numbers identifies participants followed by D for doctor or N for nurse. Four main themes and associated sub-themes emerged during data analysis Themes and sub-themes are supported by a literature control and participants' verbatim statements that are presented in italics

4.2 THEMES AND SUB-THEMES

Four main themes and associated sub-themes emerged during data analysis as summarized in Table 3. A literature control and participants' verbatim statements support themes sub-themes.

Table 3: Theme and sub-theme.

Themes	Sub-themes
4.2.1.Lack of resources	4.2.1.1 Limited ICU beds 4.2.1.2 Shortage of ventilators 4.2.1.3 No intensivist 4.2.1.4 Inadequate ICU trained staff 4.2.1.5 Insufficient of equipment

4.2.2 Unsuitable infrastructure	4.2.2.1 No High Care Unit 4.2.2.2.Lack of isolation measures 4.2.2.3 Privacy and confidentiality
4.2.3 Hospital policies	4.2.3.1.Admission criteria 4.2.3.2.Discharge criteria 4.2.3.3 Transfer to tertiary institution
4.2.4 Patient`s decision making	4.2.4.1 Refusal of consent 4.2.4.2 Patient`s belief

4.2.1 Theme: Lack of resources

For effective and efficient functioning of any ICU, sufficient material and human resources are needed. The resources must be in adequate number and well maintained. Proper guidelines and policies must be in place for proper use of the resources. Lack of adequate material resources result in staff demoralisation, whereas lack of human resources lead to improper patient management.

4.2.1.1 Limited ICU beds

Six (6) participants expressed that limited ICU beds create a dilemma for them. Doctors expressed dilemma related to not finding a bed when they want to admit a patient in ICU. Nurse`s dilemma is related to their duty of saving lives for the patients. They feel that every patient must be given a chance of being admitted in ICU. Participants indicated that the greatest dilemma created by limited ICU beds is to choose which patient is to be admitted to ICU when they have one or more patients who deserve. Lack of beds makes it difficult to decide whom they must admit in ICU regardless of the patient`s condition. Participants indicated that it is very

painful if a patient is not given a chance for proper management because there is no ICU bed. Participants further highlighted that because of lack of beds, some admissions are delayed; resulting in some complications. These sentiments are aptly expressed in the following excerpts:

Participant No: 9D said:

On few occasions, I have tried to transfer the patient to another hospital, the same story, no ICU bed

Participants No: 17D said:

One of the main ethical dilemma is created by the fact that this ICU only has four beds. Therefore, that means this beds are not enough for the patients of Vhembe district. And it means that there will be time when I need a bed in ICU and ICU is full.

Participant No: 11D pointed out:

Quite often we are faced with the situation where we see a patient and we need to decide, based not only on the condition of the patient but on the availability of ICU beds. Whether we are going to take this patient to ICU or not. This is an ethical dilemma more than a medical dilemma because medically speaking you`ve got no doubt that this patient needs ICU but let`s say you`ve got one ICU bed and you`ve got three patients who needs ICU. You cannot admit all of them because you don't have beds.

Participant No: 13D stated:

Because of our resource limitation, as a doctor I am suppose to choose who needs ICU now as compared to the other one. That happens mostly if we have two patients who actually need a bed and you only have limited number. So in those instances I have to choose who have the best chance to actually survive. Choosing is like playing God. I have to choose the best patient for the bed and sometimes is not easy, or I may not have made the right choice at all. Everybody has the right to live.

Participants No: 9D put it in this way:

We have to prioritize the patient for the limited resources.

Participant No: 6N indicated:

Recently a fifth bed was squeezed in order to admit the fifth patient.

Worldwide, the demand for ICU beds exceeds the supply hence beds shortage occurs daily in every ICU. In South Africa, unfair distribution of resources is among the ethical dilemmas that the doctors and nurses are facing. There is limited number of ICU beds in South Africa both in public and in private sector (Naidoo et al. 2013). Giannini and Consonni (2006) also mentioned that shortage of beds occurs every day in many ICUs. Robert, Reignier, Tournoux-Facon, Boulain and Lesieur (2012) added that in a region the political and economic influences are the major determinants of the allocation of ICU beds.

It is generally taken as normal for lower level hospitals to have fewer ICU beds. This is relative to the lower level of care that is offered in those hospitals. The high number of beds in tertiary hospitals is equivalent to the therapeutic interventions and the complications associated with care provided in those hospitals (de Beer, Brysiewicz & Bhengu 2011).

Robert et al (2012) indicated that while some patients may not be admitted in ICU because according to the admission criteria, they are classified as very ill or too well for ICU to be of help, however, some patients who can benefit are denied the opportunity because of shortage of beds. Cheng, Lu, Chung, Huang, Shen, Chen and Zhang (2014) also mentioned that poor prognosis is often related to delayed ICU admission secondary to full units.

ICU beds are a scarce resource and the demand will always exceed the supply. Balancing the need for ICU beds with the available beds is problematic. Guidelines to be followed when the unit is full can be valuable, and a high care unit can be established for patients who do not need intense care.

4.2.1.2 Shortage of ventilator

Breathing is important for the human body. Respiration is regulated by some checks and balances in the body. Infection, trauma, and other diseases can easily affect this

state of equilibrium. Once this occurs, the patients go into respiratory failure and mechanical ventilation will be the only way to save their lives.

Eight (8) participants indicated that shortage of ventilator in Tshilidzini ICU expose them to ethical dilemma because it makes it impossible to manage the patients who need ventilation. They also indicated that patients cannot be accepted in tertiary hospital if the reason for transfer is lack of ventilators.

Participants No: 13D stated:

I remember there was one patient who died because of near drowning, he needed a ventilator, and there was no ventilator, so that patient died.

Participants No: 9D mentioned:

The lack of functional ventilators at all times is also a problem. The hospital has not purchased a ventilator in many years although it is admitting patients who need ventilators. The ventilators that are used are from other hospitals, Polokwane and Elim respectively because they were no longer using them. These ventilators are very old and have not been serviced in a long time.

Participant No: 8N said:

I remember there was one time where patients had to share ventilators. We will put patient on ventilator for four hours and the next four hour he will be on T-piece and the ventilator will be on the other patient.

Participant No: 11D

Now and then we have for instance a situation where maybe some of the ventilators are out of order, they are sent for service so we do not have enough ventilators to ventilate all the patient who really need it.

Participant No: 15N said:

There is great shortage of ventilators. We have only two functioning ventilators now, which are always functioning. They are moved from one patient to the other. If the

third patient who is in ICU changes condition and needs ventilation, he won`t get that opportunity.

Participant No: 4N added:

Ideally, we must have four ventilators for the four beds, and in our situation we find that most of the time we have only two ventilators for the four beds. And they might be in use, when we admit the third patient is always a dilemma as to whether the patient will cope on oxygen or T-piece because we cannot use the portable ventilator because is meant for transport.

Participant No: 14N said:

We do not have ventilators. Our ventilators are very old, always working and seldom serviced, this makes them to just stop ventilating when they are in use. Inspite of being checked every morning to ensure that they are functioning, by the time, you want to use it you may find that it is no longer ventilating well. Using them is very risky to the patients.

Participant No: 1N said:

A well functioning ventilator has some complication and what more if this ventilator is not functioning well. We are putting these patients in danger. Seated as we are, I cannot show any ventilator, which is functioning properly, which I can say if anything wrong happen to the patient it was just an accident. This is the biggest dilemma because I have to help the patient anyway.

Krishnamoorthy et al (2014) mentioned that, ventilators saves many lives in developed countries, but many patient die of reversible conditions in developing countries due to lack of ventilators. Krishnamoorthy et al (2014) added that ventilators could be vulnerable machines and require appropriate maintenance. However, Esteban, Frutos-Vivar, Muriel, et al (2013) reported that in mechanically ventilated patients, short-term mortality has decreased over time.

Ventilators are the most useful machines in ICU hence their availability is of utmost importance. The above narratives indicates that there are few ventilators which are not well functioning. For proper management of the patients, there must be adequate

number of ventilators, which are well maintained. Nevertheless, malfunctioning ventilator are a death trap to the patients. The hospital must have an experienced technician to maintain the ventilator.

4.2.1.3 No intensivist

An intensivist is a certified critical care physician who provides clinical care exclusively in the ICU. The advantages of the presence of intensivists in ICUs is the timely and frequent titration of therapy by being physically present in ICU (Lee, Moon, Youn et al 2014). Park and Suh (2013) acknowledge that although there is shortage of ICU doctors, they are needed to staff ICUs.

Nine (9) participants indicated that in ICU, Tshilidzini hospital there is no ICU doctor and this creates dilemmas for both nurses and doctors. Nurses are faced with situations where they have to act beyond their scope of practice to save the lives of patients. Patients are resuscitated without a doctor. Furthermore, doctors indicated that their dilemma is whether to endorse something that was initiated by nurses in their absence. Participant no: 2N expressed these sentiments as follows:

For that moment, I have to think beyond my scope and do what was supposed to be done by a doctor. For example if I find that the patient is no longer breathing, I have to intubate the patient.

Participant No: 11D added:

During emergency this dilemma will hit back to ICU sisters also. They will have to assume the responsibility while the doctor is coming or is somewhere that is not the ideal ICU.

Participant No: 15N said:

Most of the time, we resuscitate alone. During resuscitation, the casualty doctor is the one who is supposed to help in ICU, before the arrival of the medical officer allocated in ICU for that day. Most of the doctors in casualty refuse to come and help with the reason that they are busy in casualty. Some even lie to say they are also resuscitating in casualty. Therefore, the nurses in ICU have to resuscitate while waiting for the doctor who promised to be there in fifteen minutes time.

Participant No: 12N further said:

There are changes that must be implemented immediately to the patient. For example, changing prescribed IV fluids to the patient because of certain results. It might be lab results or our blood gas machine. Most of the things I am saying are a bit beyond my scope but needs me to make some changes while waiting for the doctor.

Participant No: 3N mentioned:

Nurses are supposed to be given orders by a doctor but in our case, it is visa versa. Instead of helping us, we end up helping them. Most of the decisions are taken by the nurses and, the doctor just endorse. If there was an ICU doctor, it was not going to be like that.

Participants No: 17D added:

The other ethical issue about ICU is that ICU is a high tech environment, and some of us are not doctors who are working there on daily basis. We just come when we are on call. And we are not so well conversant with this machines, how to set them up. It also makes you feel inadequate but at least the nurses who are working there seem to know what they are doing. Maybe if ICU was to be looked after by someone like an anesthetists who is well conversant with this machines .So the only thing that saves in this ICU is the fact that the nurses knows this machines. I think there was supposed to be a trained doctor working there because ideally doctors must support the nurses but in our case nurses support the doctors.

Participant No: 5D said:

ICU patients are usually reviewed once a day because there is no ICU doctor. Doctors sometimes come to ICU after finishing their ward rounds, which might be late in the afternoon. These create a dilemma for nurses because until the doctor comes, there will be no new prescription. They will be continuing with yesterday's prescription assuming that the doctor will continue with the same treatment, which is not always the case. Sometimes later during the day, junior doctors will be sent just to transcribe the medication and no problems will be attended.

Participant No: 15N reported:

Sometimes I don't know whether to give treatment or not, what if the doctor does not prescribe the same medication. These usually create problems when I have to answer why I gave that medication.

Participant No: 17D mentioned:

Sometimes you may have to come and endorse something that nurses have started or put, may be you are not 100% that you really wanted to do this but, because it has already been done, then you endorse it.

Wilcox, Harrison, Short, Max, and Rowan (2014) indicated that according to the European Society of Intensive Care Medicine (ESICM) guidelines ICU must be taken care of by a specialized ICU doctor and if possible must be in ICU for 24 hour.

Those in favour of 24-hour ICU doctor suggest that the availability of a specialized doctor in ICU result in the initiation of proper treatment as soon as the patient is admitted in ICU, no delays during emergencies, patient care will be continuous, and constant advice twenty four hours (Wallace, Angus Barnato, Kramer & Kahn 2012).

For proper management of critically ill patients, there must be an experienced doctor who is allocated in ICU. ICU patients are very unstable and their conditions are unpredictable hence they require a dedicated doctor who can assist in case of emergency. In order to have good prognosis, some actions need to be taken immediately and this requires a doctor to be available all the times.

4.2.1.4 Inadequate ICU trained staff

ICU patients require specialized care for specially trained staff if we have to provide quality care. Five (5) participants indicated that they have dilemma related to lack of ICU trained registered nurses. Their dilemma is to use lower categories of nurses to nurse ICU patients. Participants highlighted that patient care is compromised due to inadequate trained staff. They have to work more than the required months of night duty due to shortage.

Participant No: 4N said to express these sentiments:

The allocation of our ICU leaves us with no choice but to use lower categories nurses like staff nurses to nurse critically ill patients. It is a dilemma because I don't have another staff, I only have those.

Participant No: 14N indicated:

ICU only have twelve trained personnel that are not enough to provide quality nursing care. Sometimes the registered enrolled nurses and the inexperienced registered nurses are allocated to nurse ventilated patient, with the aim that they will be supervised. The supervision is always inadequate because whenever there is a very ill patient, trained registered nurse who is supposed to be supervising the untrained nurses will be caring for the very ill.

Participant No: 1N mentioned:

Sometimes you find that you are the only trained nurse on duty and you have to run around like a headless chicken. Someone will be calling you this side and the other one will be calling you that side. This is tiring, sometimes you miss some important things. You can also make some wrong decisions.

Participant No: 10N said:

Because there are few trained nurses, sometimes we have to go for night duty for more than five months. This is tiring.

Participant No: 14N said:

During the night, only two trained registered nurses are allocated with a registered professional nurse and a staff nurse. Sometimes you find that the patients are so critically ill that they all need trained registered nurses or maybe experienced registered professional nurses. Because of lack of this categories we find that lower categories who are not competent are also allocated. Hence, we have problems allocating them.

Matlakala, Bezeidenhout and Botha (2014) indicated that units should be staffed with trained and experienced nurses. Bhagwanjee and Scribante (2007) reiterate that for

safe and effective intensive care practice there must be dedicated medical and nursing staff. Lack of trained staff result in increased workload to the trained staff on duty and patient care is being compromised (Ferrer, Boelle, Salomon, Miliani, Hériteau & Astagneau 2014). Gjerberg et al (2010) is also of the opinion that lack of staff and skills lead to poor end of life care.

Matlakala and Botha (2016) also concur that increased technical and patient complexity requires greater education in order to maintain and develop skills, with an increasing awareness that basic nurse education does not develop the requisite levels of specialized skills and knowledge to practice safely within critical care units.

As a specialized units ICU must have specially trained staff ,that standards for safe nurse staffing in critical care state is that every patient in a critical care unit must have immediate access to a registered nurse with a post registration qualification in this specific specialty (BACCN:2010)

Trained staff can attend immediately to changed patients` condition. Patients are safer when trained staff care for them. However, staff can be encouraged to go for private studies in order to acquire the skill if there are delays of training by the institution.

4.2.1.5 Insufficient equipment

Nine (9) participants indicated that they experience ethical dilemma due to insufficient equipment. The ICU of Tshilidzini hospital lacks even the basic equipment that must be available in every ICU. It does not get some items just because it is a regional hospital. Some of the items can only be found or used in tertiary hospitals. Participants indicate that care of the patients care is compromised and their lives are placed at risk.

Participants No: 2N said:

More than being a dilemma I think it is a political problem, because we are regarded as people who are in the rural, and we usually do not get equipments or whatever item that is used in ICU. We are categorized as people who are not suppose to get certain things. I will just make an example of a T-piece. A T-piece is a small

connection for weaning patient from ventilator to oxygen, but you will receive information from pharmacy that it is a tertiary item.

Participant No: 7N mentioned:

The worst is to ventilate the patient without the blood gas machine.

Participant No: 11D said:

I find it very strange that to get Panado for intravenous use, I must first write a motivation. This is the only treatment for pyrexia that I could give to our patients but you have to write a lot of papers and it will take days before you get it. Patients here are like patient in Polokwane

Participants indicated No: 7N said:

We become frustrated when we want to admit the third and fourth patient because it is impossible to find a monitor with all parameters. Preparation for admission takes longer than it should be because of lack of equipment. Too many monitors are to be collected because each will be showing one parameter. Quite often patients are sharing a monitor.

Participants No: 4N stated:

Sometimes you will find that the monitor that the patient is using does not show saturation. In order for you to monitor the patient's saturation patients have to share the oxyimeter.

Participant No: 4N further indicated:

Sometimes we are forced to use the same suction catheter for the whole day because they are out of stock. If I discard it with every suctioning, tomorrow there will be no suction catheter to suction at all. This is very bad.

Participant No: 15N added:

We sometimes spend a lot of time without suctioning catheters size 14 or 12 and is the once that are user-friendly to those patients and then we tend to use one in all the orifices, the nose, the trachea and the mouth. So our patients are exposed to

infections of the lungs. It's an ethical dilemma because having it today knowing that next week we won't have it or for the last two weeks we were not having it. We will be compelled to use it sparingly.

Participant No: 8N further indicated:

Just yesterday, our three patients were having diarrhea, and there was no linen. How are we supposed to clean these patients? Must we leave them on the mattresses? They will mess up the mattress. Moreover, there was no hand washing soap. We have to move changing from one patient to the other without proper hand wash.

Participant No: 2N said:

We have two or three machines that we have received without ordering them and they are still new. We couldn't say take them back, we just keep them hoping that one day we will need them. Some don't even have the accessories.

The study by De Mello and Barbosa (2013) find out that the equipments used in ICU can cause harm to the patients if they are not subjected to proper selection, acquisition processes and maintenance. In order to increase patient`s safety, there must be an increased number, quality, and maintenance of material resources.

De Beer et al (2011) also mentioned that ICUs are structured and graded in level. From level I - level IV. Level I units are found in tertiary hospitals, which are affiliated to universities and they specialized units catering for neurological or coronary care, level III units are the have high tech equipment. Level II - IV units are in the private sector. Level II units are critical care units found in community hospitals, which can provide limited invasive monitoring, and level IV units are high care units.

The above narratives indicate the improper distribution of material resources. Every ICU must have all the necessary equipment at all times. However, the hospital policy on procurement and maintenance of equipment must ensure that there is adequate equipment. Inspite of being a rural ICU, patients must be well managed, with proper equipments and medication. The unit must also keep adequate stock to prevent shortage.

4.2.2 Unsuitable infrastructure

4.2.2.1 No high care unit

Five (5) participants indicated that they experienced dilemma due to lack of high care unit. Participants indicated that because there is no high care unit, most of the time ICU is occupied by high care patients. These patients have recovered but still needs specialized care. Most of these patients no longer need continuous but they need close observation. These patients tend to stay longer in ICU, occupying a bed that could have been used for ICU patient.

Participants No: 10N mentioned:

The lack of high care unit is a big dilemma for us, because there are some patients who after being stabilized in ICU could be transferred to high care, but because there is no high care. We keep them there longer, they occupy the bed, you know that if you move this one to the general ward is going to die. Sometimes you make those decisions based on knowing that if I move this patient now, there is one patient who need the bed more than this one but you can't move this one because in the ward is going to die anyway.

Participant No: 17D reaffirmed:

The biggest problem is if our hospital had high care unit that would have been the best place to discharge this patient to, where they will still be cared for by people with more expertise than ordinary nurses in the ward. Nurses in the ward are overwhelmed with many patients so they can't give this specialized care or individualized care for this patient.

Participant No: 1N stated:

We are compelled to nurse a high care patient in ICU and the ICU remains full. When critically ill patients need bed in ICU, there is no bed. We end up transferring high care patient to the general ward were the standard of care is very low. Most of our patients don't make it in the wards.

Participant No: 7N said:

Now there is a standing order that every eclampsia must come to ICU after caesarean section. Our unit has just turned into a recovery room.

Participant No: 11D said:

The main problem we have in our ICU concerning ethical dilemma is the shortage of beds, we have few ICU beds and no high care. Because, if there was a high care unit then, it will be easier to decide.

High care is viewed as a step-down facility for those who have recovered from intensive care, or alternatively a pre-emptive step that can prevent exposure to ICU for a significant proportion of patients (Bhagwanjee & Scribante 2007). However, Baruch and Messer (2012) highlighted that the aims of discharging a patients is to take them to the wards where they can be properly managed.

The above narratives are an indication of the misuse of the ICU and lack of proper admission protocol and policy guidelines relating to admissions and discharge of patients in ICU. Because of shortage of ICU beds, some patients who meet the criteria for admission in ICU are not admitted. These led to the establishment of an intermediate structure in a form of a high care. High care is a unit which admits patients who are too sick to be admitted in the general wads. These patients need constant monitoring. Their vital signs and treatment are monitored every hour or every two hours, which cannot be possible in general wards. Although the nurse patient ratio is not the same as in ICU, it is higher than in the general wards.

4 2.2.2 Lack of isolation measures

Five (5) participants expressed that they experience dilemma when they have to admit an infectious patient because of lack of isolation measures. Participants indicated that there is a separate room that they usually use to admit infectious or septic patients but it is not equipped for that. They express dilemma when they have to admit two patients on which sterility must be practiced. They felt patients are being exposed to infections.

Participant No 3N reported:

One day we have to admit the second burns patient. The doctors tried to transfer the patient to other hospitals and there were no beds available. We were forced to nurse that burns patient in the main ward because the separate room was already having a burns patient. Can you imagine, nursing sixty percent burns in a ward where everyone just walks in?

Participants No: 1N added:

A *patient with gangrenous foot is admitted in the side ward and we have a dilemma of where do we admit this patient from theatre with open abdomen. The patient in side ward cannot be nursed in the main ward and cannot be transferred to the ward because is on the inotropes. On the other hand, patient with open abdomen cannot be taken to the ward.*

Participants No: 15N said:

The hospital only has one blood gas machine and an ECG machine which is stationed in ICU. People will be flocking in for blood gas and ECG machine. This makes it difficult to prevent infection. They don't even understand when they are asked to wash their hands. Entry to ICU must be restricted.

Participant No: 8N mentioned:

We don't have an isolation room. The room that we use as an isolation is not well equipped to be an isolation.

Participant No 6N reported:

Sometimes we nurse patients without the protective clothing. You move from one patient to the other using the same apron. When we don't have the paper towel we also use the same apron to dry our hands.

Kiarie (2011) stated that hospital acquired infections results in patients staying longer in ICU, development of some complications, financial implications to hospital and families and even death. The study conducted by Mbangula (2015) at Witbank

hospital also find that shortage of protective garments such as masks and gowns exposed nurses to the risk of becoming infected with infectious diseases such as TB.

The most important indicators of the quality of care in ICU are the hospital-acquired infections. Although their normal defense has been interrupted, the hospital must ensure that precautionary measures are in place to protect these fragile patients. Proper hand wash can prevent infections from other patient, health care worker or visitors

4.2.2.3 Confidentiality and privacy

Seven (7) participants expressed that the structure of ICU makes it difficult to maintain privacy and confidentiality. Patient of all ages and different sexes are admitted in a single room. All patients are lying in an open space and are separated from each other by just a curtain. These patients can be easily seen by anyone entering the ward. Participants also indicated that during doctor's rounds, patient`s progress is discussed at the bedside of the patient and conscious patients can hear the conversation. They further indicated that conscious patients hear every telephone conversation because the telephone is in front of them. Participants also indicated that it is also sometimes difficult to give information to anyone who is requesting patient`s information because he is visiting the patient, people do lie regarding their relationship with the patient in order to get the information. Participants indicated that the patient`s records are easily accessible to anyone.

Participants No 9D mentioned:

We always have a problem when someone famous or a staff member is admitted. Nurses will come in as if they are here to ask something and we know they want to see the patient. They know that if you enter this ward you can see everyone who is on the bed.

Participant No 7N further said:

Visitors also see every patient and when they go home tell everyone that Mr Who is also admitted in ICU.

Participant No: 14N said:

There is no place called away from the patients where patients can be discussed because the room is so small".

Participant No: 11D mentioned:

In ICU, we don't actually have an area where we can probably talk to the relatives when they want to hear about the conditions of the patients. Sometimes they want to know and you have no choice but to sit down there and explain to them in an area were confidentiality is not much.

Participant No 4N mentioned:

Patient`s charts are always placed on the patients table and some relatives read the charts.

Participant No: 3N said:

There is no counseling room were relatives can be interviewed. Relatives are interviewed in front of other patients.

Participant No: 5D said:

It is difficult to maintain confidentiality in ICU, especially when you are dealing with unconscious patients. There are patients who can take chronic medication for years without anyone knowing, so when you start asking about his chronic medication they become surprised.

In their study, Fernandez and Moire (2012) also find out that the layout of the ICU is the major determinant when it comes to patient`s privacy and confidentiality. The way in which ICUs are structured, lead to the breach of patient`s privacy and confidentiality unintentional. McGowan (2012) also mentioned that because sometimes patients cannot talk for themselves, friends and relatives ask for information about the patients from the health care providers, which can also lead to breach of patient`s confidentiality.

Privacy and confidentiality are the basic human rights. However many practices in ICU violate these rights. The single room system that promotes easy access and monitoring of all the patients promote the breach of patient privacy. It is obvious that

to maintain good relationship between health care workers and the patients and the patient`s relatives, there must be good communication. Relatives are satisfied when they receive information about patient`s illness. However, in the process of giving information to relatives, patient`s confidentiality can be breached.

4.2.3 Hospital policies

4.2.3.1 Discharge of patients from ICU

Four (4) participants expressed dilemma related to premature discharge of patients, and nurses expressed dilemmas related to patients who are ready but are not discharged. Participants expressed that they are faced with ethical dilemma when it comes to patient`s discharge. Most patients are discharged not because they are fit for discharge but just because there is a need for a bed. The discharge of patient in ICU is influenced by shortage of bed.

Participants No: 11D said:

Discharging a patient from ICU possess an ethical dilemma which is influenced significantly by shortage of beds. More often, we find that there are patients in ICU who are much better, or who are improving a lot however, is not hundred percent ready to go to the general wards. But I can see the patient is much better. At the same time, I do not have any empty bed in ICU and I have a new patient coming in who is critically ill, who needs intubation, ventilation. And in ICU I have got a patient who is ninety-five percent ready to go. Ideally, I would have waited for the patient to be hundred percent ok to transfer the patient to the other ward. In casualty I have a patient who desperately needs an ICU bed. If I keep this patient who is ninety to ninety five percent to go, I might be denying the one who is I casualty the chance to survive.

Participants No: 17D said:

Although there are guidelines regarding the discharge of a patient, they are rarely followed. This is because the discharge of the patient is always influenced by the need of a bed. You are faced with a situation where you have to choose to risk the

life of the patient you are discharging in order to save the life of the patient you want to admit.

Participants No: 8N said:

Sometimes the doctors keep their patients so that they do not struggle when they need the bed. They know that if they have an admission, there is a patient who is ready for discharge in ICU.

Participants No 3N further mentioned:
If the patient is not discharged on Friday, it means that he will occupy the bed for the whole weekend even if he is fine waiting for his doctor on Monday.

The findings of this study is congruent with the study by Oerlemans et al (2015), in their study they find out that most of the time doctors are force to transfer a patients to the general wards who are not yet hundred percent ready to be transferred because they need to admit a patient who is very ill than this one and this creates a dilemma. Furthermore, Robert et al (2012) indicated that when the demand of beds is high, patients are only kept in ICU for a short space of time and they are discharged when they sick as compared to when the demand of beds is low.

From the narratives, it is apparent that there are two types of discharges in ICU. There is a normal discharge which is done when the patient has fully recovered. Another discharge is promulgated by need of bed. Premature discharges are common in order admit patients that are very sick. Discharges in ICU involve collaboration between the nurses and doctors. Lack of equipments in the general wards and skilled nurses lead to poor prognosis of the patients who are prematurely discharged to the wards. A high care unit can be helpful to those patients who are discharged prematurely. Protocols must be made that compels ICU nurses to do follow-up visits for patients who have been discharged.

4.2.3.2 Admission of patient in ICU

Seven (7) participants expressed dilemma related to admission of patients in ICU. Participant acknowledged that there is a policy on admission criteria but it is not always easy to follow the criteria. The admission of patients in ICU is determined by

the availability of beds. Participants highlighted that sometimes the doctors just admit patients who are too ill to benefit from ICU, just because there is nowhere they can they can take them after intubation. Participants further indicated that, once the patient is intubated, he must be admitted in ICU whether he will benefit or not. Participant also indicated that if the senior doctor were there on admission, only the right candidates would be admitted in ICU.

Participant No 11D said:

The first dilemma we face is admission criteria to ICU. Quite often, we are faced with a situation where we see a patient and we need to decide based not only on the condition of the patient but, on the availability of ICU beds whether we are going to admit this patient in ICU or not. This is an ethical dilemma more than a medical dilemma, because medically speaking you has no doubt that this patient need ICU.

Participants No: 17D:

Because we lack that proper guidance, sometimes we are bringing in patients we shouldn`t have brought to ICU. We should be able to assess and say if this patient should definitely die, she must die.

Participant No: 17D further mentions:

Sometimes when you are bringing a patient the nurses will just look at you thinking you are just bringing a corpse. But what else am I suppose to do? What is worse is when the patient is intubated. Remember, I am not in casualty when the patient arrive, I am called and when I arrive the patient is already intubated. Am I going to say extubate this patient? I cannot. This means even if this patient looks just like a corpse, the fact is the patient is intubated and I have got nowhere else to take him except ICU.

Participant No: 2N said:

Although it is a standard that we must not take ten minute to admit a patient after the bed was requested, some admissions are delayed because the admitting doctor is still busy in casualty or we still have to discharge another patient.

Participants No: 7N mentioned*:*

The first hour of admission is very important in the management of an ICU patient. If the patient is not managed well during this first hour, he might have the long-term complications. So there are times that we can prepare a bed and the patient does not come. When you try to find out what is delaying the patient, you find out that the doctor who is suppose to bring the patient in ICU is still busy in casualty.

Participant No: 15N mentioned:

I remember a patient who came here as a transfer from Polokwane hospital. The EMS personnel brought the patient straight to ICU, the patient was gasping. When we call the receiving doctor, he said he would arrive in twenty minutes time. He asked us to get help from casualty. We have to resuscitate the patient without a doctor as we couldn't get help from casualty.

Participant No: 15N further said:

Some of these patients you will find that they do not even need ICU and you cannot turn them back. When the doctor comes and assess the patient he just said let's just keep her for now, we will send her to the ward tomorrow morning or if we need a bed we will transfer her out.

Oerlemans et al (2015) supported the above narratives by indicating that, admitting a patient in ICU is not only a medical decision. Other issues, such as availability of beds, may play a role in the decision-making process. However the study findings are contrary to the findings of Gordon et al (2015) which indicate that admission of patient in ICU can be refused base on no perceived benefit for the patient. Smith and Nielsen (1999) concur that patients who do not meet the criteria for admission in ICU by the fact that they are too well to benefit or those whose prognosis are very poor to live a meaningful life after recovery should not be admitted in ICU. Furthermore they indicated that admission in ICU must not be determined by patient`s age however, doctors must bear in mind that as the person get older they are more likely to have some coexisting illnesses and their body functioning cannot return to their former stage. Robert et al (2012) also mentioned that patients whose admission to ICU was delayed due to shortage of beds have greater chance of poor prognosis even after

they have been admitted in ICU. Contrary to the study by Oerlemans et al (2015) admissions are not influenced by political and management pressures.

From the narrative it is apparent that the criteria for admission in ICU are not followed. Every patient who is very sick despite the age and the co morbidity is admitted in ICU. For proper management of the unit, protocols and policies must be strictly adhered to. Admissions must be done in consultation with the physician on call.

4.2.3.3 Transfer to tertiary hospital

The attending doctor arranges transfer to a tertiary hospital. The transferring doctor must find the receiving doctor in the tertiary hospital. The condition of the patient and the reason for transfer is explained to the doctor who will then accept the patient. A formal request is then written on a standardized transfer form (Gordon, Allorto & Wise 2015).

Majority of participants indicated that most of the time they are stuck with the patients whom they cannot manage. These are patients who need specialists and specialized equipments that are only found at tertiary hospitals. Most patients are not accepted at tertiary hospital because they are too ill, age, or because there is no bed in ICU of the tertiary hospital. Participants also highlighted dilemma related to relatives who want their patient to be transferred to tertiary hospital.

Participants No 16D mentioned:

Sometimes we are stuck with patients who need tertiary intervention, we struggle to get a doctor who will receive the patient. You can spend almost three hours just to find the relevant doctor. After finding the doctor when you present the patient, you are told the prognosis is poor. This is very bad because you can see that if something can be done to this patient, he might improve.

Participants No: 16D further said:

Worse is when you want to transfer the patient may be for CT-scan and the patient is done CT scan, and the diagnosis is established and that patient needs further intervention but is send back with the note that bring the patient for surgery if the

condition worsen. Let me give you an example of a 16 years old with brain abscess, the patient was fitting continuously but was turned back and to go back to Polokwane after two weeks. This is tormenting, when you know that there is nothing you can offer to this patient. You only have to send the patient back when the patient`s condition has deteriorated and has developed some complications.

Participant No: 8N said:

Sometimes we have to push really hard for our doctors to transfer the patient to Polokwane hospital. You will find that the doctor has admitted a head injury patient with the Glasgow coma scale (GCS) of 10/15 and does not send the patient for CT-Scan. This patient needs scan and neurosurgeon for proper management. They will wait until the patient is intubated and the GCS is now 3/10.

Participant No: 13D added:

What is the reason of keeping a cardiac patient when we do not even have a cardiologist?

Participant No: 17D

Our patients have to travel more than hundred and sixty kilometers to a tertiary hospital, in Polokwane. Our ambulance are ill equipped and we are just risking our patient`s life. Keeping the patient here, we will not have the proper diagnosis and transporting can even worsen the condition of the patient, this is a dilemma.

Participant No: 10N said:

People are literate these days; they will be asking why you are not transferring the patient for further management. There was once a young man who`s mother was having renal failure. Every day he will ask when the patient is going to start dialyses. We have to tell him that dialysis is only done in Polokwane hospital but can you really tell him that his mother could not be accepted for dialysis because she is sixty years old. No! I cannot. But he wanted his mother to be transferred.

Participant No: 10N further mentioned:

One family wanted to go as far as the MEC of health to find out why their patient was not transferred further.

The study by Gordon et al (2015) reported similar findings that in attempt to transfer patients to tertiary facilities, the doctors are reluctant to accept patients who are considered to be very ill. Gordon et al (2015) further mentioned that patients refused on the basis of being too well may be re-referred should their condition deteriorate. The findings of this study are congruent with the findings of the study conducted by Tomaschewski-Barlem et al (2016), the study find out that, some organizational policies are the boundaries for nurses in their attempt to advocate for the patients. Nurses are taken as inferior hence when they address issues related to patient`s rights they are not taken seriously. Several other factors prevent them from advocating for the patient`s well being. Crandon, Harding, Williams and Cawich (2008) indicated that inter-hospital patient transfer may results in deterioration of the patient`s condition and also lead to other complication.

For proper management, patients patient need to be transferred to tertiary hospital for diagnosis and further management. However, certain things must be taken in to consideration such as the condition of the patient, mode of transport and the skill of the transporting personnel. National guidelines regarding arrangement of transfer must be instituted to assist the transferring doctor.

4.2.4 Patient`s decision making

Henry, Rushton, Beach, and Faden (2015) mentioned that many patients in ICU are unable to make decisions due to sedation, chemically imbalances, or have suffered injuries, diseases, or complications that make them incapable of participating in treatment decisions. Their relatives have to decide for them and sometimes the relatives refuse to give consent (Tejwani et al 2013).

4.2.4.1 Refusal of consent

Four (4) participants indicated that they experience ethical dilemma related to refusal of consent. The patient or the relatives can refuse to give consent.

Participants No 17D indicate:

There was a patient who was in acute renal failure, he needed dialysis. People at Polokwane wanted to know the HIV status because they need to decide which machine to put the patient on. When the patient was still talking before he went into coma, he totally refused to be tested for HIV. Now that the patient is in coma the relatives say they can give consent to test for HIV. Our hands were tied. The relatives cannot supersede the will of the patients.

Participant No: 13D said:

There was another lady, when in pain she will say lets amputate this arm but when she is not in pain she will refuse to be amputated.

Participant No: 17D added:

Now there was another case where a patient was to be transferred to Polokwane hospital and the relatives refused. And now that's the problem, if the relatives refused, do you take the patient to Polokwane? What if the patient arrive there and die they will say we have told you. If you keep the patient here, you know according to your own training, this patient will get better if they go to Polokwane.

Participant No: 2N said:

There is a religion one, that once happen, the patient said no to blood transfusion because of religion and the relatives said yes and then the patient went into a delirious state. But when she was awake he said no.

The findings of the study is supported by Ingravallo, Sandroni, D'Addio and Miccinesi (2015), they agree that patient's or relatives decision to refuse treatment that could potentially save their live create a dilemma for the health care professionals between respecting autonomy of the patient and their duty to care for the patient.

The findings of the study are consistent with the findings of the study by Azoulay et al (2014) in that relatives may have problems in changing from what they want to what the patient want, this is because patients do not always discuss their preferences with their families.

Every individual is an autonomous being. He or she has the right to make decision, including the right to refuse treatment. Cultural belief, educational background, religion and prior knowledge has a role to play on patient`s decision making. However, it is the duty of the health care professionals to respect the will of the patients and, for those who are deciding for them, despite the consequences.

4.2.4.2 Patient`s belief

Five (5) participants indicate that they experience dilemmas related to patients beliefs which is contrary to medical practice. Participants also expressed a dilemma related to patients beliefs where by family does not want other family members to visit the patient. Participant expressed their frustration when they are not supposed to allow some family members to visit the patient.

Participant No: 10N said:

Nowadays the patients have the right to choose what they want to use, traditional or modern medicine. We also come across patients or relatives who do not believe on the diagnosis or cause of their disease. In Tshivenda, if a young man aged 20 or 21 is very sick, they believe that "o wela" this literally means that the patient has slept with someone who has terminated the pregnancy or with sexual diseases. While we as professionals know that, the patient is having Meningitis and what treatment he needs.

Participants No: 17D said:

You know when a patient is very ill, and you know you have got nothing more to offer, then the relatives come with their own things. And you are sure this patient is not going to make it. Do you allow them or not? Sometimes they ask to bring something for the patient, what should we do, do we allow them?

Participant No: 8N mentioned:

On other occasion we have come across a situation where the relative even ask for the critically ill patients. They say they wanted to explore other alternatives.

Participant No: 7N said:

Sometimes we are given some newspapers which we are suppose to put under the patients pillow, or the anointing oil. The Indians will tie rope on the wrist and ankles and ask you not to remove them.

Participant No: 14N mentioned:

Sometimes we got stuck between the family fights. Every child has the right to visit his or her mother when she is sick. But sometime you find that there are some misunderstanding in the family and some family members are not allowed to visit the patient. What do I do when they knock at the door? It is very difficult to tell them that we have been given an order by your brother not to let you in. This is very difficult and is happening every day.

Keer, Deschepper, Francke, Huyghens and Bilsen (2015) indicated that there is always different beliefs between the health care professionals and patient`s relatives with regard to the cause of illness, treatment, religious beliefs, language and ethno-cultural norms and values, which results in tension between patients` families and health care professionals. Furthermore, lack of knowledge cultural differences, and ethnic stereotyping creates also tension between healthcare professionals and patient`s families. However, these differences can hinder provision of quality care. Loghman, Borhan and Abbasside (2014) added that difference in belief regarding Western and traditional medicine is the major source of conflict between nurses and patients. Mason (2014) concurs that patients may have different views regarding the cause of illness and its treatment modalities.

The findings of this study are congruent with those of Van Keer et al (2015) in that families' has some care practices, which are closely related to their culture, role expectations family structures which are contrary to healthcare professional's duty to safeguard the patient and to control the ICU environment.

Every patient has a spiritual need, hence meeting the spiritual demands of the patients satisfies the patients and their relatives, however, health care professional must be equipped on how to meet the spiritual needs of the patients. It is imperative that cultural need of every patient must be met. Health care professionals must be equipped with knowledge of cultural diversity.

4.3 CONCLUSION

The findings of the study indicated that health care professionals were experiencing ethical dilemmas related to lack of resources, unsuitable ICU structure, hospital policies and decision making by patients and relatives.

Chapter 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

This chapter presents the summary of the findings of the study on the ethical dilemmas experienced by health care professionals working in ICU, Tshilidzini hospital, Vhembe district in Limpopo Province. It also presents the extent to which the objectives of the study have been achieved and the limitations of the study. Recommendations were drawn from the findings of the study as presented in Chapter 4.

5.2 PURPOSE OF THE STUDY

To investigate the ethical dilemmas experienced by health care professionals working in ICU, Tshilidzini hospital, Vhembe district in Limpopo Province

5.3 RESEARCH OBJECTIVES

The objectives of the study as stated in Chapter 1 were achieved and are evaluated as follows:

Objective 1**:** To explore the ethical dilemma experienced by health care practitioners working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

Objective 2: To describe the ethical dilemma experienced by health care practitioners working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

These objectives were achieved as outlined in the summary of the findings (section 5.4).

5.4 SUMMARY OF THE FINDINGS OF THE STUDY

Participants expressed clearly the ethical dilemmas they experienced working in ICU Tshilidzini hospital as identified in the four major themes and sub-themes that emerged from data analysis.

5.4.1 Lack of resources

The study showed that lack of human and material resources created dilemma for participants. Because of limited number of ICU beds, it was difficult for doctors to find a bed when they wanted to admit a patient in ICU. Due to limited ICU beds, doctors had to choose which patient is to be admitted to ICU when they have one or more patients who deserve. Limited beds makes them make difficult decision regarding admission in ICU regardless of the patient`s condition. Some patients who deserve to be admitted in ICU are not admitted in ICU because of limited ICU beds. Shortage of ventilators makes it impossible for participants to manage critically ill well. Participants have experienced patients dying because of shortage of ventilators. The ventilators that are being used are not serviced and they just stop at any point and are very risky to the patients. A transport ventilator is sometimes used and patients do not always cope in this ventilator as it has only one mode.

The study has find out that health care professionals are experiencing ethical dilemma related to lack of intensivist. The availability of ICU doctor is important in terms of timely diagnosis, treatment, and multidisciplinary team approach (Park & Suh 2013). Participants are faced with situations where they have to act beyond their scope of practice to save the lives of patients. ICU is a high technology environment, which need a doctor who is used to those machines. Because no specialist can be in ICU at all times, most doctors depend on ICU nurse for proper management of the patient.

Because there is no intensivist, ICU patients are usually reviewed once a day. These create a dilemma for nurses because until the doctor comes, there will be no new prescription. They will be continuing with yesterday's prescription assuming that the doctor will continue with the same treatment, which is not always the case. Doctors have to endorse some things that they did not order or would opt for because the nurses has already given in their absence.

The findings of the study revealed that most senior nurses indicated that they have dilemma related to inadequate ICU trained registered nurses. Lower category nurses are allocated nurse critically ill patients. The available trained personnel are not enough to provide quality nursing care. Sometimes the registered enrolled nurses and the inexperienced registered nurses are assigned to nurse ventilated patient,

with the aim that they will be supervised. The supervision is always inadequate because whenever there is a very ill patient, trained registered nurse who is supposed to be supervising the untrained nurses will be caring for the very ill. This result in increased workload to the trained staff on duty and patient care is compromised (Ferrer, Boelle, Salomon, Miliani Hériteau & Astagneau, 2014). Patients care is compromised due to lack of staff as indicated by Gjerberg et al (2010) .They mentioned that lack of staff and skills lead to poor end of life care.

The manager indicated that she also experience this dilemma when she have to call staff for overtime. She does not know which category of nurse she must call since she doesn`t know the acuity of the patients who might be admitted.

The findings of the study revealed that health care professionals experience ethical dilemma due to lack of equipment. The ICU of Tshilidzini hospital lacks even the basic equipment that must be available in every ICU. It does not get some items just because it is a regional hospital.

5.4.2 Unsuitable structure

Participants indicated that because of lack of high care unit, most of the time ICU is occupied by high care patients. These patients have recovered but still needs specialized care. Most of these patients no longer need continuous but they need close observation. These patients tend to stay longer in ICU, occupying a bed that could have been used for ICU patient. The study find that the biggest dilemma created by lack of high care unit is when the patient who is not yet fully stabilized has to be transferred to the general ward to create a bed for a very ill patient. Participants indicated that most of the patients who died after being transferred to the general wards; their lives would have been spared if there was a high care unit. Participant further indicated that because there is no high care unit, ICU is now admitting patients for observation.

Participants expressed that they experience dilemma when they have to admit an infectious patient because of lack of isolation measures. Participants indicated that there is a separate room that they usually use to admit infectious or septic patients but it is not equipped for that.

The study found that the structure of ICU makes it difficult to maintain privacy and confidentiality. Patient of all ages and different sexes are admitted in a single room. All patients are lying in an open space and are separated from each other by just a curtain. These patients can be easily seen by anyone entering the ward. Participants also indicated that during doctor's rounds, patient`s progress is discussed at the bedside of the patient and conscious patients can hear the conversation. They further indicated that conscious patients hear every telephone conversation because the telephone is in front of them. They also expressed that the patient`s records are easily accessible to anyone. They further highlighted that there is no counselling room were relatives can be interviewed. Relatives are interviewed in front of other patients.

The study found that it is difficult to maintain confidentiality on unconscious patients because patient`s treatment is discussed with the relatives. Participants also indicated that it is also sometimes difficult to give information to anyone who is requesting patient`s information because he is visiting the patient, people do lie regarding their relationship with the patient in order to get the information.

5 4 3 Hospital policies

The findings of the study revealed that, majority of doctors expressed dilemma related to premature discharge of patients, and nurses expressed dilemmas related to patients who are ready but are not discharged. They indicated that most patients are discharged not because they are fit for discharge but just because there is a need for a bed. The discharge of patient in ICU is influenced by shortage of bed. Participants further indicated that some discharges are forced to be done after hours because of the need of beds. Participants expressed that patients who are discharged because of the demand of bed are exposed to risks of complicating.

The study also finds that there is a policy on admission criteria but it is not always easy to follow the criteria. The admission of patients in ICU is determined by the availability of beds. Participants highlighted that sometimes the doctors just admit patients who are too ill to benefit from ICU, just because there is nowhere they can they can take them after intubation. Participant also expressed that, although it is a standard that it must not take ten minute to admit a patient after the bed was

requested, some admissions are delayed. This happens when there is a patient who is to be discharged before the other one is admitted. Some participants, senior nurse expressed the dilemma related to patients who are brought to ICU not accompanied by the doctor especially the transfers from other hospitals. These patients are brought straight to ICU without being reassessed in casualty. Some of this patients you find that they are even too well to be admitted in ICU. Participant expressed that if the doctor were there on admission, only the right candidates would be admitted in ICU.

Participants are sometimes stuck with patient they cannot manage because they are not accepted in tertiary hospital. Patients are not accepted because they are too sick or too well to be transferred to tertiary hospital. Relatives also demand that their patients be transferred to tertiary hospitals while other refused their patients to be transferred to tertiary hospitals.

Majority of nurses highlighted that they experience dilemma related to patient advocacy. Sometime the doctors keep the patient whom they cannot manage in ICU. These patients need specialists or some treatment that can only be done in tertiary hospital. Some need to be transferred for diagnostic purposes. Instead of transferring the patients, they keep them until the condition deteriorate. Some doctors do not even attempt to arrange for transfer

5.4.4 Patient's decision-making

The findings of the study revealed that participants expressed dilemma related to patients or relatives refused to give consent. Patients have the right, to refuse treatment even if is not in their best interests. They expressed that the patient's wishes must be respected. This dilemma is most stressing when the patient`s life is at stake. The study also finds that participants experience ethical dilemma related to refusal of consent based on religion. This is related to blood transfusion. The patient refuses to give consent for blood transfusion based on their religion. Participants also indicated another dilemma related to religion. They are sometimes given something to apply to the patient after bath, which is against their professional and personal values Participants further mentioned that because the patients has rights, health professionals has to do things that are contrary to their professional values.

When patients are very sick, relatives' loose trust to western medicine and want to try everything they believe will help the patient. The study also found a dilemma related to patient's belief where by family does not want other family members to visit the patient. Participant expressed their frustration when they are not supposed to allow some family members to visit the patient. This is associated to the belief that the patient is bewitched.

5.5 INTEGRATION OF FINDINGS RELATED TO THEORETICAL FRAMEWORK

James Rest develop a 4-components model that assists the health care professionals from the realization of the dilemma until the dilemma is resolved. This model consists of moral sensitivity, moral judgment, moral motivation, and moral action (Rushton & Penticuff 2007).

The findings of the study indicated that the health care professionals at Tshilidzini hospital are using the systemic framework in responding to the dilemmas. Participants acknowledge that they are experiencing some ethical dilemmas. Participants were able to explain the dilemmas they are experiencing during data collection. By explaining the dilemmas, it means that they are aware that ethical dilemmas exist. According to Rushton & Penticuff (2007), they are moral sensitive. They are sensitive to lack of resources, hospital policies, inadequate infrastructure and patient`s decision making. The health care professional use their moral judgment to protect the patient`s interest despite all the dilemmas that were identified. They are motivated to choose the decision they think is right over all possible solution like keeping equipment that is supposed to be used and be discarded because they are scarce. The health care professionals willingness to put patient`s interest ahead of their professional value indicate moral character. The moral action is when the health care professionals are implementing the decision they think was appropriate.

5.6 RECOMMENDATIONS

Based on the findings of this study, the researcher wishes to make the recommendations that will be able to address the ethical dilemmas.

5.6.1 Policy makers

The government together with the critical care societies needs to develop policies that will help guide resource allocation for ICU services. The number of ICU beds must be allocated according to the population it serves.

Because of lack of beds, some patients who may benefit from being admitted in ICU are not benefitting. However, an alternative to ICU admission can be beneficial to those patients in a form of a high care unit. The establishment of a high care unit can helpful.

Critically ill patient`s conditions are not predictable. They change now and then, during the day and during the night. In order for the patient to be safe, there must be a doctor who is responsible for ICU in twenty-four hour. The doctor can be any specialist and not necessarily an intensivist.

The hospital must ensure that there are clear policies in place to assist health care professionals in times of shortage of beds. They need to make sure all staff members are aware of the procedures available, and ensure that when such an option is chosen it can be followed through without risk of inappropriate ridicule or censure

However, it is of no use to have human resources without the material resource, regardless of its level, for optimal functioning and providing of quality care, ICU must have all the necessary equipment to be fully functional.

Ethical dilemmas affect patient care and strategies must be adopted to address ethical issues nationwide.

5.6.2 Education

Education programs for health care professionals need to include opportunities to introspect themselves with regard to their values that might, or might not, impact on decisions they make in the clinical setting.

In-service trainings must be conducted on regular bases in order to equip ICU health care professionals with knowledge of ethics and skills of decision-making.

5.6.3 Nursing practices

An active ethics committee must be elected to assist ICU practitioners when they encounter ethically challenging situation.

Appropriate support systems must be in place to assist health care professionals through any personal difficulties when they are experiencing ethically challenging situations. Effective intensive care practice requires the use of admission and discharge criteria.

5.7 IMPLICATIONS FOR FUTURE RESEARCH

This study only focused on the ethical dilemmas experienced by health care professionals working in ICU however, further research can be conducted on moral stress related to ethical dilemmas experienced by health care professionals working in ICU.

5.8 LIMITATIONS OF THE STUDY

The study was conducted in one hospital with a purposive sample of 17 health care professionals. This limits the application of the findings to a wider range of ICUs or even other hospitals in the rest of South Africa.

5.9 DISSEMINATION OF THE FINDINGS OF THE STUDY

The findings of the study were presented to the participants. A report was handed over to Tshilidzini hospital ethics committee and to the Department of Health. Presentation was done on national and international conferences and was also be published on accredited journals.

5.10 CONCLUSION

The study concluded that health care professionals working in ICU, Tshilidzini hospital are experiencing ethical dilemmas. The dilemmas that they are experiencing are related to lack or resources, the ICU structure which is unsuitable for care of critically ill patients, hospital policies and the decisions that are taken by the patients and their relatives.

The biggest dilemmas were related to lack of material and human resources. Limited ICU beds resulted in some patients who needed ICU not getting a chance of such care. Those who got a chance of being admitted in ICU, some even died because of lack of ventilators. They were even exposed to all sorts of infections due to the repeated use of the equipments that are supposed to be used only once. Patients were even discharged to the general wards prematurely because of lack of high care. The nursing staff was practicing above their scope because of lack of human resources.

The study also found that patient`s confidentiality was breached due to the structure of the unit. The patient`s belief also create dilemma as some were contrary to medical practices. However, the study strongly recommends that education programs for health care professionals need to include opportunities for them to explore how their own values and beliefs that might, or might not, impact on decisions they make in the clinical setting.

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ANNEXURE A

PARTICIPANTS INFORMATION LETTER

INTRODUCTION AND BACKGROUND

Hello, my name is Hulisani Malelelo. I am an ICU nurse and currently registered as a student at the University of the Venda, in the Department of Advanced Nursing Science for a Masters degree. I am hoping to conduct a research project as a curriculum requirement for the completion of a Masters degree to determine ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU,Tshilidzini hospital, Vhembe district in Limpopo province and I would like to invite you to participate and kindly consent to me including you in the interview.

The interview will last an hour. If you agree to take part, I will ask you questions about ethical dilemma that you experience while working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province. The questions are not a test and there are no right or wrong answers. It is your opinion that is essential for the study. My role as a researcher is to listen and understand your point of view, and not pass to judgements. If you feel uncomfortable in answering some of the questions, feel free to say so, you will not be penalised.

Confidentiality

The information that you give will be confidential. All participants will be given codes and these codes will be used when transcribing interviews. This code will only be known to the researcher. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you will say will be treated as private and confidential. No one will know how you answered the question apart from the researcher. The answers given by participants will be combined and analysed according to common themes and categories. The combined information will be written in the form of a report.

Consent

Ethical clearance will be obtained from the University of Venda Ethical Committee. Permission to carry out the study will be obtained from the School of Health

Sciences Higher Degree Committee, SENEX Committee of the University of Venda and from Tshilidzini Hospital management. I will ask you to sign an informed consent form, to participate in the study and to record the interview. If you consent, the researcher will appreciate your participation and the information you will give.

Benefits and risk of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates. There will be no penalties if you want to withdraw from the study or if you do not want to answer some of the questions if you believe they are violating your rights. However, I will really appreciate it if you share your thoughts and feelings on the questions asked.

Recording the interview

I would like to request your permission to voice record the interview because it is not possible to write down all your answers quickly enough, and to capture all the important information. I might misrepresent your responses to some of the questions that you will be asked if recording is not done. It is important for you to know that the voice recorder, digital voice data and notes will capture your honest responses to the questions.

The voice recorder will be listened to only by the researcher. The voice recorder and digital voice data interviews will be transcribed and transcripts of the interview will bear codes and not the name of the interviewee. The information will be analysed and organised into a report according to themes. The voice recorder and digital data files will be kept in a locked safe. As per national requirements, the tapes and voices digital data will be destroyed two years after the publication of the research findings.

Contact details

I will be happy to answer any question or clarify any aspect you have about this study. If you have any question about your rights or any aspect of the study, you may contact me on 076 948 1930. If you have further questions about the research or interview, contact:

Malelelo Hulisani (076948 1930)

ANNEXURE B

INFORMED CONSENT

I on this day of 2017

Give permission to be interviewed on the topic 'Ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province'

1. Follow-up interview if necessary.
2. The use of data interviewer in research report as the researcher deems appropriate.

I also understand that:

1. The study is one of the requirements of Masters in Nursing at the University of Venda.
2. My refusal to participate will involve no penalty or loss of rights to which I am entitled to.
3. I am free to end my enrolment, or to recall my consent to participate in this research at any time.
4. My participation is entirely voluntary and there will be no remuneration for your participation.
5. Anonymity is granted by the researcher in that the data will under no circumstance be reported in such manner that my identity is revealed

I hereby acknowledge that the researcher has:

1. Discuss the aims and the objectives of the study with me.
2. Inform me about the contents of this agreement.
3. Point out the implication of signing this agreement.

In co-signing this agreement the researcher undertakes to:

1. Define and explain to the volunteers in a language she/he understands, the procedures of this study

2. Maintain confidentiality, anonymity and privacy regarding the interviewee`s identity.
3. Explain aims and the risks and benefits associated with participation in the research.
4. Arrange in advance the time and place where the interview will take place.

Researcher..... Date.....

Participant..... Date.....

Witness..... Date.....

ANNEXURE C

REQUEST FOR PERMISSION TO CONDUCT THE STUDY (PROVINCE)

P.O Box 568

SHAYANDIMA

0945

The Head of Department

Provincial Department of Health

Private bag x9302

POLOKWANE

0700

Dear sir / Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I`m here by requesting for a permission to conduct a study. I am a nursing student doing Masters Curationis at the University of Venda. As part of the university requirement, I am expected to conduct a research study. My research topic is entitled ‘Ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province. The study is conducted under the supervision of Prof D.U Ramathuba and K. Netshisaulu. The study has been approved by the ethics committee of the school of Health sciences of the University of Venda and will seek approval from Tshilidzini hospital ethics committee. The purpose of the study is to determine ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province.

The objectives of the study are:

To explore the ethical dilemma experienced by health care practitioners working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

To describe the ethical dilemma experienced by health care practitioners working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

During the study, the following ethical consideration will be adhered to:

- Participants will be allowed to voluntarily choose to participate in the study and to withdraw from the research at any time.
- Consent form will be signed.
- Permission to use the voice-recorder will be obtained from the participants
- Anonymity of the participants will be maintained by using numbers instead of participant's names.
- Confidentiality will be maintained by keeping raw data under lock and key.
- Field notes and audio tapes will be destroyed after completing the study.
- The participants will be made aware that they are not forced to answer any question if they feel the questions violate their privacy.

The study recommendation may help the institution to identify the gaps in addressing ethical dilemmas and results in formulation of guidelines and standards in dealing with ethical dilemmas. These will benefit the department by improving patient care hence the reduction of lawsuits related to unethical practices by health care professionals.

I hope my application will be highly considered

Yours faithfully

Malelelo Hulisani

University of Venda
Creating Future Leaders

ANNEXURE D

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms H Malelelo

Student No:
15013914

PROJECT TITLE: Ethical dilemmas experienced by health care professionals working in Intensive Care Unit, Tshilidzi Hospital, Vhembe District in Limpopo Province.

PROJECT NO: SHS/16/PDC/32/3008

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr DU Ramathuba	University of Venda	Supervisor
Dr KG Netshisaulu	University of Venda	Co-Supervisor
Ms H Malelelo	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: September 2016
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2016 -09- 07
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 **FAX** (015) 962 9060
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ANNEXURE E

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650) Ref:4/2/2

Malelelo H
University of Venda
Private Bag X5050
Thohoyandou
0950

Greetings,

RE: Ethical dilemmas experienced by Health Care professionals working in Intensive Care Unit, Tshilidzi Hospital, Vhembe District in Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
    - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
    - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
    - In the course of your study there should be no action that disrupts the services.
    - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    - The above approval is valid for a 3 year period.
    - If the proposal has been amended, a new approval should be sought from the Department of Health.
    - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

14/12/2016
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

ANNEURE F

REQUEST FOR PERMISSION TO CONDUCT RESEARCH (DISTRICT)

P.O Box 568

SHAYANDIMA

0945

The District Manager

Vhembe District

Private bag x 5009

THOHOYANDOU

0950

Dear sir / Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I`m here by requesting for a permission to conduct a study. I am a nursing student doing Masters Curationis at the University of Venda. As part of the university requirement, I am expected to conduct a research study. My research topic is entitled ‘Ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU,Tshilidzini hospital, Vhembe district in Limpopo province’ The study is conducted under the supervision of Dr D.U Ramathuba and K. Netshisaulu. The study has been approved by the ethics committee of the school of Health sciences of the University of Venda and will seek approval from Tshilidzini hospital ethics committee. The purpose of the study is to determine ethical dilemma experienced by health care professionals (doctors and nurses) working in ICU, Tshilidzini hospital, Vhembe district in Limpopo province.

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To describe the ethical dilemma experienced by health care practitioners working in ICU, Tshilidzini hospital in Vhembe district, Limpopo province.

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- Participants will be allowed to voluntarily choose to participate in the study and to withdraw from the research at any time.
- Consent form will be signed.
- Permission to use the voice-recorder will be obtained from the participants
- Anonymity of the participants will be maintained by using numbers instead of participants names.
- Confidentiality will be maintained by keeping raw data under lock and key.
- Field notes and audio tapes will be destroyed after completing the study.
- The participants will be made aware that they are not forced to answer any question if they feel the questions violate their privacy.

The study recommendation may help the institution to identify the gaps in addressing ethical dilemmas and results in formulation of guidelines and standards in dealing with ethical dilemmas. These will benefit the department by improving patient care hence the reduction of lawsuits related to unethical practices by health care professionals.

I hope my application will be highly considered

Yours faithfully

Malelelo Hulisani

ANNEXURE G

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
VHEMBE DISTRICT

Ref: 10/1/1/1/1
Enq: Sirwali NR
Date: 21 December 2016
To: Ms Malelelo Hulisani
University of Venda
Private bag x 5050
Thohoyandou
0950

SUBJECT: Permission to conduct a research study: Ethical dilemmas experienced by Health Care Professional working in intensive Care Unit, Tshilidzini Hospital, Vhembe District in Limpopo Province.

1. The above matter has reference.
2. Vhembe district hereby approves your request to conduct research in the identified above facility within Vhembe district.
3. Kindly note that during your stay you will be obliged to adhere to the norms and standards of the department as enshrined in that facility namely ICU. The conditions as set by provincial office are also endorsed.
4. District wishes you a good study at Tshilidzini Hospital ICU and all of the best.

.....
Acing District Executive Manager

21/12/2016
Date

Private Bag X5009 THOHOYANDOU 0950
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015)962 1001/2/3/4/5/6
Fax (015) 962 2373/ (015)9622274/ 4623.

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ANNEXURE H: INTERVIEW GUIDE

What are the ethical dilemmas that you experience while working in ICU?

How do you resolve them?

ANNEXURE H: Interview Transcript

P for Participant

R for Researcher

R: Afternoon

P: Afternoon

R: How are you?

P: Fine and you?

R: I am very fine, emm. I am Hulisani. I am working in ICU

P: Yes

R: Presently I have registered for a master's degree with the University of Venda and as one of the requirement; I have to conduct a study or research. I have chosen the topic "Ethical dilemmas experienced by health care professionals working in ICU, Tshilidzini hospital". The health care professionals include Nurses and Doctors. And as one of our doctors I think you also experience some of these ethical dilemmas, so may you please explain to me, the ethical dilemmas that you are experiencing.

P: Yes you are right. ICU is an area where you actually find a lot of ethical dilemmas, not only here but, in any place of the world where you can go and work

R: Mmm

P: You will find those ethical dilemmas. The problem in this area is that those dilemmas are actually even more due to the shortage of availability of beds

R: Ok

P: Just consider that in this Vhembe district, we have estimated population of 1, 3 million people according to the last population census. So we are normally working with four ICU beds.

R: Ok

P: Which is actually, I mean a very small number of ICU beds for the population that we are looking after.

R: Ok

P: So due to that we are faced with first big dilemma, which is admitting patient in ICU.

R: Mmm!

P: Admission criteria, which patients should be admitted in ICU; which patients should not be admitted in ICU.

R: Mmm

P: Of course there are international standard for admitting a patient in ICU but those international standard, have been designed for cities where the availability of beds, is not an issue.

R: Ok

P: Then what play the major role is the condition of the patient and you don't actually consider much of the availability of beds because is not a big problem in those areas

R: Ok

P: Here as I was telling you, the first dilemma we usually find is admission criteria to ICU.

R: Ok

P: We quite often are face with a situation where we see a patient and we need to decide, based on not only the condition of the patient but on the availability of ICU beds

R: Ok

P weather we are going to take this patient to ICU or not

R: Ok

P: This is an ethical dilemma more than a medical dilemma because medical speaking, you have got no doubt that this patient needs ICU

R: Mmm

P: But let's say you have got one ICU bed

R: Mmm

P: And you got three patients who need ICU beds.

R: Ok

P: You cannot admit all of them because you do not have beds.

R: Mmm!

P: Then it become an ethical dilemma because now you have to choose which patient is the best candidate to be taken to ICU based on what you think could be the prognosis of the patient.

R: Mmm!

P: Which patient has the better prognosis? Ok, which patient really need it more… eee! Actually this is a common dilemma that we find on a daily basis in this area when it comes to ICU.

R: Mmm!

P: Just admitting a patient in ICU. Ok! if you don't have pressure with beds then the dilemma is easier because then you got beds and then you can just admit the patient who needs ICU and then is not a problem but still never know where that is going to be a problem. Because, let's say today you've got four empty beds and you receive four patient. Then ideally, you should not have any dilemma because at that point in time because you have four patients and four beds.

R: Mmm!

P But that already in your mind is a dilemma because you don't know what is going to happen tomorrow.

R: Ok!

P: Or even today in the evening, so you are always working with that dilemma should I take this patient to ICU, is this patient a real good candidate,

R: Mmm!

P: Is the prognosis not too bad mmm and I might be, I might be occupying a bed with a patient with the very poor prognosis

R: Mmm!

P: and probably denying the opportunity to another with or a better prognosis.

R: Mmm!

P: obviously if the patient is there at the moment obviously you will decide

R: Mmm

P: You will have to decide, but still it is a dilemma.

R: Ok

P: But is easy because if you got the two patient, and you have got only one bed the obviously you can assess but it is not always easy to come to a conclusion and say I am going to take this patient because has got a better prognosis and I am going to leave this one out because is older, because has got a worse prognosis. And you never know because medicine is very unpredictable sometimes.

R Mmm!

P: and you may end up in a situation that after a week or two you realize that actually the patient that you thought has a better prognosis did not do well. And the patient you thought has the worst prognosis did well.

R: Mmm!

P: Well so! This is a dilemma, definitely for me is always a dilemma here

R: Mmm!

P: Ok when I have to decide which patients I'm going to take to ICU and which patients I am not going to take to ICU based on the prognosis, medical condition, category, availability of beds all this is the first big dilemma that we have when it comes to admission.

R: Ok

P but, already once the patients are admitted at ICU; already there we do have more dilemmas coming up.

R: Ok

P: Because, when we take the patient there. There are patients who are admitted in ICU but from the beginning have a poor prognosis.

R: ok

P: Let's say a patient with severe head injury, who has already been done C-T scan in Polokwane and back with the Glasgow of 3/10

R: Mmm!

P: Apparently with brain death.

R: Mmm!

P: Which has not been confirmed yet but the patient is not responding at all

R: Mmm!

P: And then comes the second big dilemma how far do we go supporting intensive care for this patient.

R: Ok

P: Are we supposed to go all the way with the patient that we are even suspecting could be having brain death

R: Mmm!

P: In this hospital the diagnosis of brain death is difficult to establish because of lack of some of the results to confirm that.

R: Mmm!

P: And then you reach a point where the patient has been there for a long time, there are no sign of improvement.

R: Mmm!

P: sometimes this patient could be having brain death, but you are not sure of that

R: Ok

P: And then there are many questions in the management of that patient.

R: Mmm!

P: Should we really go for expensive antibiotics for instance, if the patient develops secondary infections?

R: Ok

P should we go for all the expensive interventions including inotropic support and all this eh! Should we resuscitate the patient if the patient finally goes into the cardiac arrest?

R: Ok

P: Mmm! Eeeh! If we resuscitate the patient what is the idea behind this because the patient has been there for a long time, is not responding at all.

R: Mmm

P Seemingly is in brain dead.

Eh! Already having some superimpose infections, in other words we are faced with this problem that the prognosis is very poor but are we suppose not to resuscitate, I mean, should we resuscitate or not?

R: Mmm

P: It is a big dilemma for instance that is an example of dilemmas not for a patient, but once the patient is in ICU, we do have dilemmas there

R: Mmm

P: Should we do this! Should not do this.

R: Mmm

P: Again, most of the dilemmas are actually eeeh! worsened by the fact that we don't have facilities.

R: Mmm

P: But according to the criteria for dialysis they do not qualify, we do have very strict criteria in the government to start a chronic dialysis program.

R: Mmm!

R: So it is easy that the patient does not qualify for a chronic dialysis program.

R: Ok

P: Now the patient is in intensive care unit. You know that this patient again because the patient cannot be dialyzes the prognosis is very poor, because medically speaking the only hope of this patient could be to dialyze the patient.

R: Mmm!

P: But the patient cannot be dialyzed so, again now you will realize that we are not going far with this patient because the patient cannot be dialyzed. But it doesn't mean we shouldn't do the other things ok. And if again we are going to do the other

things like giving expensive antibiotics, inotropic support, intubation, mechanical ventilation.

R: Mmm

P: Are we not wasting resources on something that we know is no going to succeed, because the patient is anuric and the patient is not going to live like that for a long time.

R: Mmm

P: On the other hand, from the ethical point of view, are we not just prolonging the suffering of this patient and the relatives, because we know that at some point this patient is just going to die

R: Mmm

P: Yes because we cannot dialyze the patient which is the only intervention that could probably improve or save the life of the patient. Should we then stop doing anything and say that lets…lets

This is a dilemma. As you can see, it is a dilemma.

R: Ok, let me first ask you from the patient with poor prognosis, what do you end up doing. If there is this patient with a very poor prognosis which you don't know whether to resuscitate , weather to continue with expensive antibiotics what do you end up doing?

P: Actually it depends on each case.

R: Ok

P: What we usually do is we assess the possibilities and even if the possibilities are minimal we try to hold on those minimal possibilities and most of the time what we end up doing everything we can, even resuscitating them, continuing with expensive antibiotics and even continuing with everything

Eeeh! Although we know that each the prognosis of the patient is actuary very bad and we prefer to clear our conscience.

R: Ok

P: And eeeh! I know the chance of this patient is very slim but at least if the patient is going to die my conscience should be clear, that I have done everything I could. But at the same time I'm thinking that, I'm not sure if this is the right thing to do, from the ethical point of view but for my own conscience this is the best and that what I'm going to do, so that I can feel better myself.

R: ok, so is the same with this patient with renal failure who doesn't qualify for dialysis. You just do whatever you are supposed to do so that you can clear your conscience.

P: This is my own view and that's what I will do but I am not saying is the right thing to do I'm saying somebody else could question it and say what I'm doing is just for my own peace of mind and is just is not scientific and is not ethical.

R: Mmm

P: It could be a big debate about that but me most of the time that is what I do. But I'm not sure if that is the best ethical things to do.

R: What else do you experience.

P: Yes as you can see I have classified this ethical dilemmas in to three main groups.

R: Ok

P: Number one is the one that I have to decide about admitting the patient, then the other dilemmas is once the patient is in ICU, but the patient has very poor prognosis.

R: Mmm

P: And then I have to decide whether to proceed with the treatment and how far should I go with the management of this patient.

R: Mmm

P: How much should I push this issue on a patient that obviously has a very poor prognosis?

R: Mmm

P: And the third group is when it comes to discharging the patient from ICU.

R: Ok

P: Already again, the discharging of patient from ICU is an ethical dilemma, which again is influenced significantly by the shortage of beds.

R: Ok

P Because quite often we are faced with a situation where we have a patient who has been in ICU for some days and the patient is actually much better the patient has improved a lot.

R: Yes

P: However, is not 100% ready to go to the general wards, but I can see the patient is much better, and then at the same time I don't have any empty bed in ICU and I have got a new patient coming in from casualty who is critically ill.

R: Mmm!

P: This patient needs intubation, ventilation, so on and on. And in ICU I've got a patient who is much better.

R: Mmm!

P: 95% ready to go to not 100%

R: Mmm!

P: Ideally I will have, I will have preferred to wait for the patient to be 100% ok to transfer the patient to the other ward.

R: Mmm!

P: But in casualty I've got a patient who desperately needs an ICU bed.

R: Mmm!

P: And because this patient even needs intubation, ventilation. If i, if i keep this patient in ICU who is 90-95% ready to go. I might be denying possibility of that one who is in casualty to survive

R: Ok!

R: Then I have to decide, should I take the patient who is in ICU to the general ward?

R: Mmm!

P: Running the 5-10% risk that the patient could still complicate in the ward, or should I keep this patient in the ward and keep that one in casualty or even sent that one to the ward knowing that this patient has 5-10% chances of complicating in the ward. The patient who is in casualty has 5-10% chances of survival in the ward, then I have to compare and this is a very common dilemma also now

R: Mmm!

P: Discharging a patient who is not yet 100% ready to go to the general ward and then you have to make a decision. You are on call and you are to decide. Ok I'm going to take this patient out to the ward, knowing that you are running a risk. The risk is low is true. Is 5-10% but is a risk. And you are running that risk to bring that one who needs ICU bed more than this one. But if something happen to this patient who is having 5-10% chance of complication in the ward again you are ethically, legally probably not but ethically you don't feel ok.

R: Ok!

P: Even Happy.

R: Ok!

P: And then…yah! That's another dilemma we find in ICU as you can see the main problem we have in our ICU is concerning ethical dilemma is the shortage of beds, we have few ICU beds.

R: Mmm

P: And the lack of high care unit, ok. Because if we were having a high care unit then, it will be easier to decide. Of course I started by saying even in the first world where they do have enough ICU beds, enough high care beds, they still face ethical dilemma

R: Ok

P: Different dilemmas, but they still have more or less these situations as well but for them is much easier than for us here because in our setting all those dilemmas are actually exacerbated by the unavailability of facilities ICU and high care facilities.

R: Ok do u have any problem with the equipment's.

P: Yah! Now and then, is the biggest ethical dilemma that we find.

R: Mmm

P: Because eeeh! Now and then we have for instance a situation where may be some of the ventilators are out of order, they are sent for service so we do not have enough ventilators to ventilate all the patient who really need it.

R: Mmm and then you want to choose which patient you are going to ventilate, which one you are going to put on a T-piece and keep them or even transfer the patient if the patient needs it desperately. When it comes to transferring that patient, it becomes a problem.

P: Because is not so simple also to transfer the patient to a higher level of care for ventilation, so is a problem. So in terms of eeeh! Facilities, I mean equipments there are some ethical dilemmas now and then, is not that we are always there but sometime we do find ethical dilemmas related to the equipment which are not there.

R: Ok!

P: We also have problems with getting medications and some surgical items. You know, getting TPN here is a big issue. Just TPN to feed the patient. I don't know but I think this issue of all things being found at tertiary hospitals must be revised. Because down here, we are also having patients.

R: Mmm! Do you have any dilemma related to the human resource?

P: Yes! Even human resource is a problem because intensive care ideally should have a dedicated doctor 24hrs.

R: Ok

P: And that is the ideal concept of intensive care.

R: Mmm!

P: And intensive care unit should have full time doctors working there 24hrs.

R Mmm!

P: I mean during working hours and during after-hours there are supposed to be doctors on call for intensive care only. Which cannot be done here

R: Mmm!

P: So here, we have to attend different issues including intensive care

R ok

P: So, it is not actually good when you see the patient in the morning and you can only come back in the afternoon to see that patient.

R: Mmm!

P: And then over the weekend the ICU patient are actually look after by a doctor who is in charge of the whole hospital, going to theatre, maternity and also coming to ICU. When you have an emergency in ICU, you have to start looking for a doctor and then some times is not so easy to find a doctor to immediately come and attend to that problem. Then the dilemma there now is that this problem will hit back to the

nurses. The ICU sister will have to assume responsibility while the doctor is coming from somewhere.

R: Mmm

P: That is not the ideal intensive care. The ideal intensive care has a doctor full time, dedicated to those patients.

R: Mmm ok. So in ICU how do you maintain confidentiality?

P: Yah! In ICU we don't actually have an area where we can probably talk to the relatives when they want to hear about the conditions of the patients. sometimes they want to know and you have no choice but to sit down there and explain to them in an area were confidentiality is not much because in that ward there and then we sit down there and explain but at the same time you may find that somebody the is listening to what we are talking. Eheee! Those things are actually not appropriate as well thus also…ethically speaking, the relatives and nobody else is present so that we can discuss issues but unfortunate due to the structural issues of the building, we don't have dedicated office were we can sit down and discuss those issues with the relatives.

R: ok. Say now you are explaining to the relatives or may be the patient how do you tell them that the prognosis is poor. I just want to know if you can really tell the relatives or the patient that there is no chance.

P This a very good question because it is a pure ethical issue. It is very ethical, mmm. There are some principles in medicine

R: ok

P: Mmm one is you have to say the truth, you can't lie to the patient and the relatives

R: Mmm!

P: But there is a second principle

R: Mmm!

P: You are not supposed to do any harm, to the patient and the relatives.

R: ok

P: and you need to look for a way that you won't lie to them, you will explain the reality, practically an concerning the disease the patient is suffering from…

R: Mmm!

P: The prognosis but at the same time you have to put it in a way that without lying, the relatives won't feel hurt by what you are saying. And you have to put it in a way that it won't actually be traumatizing to them. Because if you put it to cruel to them you can end up inflicting some harm in their psychological

Well being

R: Mmm

P: The patient and the relatives they will have to be informed the truth of the condition in a way that eeeeh… ideally we health care workers doctors and nurses we were all trained for that, I mean we had subjects in our training like ethical mmm…medical ethic as a topic where we were training for that.

R: Mmm

P: we had some elements of clinical psychology in our training which was …meant to prepare us for that, for that type of approach. And yah! Basically what we do is to try and balance the truth and the way you put it, so that the patient and the relatives can understand the reality without actually causing…I mean causing psychological problems

R: ok

P: But the other one is more of a relationship with the relatives

R: ok

P: If you manage to establish the good relationship with the patient and the relatives that dilemma can be solved easily, because then the communication flows better

R: So! You are able to tell them straight that "I don't think this patient will make it"

P: Mmm! No I don't think I will put it that way, I have never put it that way and I don't think is actually appropriate to tell the relatives of a patient that " I don't think this patient will make it'

R: Mmm

P: In fact I think it will be risky to say so because remember medicine when you say this patient has a poor prognosis you that statement is based on the statistics

R: Ok

P: Which have been compiled from different study which have been done.

R: And even from your experience

P: You combine all this but remember, patient are not statistics

R: Ok (laughing)

P: The statistics might say something and you have to tell that to the relatives yes; and you know what, according to the research and the statistics this is what the statistics says. This specific patient might go in line with those statistics or not.

R: ok

P: You will never know.

R: So you are instilling some hope to them

P: I'm being honest… I'm being honest like that. I'm not trying to actually instilling hope only I'm honest because you may have a patient e with a certain condition.

R: Mmm

P: And when you go to the researches and the scientific evidence, they will tell you…you will never find evidence which tells you that 100% of these patients will die.

R Mmm!

P: You will find probably evidence which says 99 % of the patients die.

R: Ok

P: But how are you going to know that this patient, this one specifically (Laughing) does not belong to the 1% who survived how will you know that

R: ok

P: So you have to explain that to the relatives of a patient, that what I do normally when people come, when relatives come asking for prognosis, I try to put it like that. Even if is a very poor prognosis. I explain to them that yes the prognosis is very poor

R: Mmm

P: This is true but it is only based on the statistics and the researches and my experience, but your relatives is a patient, he is not a statistics, statistics are numbers

R: Mmm

P: Patients are there, I cannot tell you whether he is going to be the exceptional

Case was going to make it all I can tell you is that based on the medical evidence, the prognosis is really very poor but I cannot tell you for sure that he is going to make it, that one I can't I will never say so

R: Ok

P: Because in medicine is very risky to say that, because you might be proven wrong later on

R: Ok

P: In any way is a situation where we will be very happy to be proven wrong I mean, who wouldn't want to be proven wrong when you say the patient has a poor prognosis and later on they make it

Mmm

R: Ok, have you ever encounter any problem when you want consent from the relatives?

P: In ICU eeeh! Is less common but it still happen and that also brings dilemma because let's say you have got a patient in ICU who has a septic limb or septic arm and you know that medically speaking, unless you amputate that leg and control that infection there is no much of medical possibilities of this patient to recover

R: Ok

P: But then the patient or the relatives do not give you the consent to proceed with the amputation

R: Mmm

P: Then you can't do the amputation but then it becomes an ethical dilemma because what do you do then? Do you keep the patient in ICU and continue giving the patient expensive antibiotics, inotropic support intubation, ventilation, using a lot of resources

R: Mmm!

P: and at the same time probably denying another patient the possibility to be admitting in the ward.

R: Ok

P: Or do you now decide to take the patient to the other ward because in any case the patient cannot be operated because of the consent and you know that the prognosis is extremely poor without that operation

R: Mmm

P: Is a medical dilemma as well because of lack of consent I mean if the patient don't give you consent.

R: That's what I want to hear from you. Have you ever come across such situation where they have refused to give you the consent?

P: yes I have come across that situation several times.

R: Several times?

P: Yes.

R: and how did you resolve it? Sometimes the patient had been kept in ICU.

R: Mmm

P: and in other cases because there has been a need for another patient to be admitted

R Mmm

P: These patients are transferred to the general ward.

R: Ok

R: What we normally do to this patients who do not give consent, If there is no need for ICU be, they are kept in ICU so if there is a need for ICU bed, and we know that this patient actually is not going to be operated and the prognosis is very poor we have actually transferred the patient like that the ward.

R: Ok

But even then I don't know whether 100% is ethically correct. Because ethical dilemmas are very difficult to…you have to individualize the…and in each and every situation you have to apply the principle that you think will be more appropriate.

R: Ok, Is there any other dilemma you want to share with me?

P: No; I think thus basically all.

P: Ok, so let me just summaries what you have said so that I can be sure that this is what you said. The first dilemma that you are experiencing is shortage of bed, this is basically due to admission criteria. Which patient to admit in ICU and which one not to admit?

P: Yes

R: Secondly when you have admitted that patient in ICU poor prognosis when patient are admitted with poor prognosis, you don't know whether to continue with expensive antibiotics or whether to resuscitate this patient and then exactly the other dilemma you said is about facilities. In this ICU you do not dialyze. There is a patient who has renal failure, needs to be transfer for dialysis and most of the patients do not qualify for dialysis. And you don't know whether to continue with all other thing really knowing that the treatment of this patient is dialysis. And you said you just continue with all the treatment to clear you conscience under patient discharge you indicated that more often than not, the discharge of the patient is influenced by the need of a bed when there is a need of a bed: when there is a need of a bed, you assess which patient can be transferred out.

P: Yes

R: you also mention lack of high care as another dilemma that you are facing. Now and then you have problems with the ventilators.

P: Yes

R: You also mention that your ICU doesn't have an ICU doctor as it is supposed to be

P: Yah

R: you also indicate that the structure of the ward makes it imposable to maintain confidentiality. You also mentioned that you won't lie about the patient's condition, which will also depend on the relationship with the relatives. You even indicate that that patient can be 1% of the 99% that is mentioned on the statistics.

P: Exactly.

R: You even mention that there are times that the relatives deny to give consent and what you usually do depending on the need for ICU bed, you can keep the patient in the ward or transfer the patient to the general wards.

P: Yes

R: Is that all

P: Yes, that is all

R: Thank you very much for the information, I hope is going to help me a lot

P: You are welcomed and I hope so.

R: Thank you.