Original Article

Nurses' Strategies for Conscience-based Care Delivery: A Qualitative Study

Madineh Jasemi, Sima Purteimor, Roghaieh Esmaili Zabihi, Masumeh Hemmati Maslak Pak, Samereh Eghtedar

Faculty of Nursing and Midwifery, Medical Surgical Urmia University of Medical Sciences, Urmia, Iran

Abstract

Introduction: Conscience is the core of ethical values. It helps nurses protect patients' rights and provide quality dignified care. Therefore, assessing nurses' strategies for conscience-based care may help facilitate conscience-based care delivery. **Aim:** This study aimed to explore nurses' strategies for conscience-based care delivery. **Methods:** This qualitative study was conducted in 2018 on twelve hospital nurses purposively recruited from four teaching hospitals in Urmia, Iran. Data were collected through in-depth interviews and inductively analyzed through conventional content analysis. **Ethical Considerations:** This study was approved by the Ethics Committee of Urmia University of Medical Sciences. All the participants were informed of the aim of the study and a written consent was obtained from each of them. Participation in the study was entirely voluntary and the participants could withdraw at any stage of the study. **Results:** Participants' strategies for conscience-based care delivery were grouped into two main themes, namely self-empowerment for clinical role performance and attempt to deliver care beyond the routines. **Conclusion:** Clinical self-empowerment and attempt to deliver care beyond the routines are nurses' main psychosocial strategies for conscience-based care delivery. Mentorship programs are recommended for the development of nurses' time management and clinical skills and thereby, empower them for conscience-based care delivery. Moreover, continuing education programs and curricular revisions are recommended to strengthen their religious beliefs.

Keywords: Care, conscience, content analysis, nursing, qualitative study

Introduction

Nursing is a profession which deals with the private and personal aspects of people's lives. During their daily practice, nurses face ethical challenges, where they need to quickly decide on one of the several competing options. Ethical values in nursing are those values that guide nurse-patient relationships.[1] Conscience is the core of ethical values. It directs individuals towards nonmaleficence and veracity[2] and helps people understand their duties for coping with life.[3]

There are different views about conscience.[3] It is defined by healthcare professionals as ethically challenging situations in healthcare delivery and a criterion for performance evaluation which approves or disapproves actions. It is also defined as the manifestation of ethical responsibility towards self and others.[4] In nursing profession, conscience is considered as a personality-related component of professional competence which promotes nurses' sense of responsibility and requires them to use knowledge and skills in patient care delivery.[5] Affected by culture, conscience is a valuable component of nursing practice which demands sensitivity,[5] respect for human rights, and attentive and dignified care delivery.[5,6] Promotion of conscience-based practice in nursing helps nurses closely adhere to ethical standards, develops their professional roles and justice seeking, and gives them senses of calmness, happiness, satisfaction,[1,7] and inner peace. Moreover, as nurses need to make different ethical decisions during their daily practice, conscience-based ethical decision-making can protect them against feeling guilty.[8] Conscience is also a key factor behind integrity, wholeness, honesty, veracity, and professional commitment.[9,10] On the contrary, inattention to conscience in nursing may give nurses a sense of guilt[11] or troubled conscience.[9] Studies reported that most nurses suffer from pangs of conscience due to challenging critical situations.

Access this article online

Quick Response Code:

Website: www.jpalliativecare.com

DOI: 10.4103/IJPC.IJPC_65_19

Address for correspondence: Dr. Sima Purteimor, Faculty of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran.
E-mail: jasemi.phd@gmail.com

How to cite this article: Jasemi M, Purteimor S, Zabihi RE, Pak MH, Eghtedar S. Nurses' strategies for conscience-based care delivery: A qualitative study. Indian J Palliat Care 2019;25:517-22.

When they are providing care to critically-ill patients, they may remember patients to whom they failed to provide adequate care. Such ethical memory may result in self-blaming and pangs of conscience, and thereby, can exert destructive effects on nurses,[11] cause them anxiety and distress, undermine their personal integrity, and eventually require them to leave their profession.

In ethically challenging situations, nurses may use different strategies for self-protection, professional development, and personal integrity retention.[10] Assessment of these strategies is a prerequisite to the promotion of conscience-based practice, improvement of care quality, reduction of staff turnover rate, and thereby, promotion of public health.[10,12] Yet, most previous studies in this area evaluated the characteristics of conscience in nursing practice or factors affecting conscience-based care delivery and hence, there are limited data about strategies nurses use to deliver conscience-based care.[13,14] On the other hand, conscience is formed and affected by sociocultural and religious beliefs[4,5] and hence, nurses in different cultures and societies may use different strategies to deliver conscience-based care.[14] Nonetheless, no study had yet evaluated these strategies in Iran. This study was conducted to fill these gaps and provide a deeper insight in this area. The aim of the study was to explore nurses' strategies for conscience-based care delivery.

Methods

Design

This qualitative study was conducted in 2018 using content analysis. Content analysis is the subjective interpretation of textual data through data coding and categorization and theme or pattern identification.[12] It includes three main approaches, namely conventional, directed, and summative content analyses. The conventional approach was employed in this study.

Participants and setting

Study setting was the general wards and the critical care units of four teaching hospitals in Urmia, Iran. Study population consisted of all nurses in the study setting. In total, twelve nurses were purposively selected based on the following criteria: Bachelor's degree or higher in nursing, clinical work experience of >1 year, and consent for participation in the study.

Data collection

The data collection instrument was in-depth unstructured face-to-face interview. Participants were asked questions about their experiences of nursing care delivery. An example of interview questions was, "Based on your experiences, which strategies do you use to deliver conscience-based care at your workplace?" On average, interviews lasted 45 min (in the range of 30–60). Data collection was continued until data saturation. All interviews were tape-recorded and transcribed word by word.

Data analysis

The data were analyzed via conventional content analysis. Initially, each interview was listened to several times in order to understand its main ideas. Then, meaning units were identified and coded and the codes were categorized based on their similarities. The categories were also compared and combined according to their similarities in order to generate the main themes of the study.

Trustworthiness

Credibility of the findings was ensured through prolonged engagement with the data, member checking, and internal and external peer checking. Moreover, time triangulation, i.e., data collection at different time-points (including the morning, evening, and night work shifts), was employed to ensure dependability. All research-related activities (from data collection to coding and categorization) were discussed with several reviewers who were external to the study and documented in order to maintain confirmability.

Ethical considerations

The Ethics Committee of Urmia University of Medical Sciences, Urmia, Iran, approved this study (approval code: IR.UMSU.REC.242.1397). Participation in the study was voluntary and written consent was obtained from all participants.

Results

Participants were twelve hospital nurses, including three males and nine females. The means of their age and work experience were 33.63 ± 4.27 and 10.44 ± 3.76, respectively. Ten participants held bachelor's degree and two held master's degree.

Participants' strategies for conscience-based care delivery came into two main themes, namely self-empowerment for clinical role performance and attempt to deliver care beyond the routines. Together with their categories and subcategories, these themes are summarized in Table 1 and are explained in the following.

Self-empowerment for clinical role performance

Self-empowerment for clinical role performance is a psychosocial strategy for conscience-based care delivery. In order to deliver conscience-based care, nurses primarily need clinical self-empowerment. The two main categories of self-empowerment for clinical role performance are time management and knowledge development.

Time management during care delivery

According to our participants, time limitation is a major barrier to the effective fulfillment of patients' needs. Therefore, they used time management as a basic strategy for professional care delivery. The subcategories of this main category were technical skill development and care organization.

Technical skill developmen

Most participants noted that when they were novice, their limited technical skills for general and specialized techniques negatively affected their promptitude and hence, faced them with time limitation. Therefore, they primarily attempted to develop their technical skills.

Table 1: Nurses' strategies for conscience-based care delivery

Themes	Categories	Subcategories
Self-empowerment for clinical role performance	Time management during care delivery	Technical skill development
		Organization of care measures
	Background knowledge development	Attempt for theoretical learning
		Attempt for practical learning
Attempt to deliver care beyond the routines	Exploration for identifying patient problems	General assessment of patients' conditions
		Development of human relations with patients and colleagues
	Answering the inner calling for care delivery	Attentiveness to beliefs
		Attempt to find inner peace

Previously, I did not have the necessary skills for nursing practice and hence, I always faced with time limitation. I wanted to provide holistic care to my patients; but it was very difficult for me. Gradually, I achieved mastery over my work and could perform my routine care-related tasks more rapidly. Thereby, I had greater deal of time for better patient care and hence, obtained the ability to deal with other aspects of patient care (P. 8).

Organization of care measures

Another strategy our participants employed for conscience-based care delivery was the organization of care measures which refers to the prioritization of care measures. This strategy not only facilitated their time management, but also enabled them to deliver conscience-based care.

I gradually learned to organize and prioritize my tasks. I wrote my tasks on a piece of paper and gave high priority to emergency tasks. Instead of performing care-related tasks at frequent patient visits, I learned to perform all care-related affairs of a patient at a single visit. Thus, I won more time and attempted to spend it on managing other problems of my patients, particularly managing those which soothed my conscience and calmed me (P. 4).

Background knowledge development

The second main category of self-empowerment for clinical role performance was background knowledge development. Knowledge development enables nurses to provide safe care and prevents patients from injuries. The two subcategories of this main category were attempt for theoretical learning and attempt for practical learning.

Attempt for theoretical learning

To develop their background knowledge, our participants attempted to promote their theoretical learning through self-study. This strategy helped them develop their knowledge about patient needs and safe care.

Initially, I didn't have adequate knowledge about common health problems in this ward and hence, unwanted events sometimes happened for patients. To tell you the truth, I became greatly sad at causing patients unwanted events. Thus, I decided to develop my knowledge in this area and started self-study about my patients' illnesses. Thereby, I learned many things which improved the quality of my work and prevented my patients from unwanted injuries (P. 7).

Attempt for practical learning

Practical learning was another strategy for professional conscience-based care delivery. To promote their practical learning, our participants attempted to role-model their instructors and colleagues and thereby, learn the principles of professional care delivery.

One of the nurses in our ward was very excellent at practice. He performed urinary catheterization using sterile technique, accurately established an IV line, changed dressing based on the principles of quality care, and administered patient medications at the proper time. He was a role model for me. I learned most professional skills from him. Although our instructors had taught us many things during our studentship, that colleague greatly influenced my practice (P. 3).

Attempt to deliver care beyond the routines

Nurses' primary strategies for conscience-based care delivery empowered them for their clinical roles and promoted their competence in task performance so that they no longer faced with time limitation and had greater amount of time to deal with other aspects of patient care. However, self-empowerment for clinical role performance did not satisfy nurses' aspiration for conscience-based care delivery because they considered routine care delivery contradictory to conscience-based care delivery and intended to deliver care services beyond the expectations of their organization. Attempt to deliver care beyond the routines was our participants' second main strategy for conscience-based care delivery. This main theme consisted of the two main categories of exploration for identifying patients' problems and answering to the inner calling for care delivery.

Exploration for identifying patient problems

Exploration for identifying patients' problems was one of the strategies used by those nurses who attempted to deliver care beyond the routines and strived for conscience-based care delivery. These nurses attempted to attain these goals through general assessment of patient conditions and development of human relations with patients and colleagues.

General assessment of patients' conditions

General assessment of patients' conditions facilitates the identification of their problems and the delivery of conscience-based care. The prerequisites to the accurate assessment of patients' conditions are adequate time management and technical skills.

Now, I'm more skillful at my work and have adequate time and hence, completely assess my patients. I check my patients' intravenous lines, oxygenation systems, and dressing, if any. Then, I refer to their medical records and assess their laboratory test results, electrocardiographs, and medications. Moreover, I check them for potential health-related and financial problems. I check whether they had bought their medications or whether their companions had taken their blood samples to laboratories. Such assessments help me get ensure that I'm aware of all their problems and can take prompt actions and hence, soothe my conscience (P. 6).

Development of human relations with patients and colleagues

Nurses' effective communication with patients and colleagues has key roles in the identification of patients' needs and the delivery of conscience-based care. According to the participants, the necessary skills for such communication are gradually acquired during clinical self-empowerment.

I gradually understood the role of communication in identifying patients' problems and calming them and myself. Compared with before, I currently establish more extensive communications with patients and their companions and hence, have more information about their problems. When I enter the ward, I greet my patients and ask them about their conditions and hence, acquire valuable information about their conditions just in several minutes. This practice helps me very much in care delivery and calms patients. It also gives me better feelings and soothes my conscience because it ensures me that I haven't missed any care-related item (P. 11).

Accurate identification of patients' problems necessitates effective communication not only with patients, but also with all healthcare providers, so that some participants referred to conscience-based care delivery as a team-based activity.

Fulfillment of patients' needs and quality patient care delivery require effective teamwork. I need to establish relationships with physicians and their interns and residents as well as with other nurses in the ward in order to acquire adequate information about patients' problems. Close interdisciplinary collaboration helps identify all problems of patients, promotes our promptitude, and helps us have greater amount of time for patients (P. 10).

Answering the inner calling for care delivery

Another main category of the strategies for conscience-based care delivery was to answer the inner calling. By the inner calling, we mean the voice of conscience which draws nurses' attention to all patients' needs and directs them toward quality conscience-based care delivery. The two subcategories of this main category were attentiveness to beliefs and attempt to find inner peace.

Attentiveness to beliefs

Religious, ethical, and professional beliefs have significant roles in nurses' attentiveness to patients' problems and care quality. Yet, our participants noted that early in their entrance to the profession, they had been inattentive to their beliefs and had been unable to practice based on them.

In the early days of my clinical practice, I knew that inattentiveness to patients' non-clinical needs was unethical and liked to pay more attention to them. However, time limitation required me to mainly focus on my direct clinical tasks. At those days, my care was mainly task-oriented (P. 8).

However, after self-empowerment for clinical role performance and developing a care delivery beyond the routines viewpoint, participants were able to place greater importance to their beliefs and consider them in care delivery.

My beliefs were among the most important factors behind the quality of my care services and my attentiveness to patients' needs. I gradually developed greater competence in my work and hence, could perform my routine tasks more rapidly. At that time, I considered it unethical to sit and take rest after finishing my routine tasks while my patients were not in a state of adequate comfort. It gave me pangs of conscience. Therefore, I referred to patients and attempted to fulfill their other needs, including psychological or financial needs, as much as I could. It gave me a good feeling. I assessed them more and more to identify and fulfill their other needs. We need to consider conscience at work. Hospitalized patients need care and have nobody other than us to fulfill their needs. I have had these beliefs from the very beginning of my clinical practice. However, those days, I did not have adequate time to act based on my beliefs (P. 9).

Attempt to find inner peace

Attempt to find inner peace was an effective strategy to answer the inner calling for conscience-based care delivery. Our participants noted that they earnestly strived to find inner peace and alleviate their pangs of conscience caused by their previous inability to answer their inner calling due to time limitation.

At the beginning of my clinical practice, my workload was heavy and I did not have adequate time. Therefore, I felt pangs of conscience when I defaulted on patient care. However, after I gradually become more and more skillful, pangs of conscience no longer allowed me to default on patient care. Alleviating such pangs of conscience and its associated calmness were the main reasons behind my attempts for ethical care delivery (P. 6).

Discussion

This study sought to explore nurses' strategies for conscience-based care delivery. Findings revealed self-empowerment for clinical role performance and attempt to deliver care beyond the routines as nurses' main strategies for conscience-based care delivery.

Time management was one of the strategies employed by our participants for clinical self-empowerment. Time management

helps nurses have greater amount of time for attending to patients' different needs and delivering conscience-based care. Our participants attempted to manage their time through developing their technical skills. Benner also highlighted the significant role of effective time management in the effective fulfillment of patients' needs and introduced it as a strategy employed by competent nurses.[15,16] Development of technical skills is an essential strategy for effective time management and an absolute prerequisite for effective need fulfillment and conscience-based care delivery.[17-19] Another strategy our participants employed for time management was care organization. Similarly, an earlier study reported task organization as a key factor behind effective time management and quality need-based care delivery.[20]

Study findings also revealed knowledge development as another strategy for clinical self-empowerment and conscience-based care delivery. Adequate professional knowledge helps nurses identify patients' needs and develop and implement plans for holistic and conscience-based care.[21] Two earlier studies also reported that knowledge development improves nurses' understanding of patients and their needs,[22,23] facilitates conscience-based care delivery, and enhances the quality of care.[22] Benner also introduced knowledge development as a strategy to achieve professional competence.[24]

Our participants also attempted to develop their theoretical and practical knowledge through self-study, asking questions from their colleagues, observing their practice, and role-modeling them. Similarly, previous studies reported self-study, asking questions from peers, observation of peer practice, and role-modeling as strategies for knowledge development and clinical empowerment.[25-27] Peer mentorship and role-modeling were also reported as effective strategies for understanding patients and their needs and improving care quality.[28] Mentorship and preceptorship can facilitate clinical learning and conscience-based care delivery.

Attempt to deliver care beyond the routines was the other main theme of the study or main strategy for conscience-based care delivery. Exploration for identifying patients' problems was one our participants' strategies for delivering care beyond the routines. They attempted to develop their communication skills in order to establish more effective communications with their patients and colleagues and thereby, identify their patients' needs and problems. Similarly, previous studies reported communication skill development as the most important strategy for collecting patient-related data, identifying patients' needs and problems,[6,29-31] and delivering conscience-based care.[6,28] Another strategy used by our participants to explore and identify patients' needs was general assessment of patients' conditions. Different nursing scholars and researchers have introduced patient assessment as the key step to the identification of patients' needs and problems and the development and delivery of holistic conscience-based care.[4,29,32]

Answering the inner calling for care delivery was the other strategy used by our participants for the delivery of care beyond the routines. Previous studies also reported that without considering religious beliefs and inner calling, conscience-based care delivery would be impossible.[32,33] Religious, ethical, and professional beliefs direct nurses towards more proper identification of patients' needs, empower them for conscience-based care,[34] promote their professional practice, and strengthen their motivation for quality care delivery.[10] Our participants also highlighted that attentiveness to their own beliefs during patient care not only alleviated their pangs of conscience, but also calmed them. Similarly, a former study reported that nurses' beliefs give them greater pleasure at fulfilling patients' needs and hence, are a significant factor behind their greater attention to patients' needs and their intention to deliver conscience-based care.[29]

Conclusion

This study indicates clinical self-empowerment (through time management and knowledge development) and attempt to deliver care beyond the routines (through careful patient assessment and need identification) as the main strategies for conscience-based care delivery. Therefore, strategies such as mentorship programs are needed to develop time management, interpersonal communication, patient assessment, and clinical task performance skills, particularly among novice and beginner nurses. Moreover, given the role of nurses' religious beliefs in conscience-based care delivery, continuing education programs are recommended to strengthen and enrich nurses' religious beliefs. Major revisions to nursing curricula are also necessary to improve nursing students' professional skills and strengthen their beliefs.

Acknowledgement

This article was part of a research project approved and financially supported by Urmia University of Medical Sciences, Urmia, Iran. Hereby, we would like to thank this university for its financial support as well as all nurses who shared their experiences about Strategies for Conscience based Care Delivery.

Financial support and sponsorship

This study was supported by a research grant from Urmia University of Medical Sciences, Iran.

Conflicts of interest

There are no conflicts of interest.

References

1. Johnston MJ. Bioethics: A Nursing Perspective. 4th ed. London: Churchill Livingstone; 2006.
2. Burkhardt MA, Nathaniel AK. Ethics Issues in Contemporary Nursing. London: Delmar Cengage Learning; 2008.
3. Aldén M. Conscience and Lack of Conscience. Swedish: Lund University; 2002.
4. Memarian R, Salsali M, Vaaki Z, Ahmadi F, Hajizade A. Effective factors in the process of achieving clinical competency. Sci J Zanjan Univ Med Sci 2007;14:40-9.
5. Dahlqvist V, Eriksson S, Glasberg AL, Lindahl E, Lützén K, Strandberg G. Development of the perceptions of conscience questionnaire. Nurs Ethics 2007;14:181-93.

6. International Council of Nurses. The ICN Code of Ethics for Nurses. London: International Council of Nurses; 2000.
7. Jafari MT. Conscience. 4th ed. Tehran: Institute for the Publication of AllamehJafari's Works; 2009.
8. Sørlie V, Jansson L, Norberg A. The meaning of being in ethically difficult care situations in paediatric care as narrated by female registered nurses. Scand J Caring Sci 2003;17:285-92.
9. Glasberg AL. Stress of Conscience and Burnout in Healthcare Umeå University; 2007.
10. Tadd W, Clarke A, Lloyd L, Leino-Kilpi H, Strandell C, Lemonidou C. The value of nurses' codes: European nurses' views. Nurs Ethics 2006;13:376-93.
11. Carbone S, Rickwood D, Tanti C. Workforce shortages and their impact on Australian youth, mental health service reform. Adv Ment Health 2011;10:92-7.
12. Strubert H, Carpenter D. Qualitative Research in Nursing: Advancing the Humanistic Imperative. Philadelphia: Lippincott Williams & Wilkins; 2007.
13. Gaberson KB, Oermann MH. Clinical Teaching Strategies for Nursing. 2nd ed. New York: Springer Publishing Company; 2006.
14. Tazakori Z, Mozafari N, Movahedpour A, Mazaheri E, Karim Elahi M, Mohamadi MA, *et al*. Comparison of nursing students and instructors about OSPE performance and evaluation methods in common practice. Proceedings of the 7th National Congress Country Training; 2005. p. 9.
15. Mathison S. Encyclopedia of Evaluation. London: Thousand Oaks New Delphi: Sage Publication; 2004.
16. Corbin JM, Strauss AL. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. London: Sage Publications, Incorporated; 2008.
17. Zamanzadeh V, Jaemi M, Valizadeh L, Keoch B, Taleghani F. Lak of prepartion: Iranian nurses' experience during transition from college to clinical practice. J Professional Nurs 2015;31:365-73.
18. Ahmadi F, Nobahar M, Alhani F, Fallahi M. Retired nurse's view about effective factors on quality of nursing care. Hayat J Fac Nurs Midwifery Tehran Univ Med Sci 2011;17:24-34.
19. Moule M, Goodman M. Nursing Research an Introduction. 1st ed. Los Angeles: Sage Publication Ltd.; 2009.
20. McCann TV, Clark E. Grounded theory in nursing research: Part 1 – Methodology. Nurse Res 2003;11:7-18.
21. Polit DF, Beck CT. Essentials of Nursing Research: Appraising Evidence for Nursing Practice. Philadelphia: Wolters Kluwer; 2010.
22. Polit D, Beck C, Hungler B. Essentials of Nursing Research: Methods, Appraisal and Utilization. Philadelphia: Lippincott Williams & Wilkings; 2006.
23. Hegney D, Eley R, Francis K. Queensland nursing staffs' perceptions of the preparation for practice of registered and enrolled nurses. Nurse Educ Today 2013;33:1148-52.
24. Morgan S, Yoder LH. A concept analysis of person-centered care. J Holist Nurs 2012;30:6-15.
25. Cutcliffe JR, Stevenson C, Jackson S, Smith P. A modified grounded theory study of how psychiatric nurses work with suicidal people. Int J Nurs Stud 2006;43:791-802.
26. Priest HM. Novice and expert perceptions of psychological care and the development of psychological caregiving abilities. Nurse Educ Today 1999;19:556-63.
27. Seright TJ. Clinical decision-making of rural novice nurses. Rural Remote Health 2011;11:1726.
28. Kramer M. Why dose reality shock continue? In: McCloskey JC, Grace HK, editors. Current Issues in Nursing. Philadelphia: Blackwell; 1983.
29. Cheraghi M. Theorizing of the pre process of theoretical knowledge to practice in nursing. J Nurs Midwifery Hamadan 2010;17:24-34.
30. Atashzadeh Shoorideh F, Ashktorab T. Factors influencing implementation of nursing process by nurses: A qualitative study. Knowl Health 2011;6:16-23.
31. Lisa M, Emily D, Witt L. A review of personality and performance: Identifying boundaries, contingencies, and future research directions. Hum Resource Manage Rev 2011;4:297-310.
32. Whyte J 4th, Ward P, Eccles DW, Harris KR, Nandagopal K, Torof JM, *et al.* Nurses' immediate response to the fall of a hospitalized patient: A comparison of actions and cognitions of experienced and novice nurses. Int J Nurs Stud 2012;49:1054-63.
33. Rush KL, Adamack M, Gordon J, Lilly M, Janke R. Best practices of formal new graduate nurse transition programs: An integrative review. Int J Nurs Stud 2013;50:345-56.
34. da Silva DG, de Souza Sda S, Trentini M, Bonetti A, Mattosinho MM. The challenges coped by the novice in nursing practice. Rev Esc Enferm USP 2010;44:511-6.