

Research Paper

Ethical Issues Faced by Nurses during Nursing Practice in District Layyah, Pakistan

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ABSTRACT

Different Ethical issues encountered in daily nursing practice draw little consideration but can produce a stressful working environment for the nurses. This qualitative study was designed to explore the ethical issues confronted by nurses in their practice and to identify gaps using the Pakistan Nursing Council's (PNC) Ethical code framework. The study was conducted in six government hospitals of district Layyah, Pakistan. In all six focal group discussions (FGDs) with 6-8 participants in each were conducted. Content analysis identified three themes, namely; compromised professional accountability to patient, uncooperative behaviour of peers and poor image of a nurse in society. Nurses reported that they were unable to act on the PNC code fully because of many constraints in clinical practice. The reasons identified by the respondents were conflict in hospital admission procedures of patients, non-availability of medicines, conflict in informed and voluntary consent, false accusations by patients, care imbalance, compromised nursing

care, and deficiency in amenities, patient's expectations and cultural barriers. In addition, poor teamwork, inequitable workload, and poor value of nursing profession added to the challenges at the workplace.

To our knowledge, this is the first study that has specifically addressed ethical issues in the nursing practice of graduate nurses in District Layyah. Nurses were aware about their ethical responsibilities but were unable to practice them because of the multiple constraints. The findings of this study cannot be generalized to other nurses in Pakistan, but the richness of the data suggests explanations for the difficulties which many nurses face in public sector health facilities while performing their duties and adhering to ethical principles in clinical practice.

Keywords: Nursing ethics; Nursing moral and ethical aspects; Ethics; Ethical analysis; Patient relations

Abbreviations:

FGDs: Focus Group Discussions; PNC: Pakistan Nursing Council; DHQ: District Headquarters; THQ: Tehsil Headquarters; PI: Principal Investigator; BHU: Basic Health Unit; MPA: Member Provincial Assembly; LHV: Lady Health Visitor; EDO: Executive District Officer; ICU: Intensive Care Unit; MNCH: Maternal New-born and Child Health

Key Points:

Health professionals face ethical challenges in their daily practice, especially the nurses, the largest workforce in health. They are required to provide autonomous and collaborative care to individuals of all ages, while adhering to the ethical principles. The situation becomes particularly complex for nurses who work under severe resource constraints. Ethical issues in the nursing practice attract little attention, resulting in the creation of moral distress, poor professional care, unproductivity and conflict.

This study has described ethical issues encountered by Pakistani nurses of one district under three themes: compromised professional accountability to patient, uncooperative behaviour of peers and poor image of a nurse in society. Nurses despite being well aware of the ethical codes, were not able to practice it fully because of constraints. The findings showed that nurses were not the decision makers in many situations; they were subordinates in their working environment. The inadequate equipment and instruments, shortage of staff, stereotypes of the nursing profession, poor management and poor support to

address the issues resulted in distress, poor professional care, stress, conflict, compromised nursing care and violation of the PNC code.

Abstract

Different Ethical issues encountered in daily nursing practice draw little consideration but can produce a stressful working environment for the nurses. This qualitative study was designed to explore the ethical issues confronted by nurses in their practice and to identify gaps using the Pakistan Nursing Council's (PNC) Ethical code framework. The study was conducted in six government hospitals of district Layyah, Pakistan. In all six focal group discussions (FGDs) with 6-8 participants in each were conducted. Content analysis identified three themes, namely; compromised professional accountability to patient, uncooperative behaviour of peers and poor image of a nurse in society. Nurses reported that they were unable to act on the PNC code fully because of many constraints in clinical practice. The reasons identified by the respondents were conflict in hospital admission procedures of patients, non-availability of medicines, conflict in informed and voluntary consent, false accusations by patients, care imbalance, compromised nursing care, and deficiency in amenities, patient's expectations and cultural barriers. In addition, poor teamwork, inequitable workload, and poor value of nursing profession added to the challenges at the workplace.

To our knowledge, this is the first study that has specifically addressed ethical issues in the nursing practice of graduate nurses in District Layyah. Nurses were aware about their ethical

responsibilities but were unable to practice them because of the multiple constraints. The findings of this study cannot be generalized to other nurses in Pakistan, but the richness of the data suggests explanations for the difficulties which many nurses face in public sector health facilities while performing their duties and adhering to ethical principles in clinical practice.

Introduction

An ethical issue can arise in any healthcare situation where profound moral questions of “right” or “wrong” underlie professional decision-making and the care of patients [1,2]. Health professionals especially nurses face ethical challenges in their daily practice as they are required to provide autonomous and collaborative care to individuals of all ages, while adhering to the ethical principles [3,4]. The situation becomes particularly complex for nurses who work under severe resource constraints [5-7]. Additionally due to the demographic, social, scientific and technological aspects of health care, there has been an increase in complexity of ethical issues faced in the health care service delivery [5]. Ethical issues in the nursing practice attract little attention, resulting in the creation of moral distress, poor professional care, unproductivity and conflict.

The Pakistan Nursing Council (PNC) adopted its own professional code of ethics in 1999 for registered nurses [8]. The current study was undertaken to identify adherence of nurses to the Pakistan Code of Professional Ethics, with an aim to improve patient care. It also explores the ethical issues faced by nurses in their clinical setting and how they work through difficult cases. The study draws on thematic areas that are intrinsic to any clinical encounter, namely: Medical Indications, Patient Preferences, Quality of Life, Contextual Features, Teamwork and value of nursing profession. These issues were reviewed in light of the professional ethical code prescribed by the Pakistan Nursing Council, inclusive of professional accountability with reference to the clients, colleagues and one self.

Methodology

A qualitative study using content analysis was conducted [9] in District Layyah, Punjab, Pakistan. The district had one District Headquarter (DHQ) Hospital and 5 Tehsil Headquarter (THQ) Hospitals in the public sector. The total numbers of nurses working in these hospitals were 103 (63 from DHQ and 8/THQ). The five THQ hospitals and DHQ hospital with 240 beds capacity were providing emergency, medical, general and minor surgery, obstetrics and gynaecology, homeopathic and diagnostics services. Common health problems of patients seen at the THQ level included anaemia, common infections, diarrhoea, and accidental injuries. However, in case of complications, patients were referred to the DHQ hospital.

Using purposive sampling technique [10] nurses with a work experience of at least two years in the DHQ and THQ hospitals were included in the study whereas nursing students and managers who were not involved in direct patient care were excluded. Nurses willing to participate in the study were invited for Focal Group Discussions. In all forty-eight nurses participated in the study, with 6 to 8 nurses participating in each FGD.

Participants themselves decided the venue and time of the FGDs at their convenience. Each FGD was hence held at the proposed venue i.e. the office of the Head Nurse after duty hours. The co-author, a registered nurse and resident of Layyah, with a deep understanding of the local culture moderated the FGDs using a FGD guide. Probing was done where needed. Another local nurse who was trained to take notes during the FGDs took notes. Each FGD commenced with some general queries from the respondents about their background. This helped in developing a rapport between the moderator and the respondents and generated a fair amount of confidence among them. The participants shared different issues and experiences concerning clinical practices at the hospital. On average, a FGD lasted for one hour. Notes were expanded within two days of conducting the FGDs. FGDs were conducted in the native language.

The individual team members read the transcripts several times to familiarize themselves with the data. The transcribed data was analyzed using content analysis. Codes were categorized and themes identified.

The Ethical Review Committee of Health Services Academy, Islamabad, approved the study. Written approval was taken from the Department of Health, Punjab to conduct the study. Informed consent was taken from all participants.

Results

The age of the respondents ranged from 23-30 years, with work experience ranging from 3-7 years. All participants were local residents and permanent employees of the Department of Health, Government of Punjab. Table 1 shows the analysis process moving from the themes to categories. The results were reported under the three themes (Table 1).

Compromised professional accountability to patients:

Accountability is an essential component of professional nursing practice and patient safety [11]. Nurses shared that their duty to provide patient care was compromised due to managerial issues as elaborated in the following sub-sections.

Lapses in medical care: Many gaps in patient care were identified. Nurses had no authority to admit a patient. However, in reality, they were doing so in the interest of the patient because the concerned doctor, on call, was not available during evening and night shifts, especially in the obstetrics and gynaecology department.

“Patient comes with labour pains and fully dilated. We admit the patient and conduct a normal delivery so as to save the mother and child. If we do not do so, such a patient would need to travel further to another facility that may have a higher risk for her.”

However, when patients did develop complications, nurses had to face all the consequences. None of the hospitals took any action when this issue was brought to the notice of the hospital managers. Another ethical issue identified by respondents was the non-availability of medicines and equipment at THQ

Table 1: Analysis process – Moving from categories to themes.

Themes	Sub-Themes	Categories
1. Compromised Professional accountability to patients	a. Lapses in Medical	<ul style="list-style-type: none"> • Conflict in hospital admission procedure of patients conflict • Non availability of medicine
	b. Patient preferences vs. Nursing Care Requirements	<ul style="list-style-type: none"> • Conflict in Informed and voluntary consent • False accusation by patients • Influential patients and patient care imbalance • Compromised nursing care • Deficiencies in Amenities
	c. Quality of care and responsiveness of health system	<ul style="list-style-type: none"> • Patients' expectations from health care providers • Cultural Barriers
	d. Barriers to Ethical Clinical Practice in local context	<ul style="list-style-type: none"> • Additional tasks due to the national programs
2. Uncooperative behaviour of peers	a. Poor team work b. Inequitable workload	<ul style="list-style-type: none"> • Image of nursing profession • Autonomy in nursing profession • Professional development
3. Poor image of a nurse in society	a. Poor value of the Nursing profession	

hospitals, due to which the staff nurses were unable to provide full nursing care. When patients/attendants were explained about lack of hospital resources and requirement of getting medicine from private stores, nurses faced undue criticism, and often-abusive behaviour from the patients' attendants.

“Patient and attendant perception is that the government's medicine supply has been sold by nurses and other health care providers. The reality is that these medicines are not available and when we request patients to buy them and explain to them the reasons, they do not take us seriously and rebuke us.”

Patient preferences vs. nursing care requirements: The respondents reported disconnect between patients' preferences and nursing obligations. They shared that nurses as a policy were required to obtain informed consent of each patient prior to treatment. Most of the male patients gave consent of their own accord. For incapacitated patients, a male surrogate took decisions. The problem however, arose while treating female patients. One respondent in an FGD explained a situation she faced:

“A female patient was willing for a bilateral tubal ligation and came with her mother who consented for the procedure as well. Her husband turned up after an hour in the operating room, and started shouting at the staff nurses, asking us why we took consent from his wife. He said that he was responsible for her and his wife had no such right to decide on her own. As a result of this disturbance, management has instructed that no future ligations will take place without the consent of a male attendant”.

Nurses started dealing with such cases as per the verbal instruction of the management i.e. if a female patient came without a male attendant; they would call her husband, brother or father and take a written consent prior to tubal ligation. This caused delay in treatment of female patients who showed aggression towards nurses for prying into their personal matters.

Another respondent voiced concern on the way the written consent was phrased:

“The statement we've been instructed to use in obtaining informed consent is deficient. It states 'I am willing for treatment and I (the patient) am responsible for any benefit and risk (the treatment entails). I will not object in case of risk.' This statement is not in favour of the patient's interests.”

The consent statement was a standard document of hospital. When any complication resulted during the treatment, patients blamed nurses and other health care providers.

The respondents reported that they treated their patients with dignity and respected patients' confidentiality. However, they would not expect the same from patients. Narrating an incident, one of the respondents explained an unusual delivery case in which nurses were blamed for no reason.

“Patient came in labour and was admitted through the proper channel in a THQ hospital. A traditional birth attendant had handled her previously. The ultrasonography report showed an intra-uterine death of foetus. Patient was fully dilated and she delivered the dead foetus. Her attendants refused to accept the dead foetus and ran away with the patient. When this was brought to the notice of the Manager and probed further with other staff, it came to our notice that it was an illegal pregnancy. On orders from the Manager the dead foetus was buried. Unfortunately, media came to know about it and it then portrayed a notion that the nurses had killed the infant after birth. As a consequence, an Inquiry Committee was asked to investigate the matter and the duty nurses were penalized for no real reason.”

Another problem nurses encountered while dealing with patients with political or influential background was undue pressure to provide special care to them at the expense of care to other patients. Nurses therefore could not work according to

ethical principle of 'justice' i.e. providing fair, equitable and appropriate treatment

Quality of care and responsiveness of health system:

Nurses were unable to provide quality care given the shortage of staff, lack of amenities and absence of clear hospital policy for patient's attendants

"We cannot properly explain to the patient about their medical needs, medicines and inquire about their vitals as intake output record. There are many attendants around the patient and it seems inappropriate to ask such questions. This leads to delay in even recording patients' vitals."

Hospital management did not take action to rectify these problems. The patients' attendants would get annoyed over issues and end up complaining about the nurses to senior authorities and to the local Members of the Provincial Assembly (MPA). The respondents shared that they mostly were penalized and received official notices or warning letters.

They also shared that the THQ hospital was not fully equipped to provide satisfactory facilities so most patients would be admitted but never spend the night before the surgery in the hospital. The patients would walk-in in the morning causing a delay in their pre-operative preparations. When at times the surgeon would ask the patient as to why they had not come in earlier they would blame the nurses

"Dr Sahib we had come at Fajr (after dawn-early morning) time, only the nurse was not in the ward then"

Nurses claimed that these patients had never showed up at the nursing station in the ward. Similarly, the nurses complained that the patients left the hospital when they were stable but would remain admitted in the hospital. They would get the medicines for a few days and again come back after one or two days. During that time, dosage of medicines could not be regulated.

"One time dose of medicine does not treat acute or chronic health problems, patients need regular medicine for healthy life. And they just leave the hospitals..."

Some patients would leave against medical advice either to go home or seek advice from unskilled personnel or a general practitioner. Many patients attributed their illness to magic and would seek guidance from the spiritual leaders, getting amulets from them (*Dum, Ghanda, Taweez*). Such misconceptions greatly compromised their treatment.

Nurses also reported that at other times due to shortage of supplies and equipment service delivery was almost impossible. Examples given by them included availability of only one set of safe delivery kit at times; simple equipment as BP apparatus was not fixed due to budget constraints for prolonged periods, which affected patient care. The response of the administration on raising concern would suggest inform them of the budgetary constraints:

"Staff there is no budget for this year – if it was so all the supplies would be available."

Barriers to ethical clinical practice in local context:

Respondents expressed that some patients came with a certain mind-set and had certain expectations from the provider such as getting an injection or intravenous (IV) fluids as treatment for their ailments. Doctors would consider the preference of patients and switch oral medicine to injectable ones. Seeing this pattern, many nurses too followed suit and obliged patients on their requests without consulting doctors.

The patients' ethnic backgrounds largely determined expectations from the healthcare providers. An issue commonly faced by the nurses was that the labour room patients did not agree to be delivered by unmarried nurses, or if the patient was a "Pathan" (an ethnic group) when an older nurse was not present, conflict arose, as narrated by one nurse:

"These patients say that it is not good in our culture to be examined by an unmarried girl. 'Where is your senior nurse?' they'd ask. In such cases we have to call married older staff nurses for assisting us in delivering the baby even though we could easily have managed on our own independently."

Such patients had more faith in traditional birth attendants "Dais" as compared to trained nurses. Moreover, some younger patients were embarrassed to be admitted in wards, as their privacy would be compromised. One example quoted was of a patient belonging to a prestigious family and observing 'purdah'; such a patient was not happy on being admitted in the general ward. Conflicts arose in such cases when private room was not available in the hospitals. No screens would be available in the ward to satisfy the patient by providing partial privacy. The nurses understood that ethically they were bound to respect patients' religious and cultural beliefs, but practically they could offer no solutions to them.

Beliefs of the patients also hindered the nurses' patient care practices. When the IV line was to be maintained for the children (with severe diarrhoea), the parents/guardians would refuse the intravenous line to be passed on the veins on the head saying that the 'Daam'/prayers have been said on the head of the child and requested they find a vein elsewhere, which in most cases was very difficult.

Uncooperative behaviour of peers

Various issues identified by the respondents with respect to their peers are detailed hereunder:

Poor team work: Teamwork was identified as a key element for ethical practice and providing quality care. The respondents shared that they had to work with fewer number of staff due to sanctioned educational leaves, delay in hiring against vacant posts and absenteeism. As a result, the pressure of work increased day by day on the remaining few.

All respondents complained of the non-cooperative support staff (ward boy, gatekeeper, sanitary worker, sweeper and *Aya*, etc.). As the support staff did not attend to their assigned work, it led to considerable increase in nurses' workload.

When dealing with emergency cases the nurses needed additional pairs of hands, but could not count on the support staff for help.

“If we give them (support staff) work to do, they still won't finish it and then we will have to complete it. Then what it is the point (of the support staff) when we handle all the written work and any other problems patients have. And if there is a problem, then we will be held responsible.”

The respondents stated that according to PNC code nurses were considered responsible to carry out the orders advised by doctors but the reality was different. Some doctors would leave signed blank prescriptions slips with the dispenser so that patients coming in their absence would get the medicines. When nurses questioned the advice of some medicines, the patients would defend the doctors and dispensers. Dealing with such issues led to conflict between co-workers.

“But conflict arises if any medicine which is not necessary for patient is prescribed and if we explain the same to patient... they do not trust us and they think that the dispenser is a doctor and is right. Extra time is taken in clearing such issues as we have to go find a doctor, get his advice on it and then have the correction made on the medicine slip.”

Inequitable workload: Many additional duties were given to nurses, which added to their workload. Many activities under the public health programs such as MNCH (Maternal Neonatal Child Health), Dengue fever control, Polio eradication programs were conducted in the wards. This resulted in delayed patients' admissions and patient care. Moreover, the support staffs was assigned additional duties in public health programs that resulted in further compromised patient care

“We have to suffer because patient load is high and most of the support staff has been hired for public health programs. We then provide clinical care without any assistance. The public health program activities create burden on clinical tasks due to prolonged absence of the workers..... this amounts to at least one week every month.”

Poor Image of a nurse in society

The respondents with reference to professional accountability to them referred to issue of poor value of nursing profession.

Poor value of nursing profession: The respondents shared that they had invested in their career and training which demanded respect from the medical professionals. However, many a times it was very disheartening to receive derogatory statements from patients and at times even colleagues.

“Even our colleagues at times use abusive language. They sling mud on our character. Mostly this is done by male peers/colleagues.”

The respondents expressed that the perception of the nursing profession was stereotypical; patients did not trust nurses to be competent as they were less educated than doctors and mostly came from poor families. They felt that they were not valued by the society:

“When the patients see us in our white uniforms, they create an image about us that we are subordinate and belong to poor uneducated families and that is the reason we have chosen this profession. Even less privileged and uneducated patients see

us thus. They openly state that you don't know about medicine and other health interventions --- we will just obey the order of doctors. They neither believe in our abilities as a health professional nor do they trust us as other health providers. There is no respect in our society for nurses”

“The government has labelled us as BPS-16 level officers but in reality we are not facilitated as any other officer in the Health Department.”

Autonomous decision-making was considered an important aspect of nursing by the respondents but it was seen to be lacking in their practice.

“We are not able to inform patients about what treatment or intervention is best. This is because in our training we have been told to follow doctors' orders. When doctors are not present on duty, we have to manage patients on their behalf. When a patient comes in emergency, we have no option but to wait for the doctor. Sometimes we act on our own and there is always a conflict concerning whether we should intervene or not. This results in patients being mismanaged.”

There were only two staff nurses present in the morning shift in most of the hospitals. The doctors posted would attend to the outdoor patients all day and at times would not have time to take round for the indoor patients. As per the PNC ethics code, the respondents shared that they were to follow the advice of doctors' standing orders. However, in practice because of these constraints, patients were neglected, ignored and poorly managed.

The nurses felt that they needed to be trained further and craved for support for higher education but the system did not support such career growth. They were not satisfied with their training and education as a nursing graduate.

“We cannot receive further education because of many reasons as lack of support for study leave, or working at bigger facility on deputation, no time given during routine work and distant learning opportunities for nursing education are not recognized by Pakistan Nursing Council.”

One respondent shared:

“Our education and further training is not a priority for our seniors due to shortage of nursing staff”.

“We want to take classes after duty hours but we are so tired after this hectic job that it is not possible. When we go home, family commitments do not allow us to pursue higher education in our own time. We are always ready to give attention to all patients as well as to families. Also we have no say on further education after marriage.”

The nurses felt that facilitation of management by ensuring presence of adequate staff would help them realize their aspirations for higher education.

Almost all respondents pointed out the need to make their workplace safe. Security was a major issue for them especially at night. Security guards or ward boys posted at the entry points were not at their appointed places at all times. Nurses continued to work full time under these circumstances.

“It’s never happened that nurses leave the ward because we can’t leave the patients alone. We are alone in the evenings and during night duty with no other staff present. We are doing our work in the absence of any security measures ensured by the administration. If we refuse to perform duty at night in such conditions, we are given threats by the Medical Superintendent who threatens to report us to the higher authorities and to have us transferred to another facility. There is no one who tries to understand the actual reasons of refusal to work in these circumstances.”

Discussion

The current study brought out situations, which nurses encountered during clinical practice in resource constraint settings and identified areas for future strategies to improve working conditions for nurses. The findings of the study were consistent with other studies, showing that nurses face ethical issues at work routinely, which contribute to their distress [6,12].

Nurses of the district Layyah were well aware of the PNC code of ethics. Although the ethical issues brought out in the study warranted action but hospital management did not consider them a priority. The most common issues faced by the nurses were regarding admission procedure, compromised nursing care, dissatisfaction of patients due to inadequate equipment, deficient supply of medicines, uncooperative support staff, stereotypes about nursing profession, professional incompetence of nurses, security issues and undue political interference in their work. Jafree et al. [6] identified similar ethical violations in practice in two tertiary care hospitals in Lahore, Pakistan. Nurses were facing problems in providing care due to reluctance of patients to receive treatment from them. Patients were discriminated based on their socio-economic status.

In this study nurses underscored the problems encountered during hospital admissions of patients with obstetrical emergency when doctors were not available. This finding is consistent with a facility based study conducted by Shamshad et al. in Pakistan which indicated that most of the maternal deaths in hospital admitted patient were preventable and could be prevented by provision of skilled care and timely management of complications [13]. Report of American Association of Retired Person Public Policy Institute [14], recognized similar barriers in another setting and allowed Advanced Practice Registered Nurse Practitioners (APRNs) hospital privileges which resulted in benefits to consumers and improved the health care delivery system especially for Medicare patients. Such measures potentially decreased costs and expedited treatment by eliminating the need for physician to sign-off on every service provided. This improved the quality of services as the physicians then could focus on specialized services. Based on the same principle Ontario Hospital Association in its guidelines [15], enabled the registered nurse practitioners to have privileges to admit and discharge patient. Given the shortage of skilled health care professionals in Pakistan, similar privileges to registered nursing professionals may help improve quality of healthcare services. Jafree et al. [6] have reported problems due to patient preferences and informed consent from female patients as identified in the current study.

The most frequently voiced issue was the inequitable workload. There was high turnover of patients and less number of nurses available. These findings are similar to those identified by Hussain and Buchan [16,17]. Another contributing factor identified in the current study was the pressure exerted on nurses by influential patients to attend to their needs on priority, which further hindered equitable patient care.

Due to overburdened hospital staff, non-availability of private rooms and screens the nurses also faced issues of breach of confidentiality and privacy. Even though nurses were aware of the ethical principles, they could not do much to improve care for the patients.

Majority of nurses were not aware of their job description and became entangled in departmental procedures, which left them less time for their primary duty of providing care to patients. To ensure patient safety and quality care provision roles and responsibilities of hospital staff and accountability systems need to be defined and implemented.

The main strength of this study was the rich data collected using a qualitative approach from nurses working in secondary level health care facilities of the government. FGDs proved to be a valuable method that allowed the participants to freely carry out lively discussions and bring out issues pertaining to their clinical practice. Since the moderator was a nurse too, a friendly environment enabled participants to openly voice their thoughts and feelings about ethical issues faced by them.

The findings of this study were based on a limited number of focus group discussions. They can thus not be generalized, but it is plausible to think that what the participants shared is also valid for other nurses from similar backgrounds and in similar settings [18].

Certain limitations had been identified. The authors solely relied on the participant’s own knowledge, perception, and experiences about ethical issues. The perspective of other health care providers, administrators and patients is missing. This study was conducted in a relatively underdeveloped district of Pakistan. There is a need to conduct empirical studies in developed districts and with larger samples by using both qualitative and quantitative methodologies to assess the magnitude of the problem and diversity of ethical issues faced by nurses.

Conclusion

This study identified various ethical issues faced by nurses in their clinical practice. To our knowledge, this was the first study that specifically addressed the ethical issues in nursing practice of graduate nurses in District Layyah. The study also clearly indicated that nurses were aware about their ethical responsibilities but were often unable to practice them. The findings showed that nurses were not the decision makers in many situations; they were subordinates in their working environment. The inadequate equipment and instruments, shortage of staff, stereotypes of the nursing profession, poor management and poor support to address the issues resulted in distress, poor professional care, stress, conflict, compromised nursing care and patient safety.

The diversity of the research team members enriched the analysis and the different perspectives helped understand the meanings nurses associate with their experiences of facing the issues. The findings of this study cannot be generalized to other nurses in Pakistan, but the richness of the data suggests explanations for the difficulties which many nurses face in public sector health facilities in Pakistan while performing their duties and adhering to ethical principles in clinical practice.

Recommendations

Ethical issues faced by nursing professionals in Pakistan need to be addressed to ensure patient care and safety by clearly defining their job description, including their roles and responsibilities. Concerned government departments and hospital management should work toward ensuring a suitable and safe working environment to nurses by improving accountability system. Authorities need to provide suitable opportunities for the professional development for the nurses to improve their competency. Privileges of hospital admission and discharge may be provided to senior nursing professionals in special circumstances. Further research on these issues may be beneficial in assisting the organizations to implement ethical codes in clinical practice of nurses and patient care.

Competing Interests

The authors declare no competing interest.

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