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Kristen Jones-Bonofiglio and Manal M. Alzghoul

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Article abstract

Context: Nurses are often hesitant to talk about ethical issues in their practice for many unique and valid reasons. What if the burden of risk was lifted upon retirement, even if just slightly? The purpose of this study was to explore retired nurses' reflections on their experiences of ethical issues and decision making in various nursing practice settings throughout their careers and to glean recommendations for ethics in contemporary nursing practice. *Methods:* Data were collected via in-depth, individual, semi-structured interviews. Guided by an interpretive, descriptive approach, data were managed with NVivo v.11 and analyzed with an inductive, comparative, thematic approach. In northern Ontario, two nurse researchers co-interviewed eight retired nurses with decades of practice experience across diverse Canadian health care settings. Ethics approval was obtained through Lakehead University's Research Ethics Board. *Findings:* Three themes emerged to address ethical issues in practice; these are creativity, resourcefulness, and a strong sense of community with other nurses. Further, the retired nurses' collated reflections on ethics in practice are presented as the FIG model: **F**ellowship, **I**ngenuity, and **G**umption. *Conclusions:* This study identifies ethical underpinnings that retired nurses have used to effectively respond to ethical issues in their practice. Those who are currently nursing, and nursing as a profession, may wish to recognize and retain these strategies in order to continue to deliver a high standard of quality, ethical care. Recommendations for practice, research, and education are offered.

Into the Grey Zone: Retired Nurses' Reflections on Ethics in Canadian Nursing Practice

Kristen Jones-Bonofiglio[a,b], Manal M. Alzghoul[a,b]

Résumé

Contexte : Les infirmières hésitent souvent à parler des questions d'éthique dans leur pratique pour de nombreuses raisons uniques et valables. Et si le fardeau du risque était allégé à la retraite, ne serait-ce que légèrement? L'objectif de cette étude était d'explorer les réflexions des infirmières et infirmiers à la retraite sur leurs expériences des questions éthiques et de la prise de décision dans divers contextes de pratique infirmière tout au long de leur carrière et de glaner des recommandations sur l'éthique dans la pratique infirmière contemporaine. *Méthodes* : Les données ont été recueillies au moyen d'entretiens individuels semi-structurés approfondis. Guidées par une approche interprétative et descriptive, les données ont été gérées avec NVivo v.11 et analysées selon une approche inductive, comparative et thématique. Dans le nord de l'Ontario, deux infirmières chercheuses ont co-interviewé huit infirmières à la retraite ayant des décennies d'expérience de la pratique dans divers milieux de soins de santé canadiens. L'approbation éthique a été obtenue auprès du comité d'éthique de la recherche de l'Université Lakehead. *Résultats :* Trois thèmes ont émergé pour aborder les questions d'éthique dans la pratique : la créativité, l'ingéniosité et un fort sentiment de communauté avec les autres infirmières. De plus, les réflexions rassemblées par les infirmières à la retraite sur l'éthique dans la pratique sont présentées comme le modèle FIG : **F**ellowship, **I**ngenuity, and **G**umption. *Conclusions :* Cette étude identifie les fondements éthiques que les infirmières à la retraite ont utilisés pour répondre efficacement aux questions éthiques dans leur pratique. Ceux qui sont actuellement infirmiers et infirmières en tant que profession pourraient souhaiter reconnaître et conserver ces stratégies afin de continuer à fournir des soins de qualité et éthiques. Des recommandations pour la pratique, la recherche et l'éducation sont proposées.

Abstract

Context: Nurses are often hesitant to talk about ethical issues in their practice for many unique and valid reasons. What if the burden of risk was lifted upon retirement, even if just slightly? The purpose of this study was to explore retired nurses' reflections on their experiences of ethical issues and decision making in various nursing practice settings throughout their careers and to glean recommendations for ethics in contemporary nursing practice. *Methods:* Data were collected via in-depth, individual, semi-structured interviews. Guided by an interpretive, descriptive approach, data were managed with NVivo v.11 and analyzed with an inductive, comparative, thematic approach. In northern Ontario, two nurse researchers co-interviewed eight retired nurses with decades of practice experience across diverse Canadian health care settings. Ethics approval was obtained through Lakehead University's Research Ethics Board. *Findings:* Three themes emerged to address ethical issues in practice; these are creativity, resourcefulness, and a strong sense of community with other nurses. Further, the retired nurses' collated reflections on ethics in practice are presented as the FIG model: **F**ellowship, **I**ngenuity, and **G**umption. *Conclusions:* This study identifies ethical underpinnings that retired nurses have used to effectively respond to ethical issues in their practice. Those who are currently nursing, and nursing as a profession, may wish to recognize and retain these strategies in order to continue to deliver a high standard of quality, ethical care. Recommendations for practice, research, and education are offered.

Mots-clés

infirmières, infirmiers, retraité, éthique, prise de décision éthique, pratique infirmière, Canada

Keywords

retired nurses, ethics, ethical decision making, nursing practice, Canada

Affiliations

[a] School of Nursing, Lakehead University, Thunder Bay, Canada
[b] Lakehead University Centre for Health Care Ethics, Unit of the International Network of the UNESCO Chair in Bioethics, Thunder Bay, Canada

Correspondance / Correspondence: Kristen Jones-Bonofiglio, Kristen.Jones@lakeheadu.ca

INTRODUCTION

Designated as International Year of the Nurse and the Midwife, 2020 coincided with the 200th anniversary of Florence Nightingale's birthday (1). In Nightingale's time, the nurse's duty was to the patient first, with formal ethical decision-making in the exclusive domain of physicians. It was not until the 1950s that the role of the nurse and the scope of nursing practice changed significantly. In 1953, the International Council of Nurses (ICN) (2) produced the first international code of ethics for nurses to ensure that nursing care was grounded in ethical principles to meet patients' needs and right to respect, dignity, quality of life, and safety (3). The role of the nurse has since evolved to include ethical decision-making as a core nursing responsibility.

Like many other countries who were members of the ICN, Canada adopted the international code of ethics for its nurses until it developed its own code in 1980 (4). The latest update on the Canadian *Code of Ethics for Registered Nurses* was introduced in 2017 by the Canadian Nurses Association (CNA) and represents the sixth revision of the original Canadian document (4). Further, professional organizations such as the Registered Nurses Association of Ontario (RNAO) (5) and licensing bodies

such as the College of Nurses of Ontario (CNO) (6) also provide provincial support to uphold professional standards for ethical behaviour and offer resources to promote the resolution of ethical problems in practice. Ethical problems in nursing practice can be defined as situations that unsettle a nurse's conscience, which may have multiple possible courses of action and thus require ethical deliberation or decision-making. However, this is different from an experience of ethical dilemmas where there are only two choices of action, and the nurse must choose between these extremes (7). For the purpose of discussion in this paper, ethical problems and ethical dilemmas will be collectively known as ethical issues.

In order to address ethical issues, nursing has borrowed from medicine's bioethics principles – such as those of Beauchamp and Childress (8) – to speak for itself on the requirements and responsibilities of professional nursing ethics. Further, contemporary nurses have assumed formal roles in health care ethics research (9,10) and in ethics in clinical practice (11). Attention to the need for health care ethics content in nursing education has also seen changes over time. Whereas nursing education used to focus primarily on one-to-one relationships or patient-nurse dyads, students now learn about nursing as relational practice (12,13) in the context of interprofessional teams and collaboration (14), as well as the influences of the social determinants of health (15).

With its diverse roles and responsibilities, the complexity of today's nursing practice often leads individuals to seek graduate education at the master's and doctoral levels. Continuing professional development allows nurses to take a broad perspective of ethical issues in practice; address issues at the micro (e.g., individual, intrapersonal), meso (e.g., interpersonal, team, patient/family/health care provider), and macro levels (e.g., unit, organization, system); and to more fully consider the impacts of sociopolitical, cultural, and historical contexts on ethical issues in practice (16). Despite progress and contributions from nurses in the contexts of practice, research, and education, little has changed in Canadian nursing codes of ethics to more fully support nurses to address complex and sometimes messy ethical issues and decisions in everyday practice (17). One outcome related to serious frustrations about ethical issues and circumstances leading to moral distress in nursing practice, is that experienced nurses are leaving the profession (18).

Retired Nurses in Canada

Retirement is an expected and often highly anticipated life stage, as well as a complex social phenomenon (19). In Canada there is no mandatory retirement age and nurses can continue to work for as long as they wish to and are able (20). According to the Canadian Institute for Health Information (CIHI) data from 2019, less than 24% of registered nurses (RNs) currently working in Canada are designated as late career and are over the age of 55 years (21). Data from almost 20 years ago showed that just over 30% of working Canadian RNs were age 50 years or older (22). In fact, early retirement (before age 65) is actually the norm for many Canadian health care professionals (23). Enjoying the company of colleagues and financial benefits are the main reasons cited as influencing nurses' decisions to delay retirement (20). For nurses who choose retirement, the main factors are classified as personal, personal/financial, and work related (24).

Ethics and ethical decision-making in health care have been referred to as a moral grey zone (25,26). The majority of research on nursing ethics and ethical decision making has been conducted with nurses who are active in clinical practice (27,28). Although the academic literature has addressed the topic of nursing and retirement (29,30), it is rare that retired nurses have been asked to contribute their perspectives on ethics in practice (31,32). The fact that, individually and collectively, retired nurses have witnessed transitions in professional nursing practice across time makes them a valuable potential resource to offer perspectives about their experiences. Therefore, the purpose of our study was to explore the personal reflections of retired nurses on ethical issues and ethical decision-making in nursing practice. Findings from this study can contribute to ongoing dialogue about ethical practice and decision-making of working nurses and may inform revisions to codes of ethics for nursing as a profession. Recommendations for practice, research, and education are also offered.

METHODS

This qualitative study received approval from Lakehead University's Research Ethics Board in congruence with the principles of the *Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. All participants gave informed written consent prior to being interviewed. Two nurse researchers conducted in-depth, semi-structured interviews with participants. The interviews were audio recorded with permission and transcribed verbatim by an independent transcriber. Later, the transcripts were returned to participants for member checking and to correct any errors or omissions.

Data Collection and Analysis

Recruitment occurred over a period of seven months through purposive snowball sampling, word-of-mouth, and via paper posters on public message boards in three communities in northern Ontario, Canada. Inclusion criteria were: being a retired nurse (e.g., holding a license that recognizes being a retired registered nurse or having given up their license as an RN); and having previously worked in an acute care setting in northern Ontario. After contacting one of the researchers by phone or email, each participant received an information letter explaining the study and a consent form by e-mail. Nine potential participants contacted the researchers directly. A total of eight participants took part in the study; one retired nurse voluntarily withdrew from the study before the interview due to illness.

Each participant was co-interviewed by the nurse researchers at mutually convenient times and locations; six interviews occurred over the phone and two were conducted in-person, per individual participant's request. Opportunities for participants to ask the nurse researchers questions were provided before participation was confirmed and again at the beginning of each interview session. Redundancy of thematic information and data saturation occurred after eight interviews thus no further participants were sought for the study.

During the interviews, participants were asked to reflect on ethical situations during their nursing careers and to share examples of when it was difficult to know the right thing to do. After exploring demographic information (see Table 1), the researchers asked participants about how they made decisions during ethically challenging circumstances in their past nursing practice. Specifically, the following statements were used to stimulate further discussion:
- Describe your experience with an ethical issue in your nursing practice.
- Describe your experiences of addressing ethical issues and making ethical decisions.
- Describe if/how working in northern Ontario has shaped your nursing experiences and ethical decision-making.

Verbatim transcripts were first sent to individual participants for their review; to correct any errors or omissions, to add any information recalled after the interview, or to request content removal. No changes to the transcripts were requested by any of the participants. Data analysis was guided by an interpretive, descriptive approach (33,34). First, each researcher reviewed and reread the transcripts and interview field notes independently. Next, the researchers reviewed the transcripts and interview field notes together. Data were then coded into main themes that described emergent patterns using NVivo, version 11 (35). Data analysis of the retired nurses' reflections revealed three key themes.

FINDINGS

The average interview was one hour long, the average transcript was 16 pages long, and the average field note was two pages (double sided and hand-written). All participants identified as female with an average age of 65 (youngest was 56 and oldest was 69). All participants held a diploma in nursing, and some held additional post-secondary education, including specialty certifications. The range of nursing experience was between 30 and 45 years in various practice settings (see Table 1 for further aggregated demographic details about the participants). Three participants were retired for approximately 10 years, while the remaining five had been retired for two years or less.

Table 1. Participant demographics

Participant	Education/Training	Specialty areas of practice
Retired Nurse 1	Diploma, undergraduate degree, master's, CNS specialization, PhD	ACAD, HOSP, CANC, ADM, MED, SURG, ICU
Retired Nurse 2	Diploma, undergraduate degree, NP certificate, palliative care certificate	HOSP, ER, SURG, REHAB, COMM, LTC, FNC
Retired Nurse 3	Hospital-trained diploma, undergraduate degree, lactation consultant, NICU certificate	HOSP, PAEDS, OBS, LTC, COMM, PH; 25 years in palliative care
Retired Nurse 4	Diploma	HOSP, OBS, PSYC
Retired Nurse 5	Hospital-trained diploma, undergraduate degree, master's	ACAD, HOSP, CARD, NEURO, SURG, ICU; 32 years teaching
Retired Nurse 6	Hospital-trained diploma, undergraduate degree	ACAD, HOSP, CAR, MED, REHAB, GERO, LTC, ADM, COMM, GERO
Retired Nurse 7	Hospital-trained diploma, undergraduate degree	HOSP, NICU, PAEDS, SURG, ICU
Retired Nurse 8	Diploma, undergraduate degree, master's, certificates	HOSP, ADM, PAED, FNC, COMM; 15 years as a manager

ACAD: academia/teaching; ADM: manager/administrator/director of care; COMM: community health care; FNC: First Nations community/reserve; HOSP: hospital; CANC: cancer care; CARD: cardiac; ER: emergency room; GERO: older adult specialty; ICU: intensive care unit; MED: medical; NICU: neonatal intensive care unit; OBS: obstetrics/maternal child; PAEDS: paediatric; PSYC: psychiatric/mental health; REHAB: rehabilitation/chronic care; SURG: surgical
LTC: long-term care homes; PH: public health nursing.

Three key themes were identified from the analyzed data: *fellowship*, *ingenuity*, and *gumption*. These findings are presented using a FIG (Fellowship, Ingenuity, and Gumption) model (see Figure 1) that was created by the researchers to demonstrate the interconnected nature of the themes.

Figure 1. FIG model
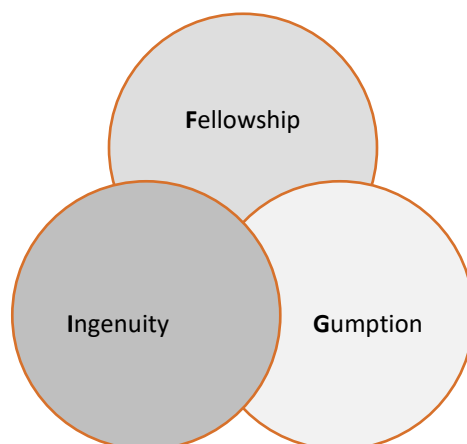
Because the participants had spent decades working in small communities where their stories could easily be identified (as the "retired nurse in the community"), the researchers chose not to match the quotations (used to support the themes) to the information listed in Table 1. Therefore, the quotes below are not attributed to specific nurses in this study. However, quotes from across all eight interviews were selected to ensure fairness and representativeness in the quotes presented.

Theme 1: Fellowship

Fellowship can be defined as a *group* of individuals with a common purpose and, using an older perhaps less common definition, as a *feeling* between people with a shared interest or activity (36). As such, fellowship was used in data analysis as a theme that was found to occur when participants routinely described a tangible "*spirit of togetherness*" with other nurses in the context of their reflections on nursing practice. They spoke of nursing in a collective, community, and in a relational sense that involved the need to respect, listen, share, and support each other. In narratives that highlighted team nursing approaches, they described not thinking twice about staying late after a shift to "*get the job done*" and be accountable to patients and other members of their team. One nurse said, "*I collaborated with the girls if there was a problem.*" This sense of group connection and cohesion stemmed from a keen sense of respect for and responsibility to their role as a nurse, to other nurses, and to nursing as a profession. One nurse stated: "*Well, I think that because the first experience I had was working – the first year I worked – was a very positive experience. People were really good at what they did, and the people I worked with had lots of experience, and they were very good to new staff. I think that in itself helps a new nurse, that if you have people to support you that have been around and are willing to do that, I think that's huge.*"

The nurses shared a keen sense of accountability toward their individual patients, patients' families, and other team members. In addition to their commitment to the profession, they described commitments to their employer (i.e., the health care organization that they were working for at the time) and to their community (i.e., where they lived; sometimes the health care sector where they worked). One nurse said that she "*went to community to get compassion back.*" Their stories of ethics in nursing practice described collaborations with diverse stakeholders, such as human resources departments, unions, interpreters/cultural liaisons, hospital ethics committees, administration personnel, psychologists, boards of directors, chaplains, Elders' councils, and physicians. Further, nurse managers who were supportive were described as an invaluable source of leadership and assistance with ethical issues in practice. Good nurse managers could recognize the often invisible work of nurses and patients' unique needs by "*respecting the choices, not judging others.*" There was an unspoken understanding, described as "*knowing each other's cues*" and "*liv[ing] out of each other's pockets.*"

Participants shared their views about different challenges in nursing that they perceived as losses, things that they feared are being lost among today's nurses, and the potential for a negative impact on ethics in nursing practice. They described a sense of loss linked to the concept of fellowship. They shared that the "*soft part [is] missing*" from nursing now. In their recent years leading up to retirement, they described the increased engagement of nurses in harmful gossip, cliques, and selfishness, and being unprepared or unwilling to learn. These retired nurses felt a tangible loss of the valued social and professional connections with other nurses and as members of well-functioning teams. The lack of trust and validation from their nursing colleagues was a contributing factor to the decision to retire. With retirement, their own departure from being nurses and being part of the profession itself was seen as the loss of a treasured piece of their self-identity as a fellow nurse.

Theme 2: Ingenuity

Ingenuity can be defined as the ability to *think cleverly* and problem solve in new ways (37). Therefore, ingenuity was identified in data analysis as a theme found to occur when participants described the need to face ethical issues and ethical decision-making with creativity. They described an ongoing search for the best options and alternatives to meet the needs of patients

in their care. Patients always remained central to their descriptions of ethical practice and quality nursing care, with one nurse stating that "*as long as [we're]…putting patients first, we can't go wrong.*" When these nurses faced ethical situations where there were no clear options or actions, they depended on their own creativity to devise solutions and make the most appropriate decisions at the time. They described examples of finding new ways to solve problems, especially when traditional approaches to situations were not working.

They spoke of the desire to always find a way and to "*think like a nurse.*" Often, they described having little to no formal resources, thus necessitating the need to fight for practical things. This required "*outside of the box*" approaches and sometimes "*bending over backwards*" to support quality patient care. They described that ethics in nursing practice needs to be about more than just complaining about the things that are not right ("*sour grapes*"). They expressed that ethics needs to be about getting the job done as soon as possible by using the resources that are available. Some of the nurses spoke about ethical issues that they had experienced in remote and rural communities where resources were in short supply. They realized that there were limits to what the system could do, and they were painfully aware of limited abilities to provide adequate patient care. However, their belief in the need to deliver health care in equitable ways, even in difficult situations, pushed them to think about solutions to overcome problems. One nurse said:

> I think that it's very wearing when you're not able to do that, and it's very wearing when the system tells you, you can't do that for them, even though you're willing to do it. One of the things that happened… I had another very, very small community, and there was a man who needed something urgently, and I called the nursing station, and I was prepared to get on a Ski Doo and go and help them and was told I couldn't because it was against the rules… and I couldn't go and I had to radio and tell them that I couldn't go…I had to wait for the storm to pass for XXX to bring him in and I had thought – I could've gone. So those kinds of things I think are really hard and build up over time, like when you can't do what you know would be the right thing because the system can't support it.

Therefore, situations that blocked the nurse's ability, to creatively problem solve and respond with ingenuity, were particularly difficult experiences to endure. Participants also described a sense of loss related to changes in the nurse's role and expectations for critical thinking in a complex care environment. They said that the loss (described earlier) that they experienced was not only a change in nurses' behaviours with each other but also related to a change in how often nurses are pulled away from the beside into "*desk-side nursing*" related to administrative duties and electronic health record (EHR) documentation. They commented that the nursing role itself was being transformed into task-based functions devoid of critical thinking or creativity (devoid of ingenuity). More and more, it was becoming just a job. Participants expressed concern that this change was occurring in nursing at a time when relationships, role clarity, and the need for a caring ethical space in health care had never been greater.

Theme 3: Gumption

Gumption can be defined as the ability to choose wisely and to do so with determined energy (38). During data analysis the researchers noted that in addition to the need for creative alternatives, participants mentioned the need for courage and moral astuteness. These circumstances were coded with the theme of gumption. Examples of reflections on practice situations that required gumption included going above and beyond to care for patients whom others did not want to care for, e.g., women receiving elective abortions, persons experiencing homelessness, persons engaged in sex work, preterm babies who were not expected to survive, prisoners, persons who were morbidly obese, mothers with paraplegia. Gumption in these cases involved the requirement of having one's "*heart in the right place.*" Gumption also included opportunities for self-advocacy, such as when the nurses voiced their own conscientious objection(s). Nurses with gumption were described as being "*tough cookies*" who were in dire need during situations that required someone to be outspoken and driven by their values.

One nurse shared her perspective about patients that others may not have wanted to care for:

> The issue of the day was abortion, and they were not used to dealing with people coming in requesting an abortion or whatever. It was a new thing overall, and you were talking the '70s then; so, it was coming out of the '60s into the '70s – quite a new thing that people could have legalized abortions. So, what I found was that most of the nurses didn't want to care for those cases, and so it was a constant struggle when you went into report because there would be at least one or two clients that would fit into that category and everybody was saying, "Well, I don't want that person – I don't want that person." And so, one day, I was getting very stressed out about that – everybody saying they didn't want the patient, but I thought, well, I understand they've got different values than me and they have practices in their life that it conflicts with. So, I just stood up and said – "well, I want everyone to know that I will take those patients – that's fine with me – they need to be cared for – I will take them. So, if I'm working and you're wondering who's going to take that patient, just put that patient on my list." And so, people were kind of shocked. I just know that we are providing this care now in this hospital, and I will not refuse to take care of a patient and I will always take care of them, no matter what.

Gumption was described as growing over time, meaning that upon reflection, the nurses recognized earlier points in their careers when they may have lacked gumption. For this, they expressed regret. For example, one nurse recalled not having

the gumption (at the time) to accept a gift from a patient because receiving gifts was against the rules. This action on her part was wholly offensive to the patient and a painful experience for herself and the patient. She described:

> *He was the sweetest, kindest man and he [inaudible] where I lived with my children and he would see us walking and me walking, pushing the carriage and the kids, etc. So, he knew that I had children and that it was Christmas time and his wife was dying, and he gave me a Christmas card and I said, "Oh, thank you so much," and I opened it, and he had put $25 in it and I said, "I am sorry." I told him how I felt about not being able to accept it because [inaudible]. And he said, "I won't tell and you don't tell, and you buy your children something for Christmas." And I said, "I really can't accept it," and he said, "You have to take it. It's an insult if you don't take it." So, I pretended to take it, and when he wasn't looking, I slipped it under a doily and thought [that] he'll forget. And I came to see his wife the next day – no, it was the next week because I think it was Christmas – and his daughter was there, and she said he told her that I broke his heart. And he would let me look after his wife, but he wouldn't speak to me; and I was so – and it just broke his heart and just that little $25 and going and buying my kids something would've made him the happiest man in the world, and I didn't do it because I thought it was wrong. And so, that's one I regret.*

Participants also commented that there could be serious consequences for displaying gumption. In terms of advocacy for others, even when decisions to act were clearly made with good intentions, there could be repercussions for crossing (sometimes unspoken) boundaries. One nurse shared that her ethical decision-making was an effort against a culture of silence related to assuming risk and potential liability. She would not stand idly by when someone needed her help, despite knowing that potentially overstepping her role could have repercussions. She described:

> *The ethical dilemma for me was hard because then I went to work on the Monday, and I thought I've got to be honest about this. So, I went to my director and told her what I'd done, and she wrote me up for doing something wrong and put it on my file that I had done something wrong. So, then I took that through to the council… and to a special committee and got it taken off my file because they, hearing the entire story, then agreed that there weren't a lot of options left for me and that I was doing my civic duty, not necessarily connected to my job. I was helping someone…That's the way they looked at it. But my boss said I did something very bad.*

Participants described a loss related to the development of a sense of unbalanced gumption. Perhaps as the result of fear and health care organizations (in general) becoming so risk adverse that patients no longer always come first, participants reflected on some nurses' unwillingness to speak up (lacking gumption). Participants increasingly saw the prioritization of money and budgets over people, and the impact this had on decision-making. Gumption was also seen as being employed inappropriately (misguided gumption), with nurses using their power to bully others (e.g., horizontal or lateral violence).

All participants acknowledged the complexity of patient care in contemporary health care settings and spoke only from their unique personal perspectives. Some reflected on their stage of life and how they will increasingly require care themselves, as patients, as they age. They described these experiences as the "*view from the other side of the bed*" (as a patient and formerly as a nurse). This new view caused them to reflect on their past nursing experiences in fresh ways that they may not have had access to when they were younger or while still in clinical practice.

Some of the participants initially questioned whether or not they were even eligible to participate in the study. They revealed that they had been told that they could no longer refer to themselves as nurses because the use of this designation was strictly enforced by their provincial professional college. Feeling that a piece of their core identity had been relinquished (19) and that their hard-won wisdom had been silenced, these individuals expressed a strong desire to share their experiences and to shed light on ethical issues in nursing practice. They were pleased to discuss the "*ethical edges*" of their past nursing practice and even described ethics as "*moment[s] of jeopardy*." They described their participation in the study as a great opportunity to tell their stories and expressed gratitude that their voices had been heard. For these participants, quality patient care was central to their ethical decision-making and actions to address ethical issues in practice.

DISCUSSION

Participants spoke of themselves as nurses in terms of being steadfast members of a group. From a relational perspective, they described that they were able to build good relationships with other nurses and other health care providers and teams. Nurses' loyalties to each other and to the profession is known to add strength to nurses' attention to improving patient care, feeling autonomous, and reaching optimal employment conditions, as well as promoting the best interests of public welfare (39). A keen sense of fidelity seems to have helped these nurses to navigate ethical challenges skillfully and stay in the workplace for many years. Feeling a sense of unity and of being part of a community (e.g., being part of a team, working with people with shared goals and values) may have provided a strong foundation for these nurses to have the courage to creatively respond to ethical challenges, stand up for themselves and others, and speak out against decisions and behaviours with which they did not agree (40).

A sense of fidelity and loyalty, to patients first, sets the stage for the moral courage to address and report unethical situations, speak up, and seek creative ideas and solutions (41). Situations that require moral courage have been categorized in the

literature to include seven key aspects: colleagues, managers, physicians, nurses themselves, patients, patients' relatives, and organizations (40). These groupings also have been identified by nurses as factors that create ethical challenges and require tension-based ethical decisions (41,42). Moral courage helps nurses respond to ethical issues and to act to do the right thing when that choice is not easy and is probably risky (41). Research has found a positive coloration between courage and psychological empowerment among nurses, where courage improves nurses' professional integrity, quality of patient care, and levels of satisfaction and safety (43,44).

Nurses also talked about the challenges and changes among nurses in clinical practice and in the nursing profession itself that were significant to them. These changes represented a shift in the culture of nursing (45). Nurses' feelings about these experiences contributed to their decisions to retire or take or early retirement. This is important not only for retention of nurses, but also for reinforcement of known connections between improved work life (of health care providers) and enhanced patient experience, reduced costs, and improved population health (46).

Gossip and bullying behaviours in the context of employment have been described under the umbrella term of workplace incivility (39). Such phenomena, often attributed to older nurses (e.g., "eating their young") have been correlated with increased workplace stress, low rates of job satisfaction, poor self-esteem, low rates of retention for nurses, burnout, and psychological consequences such as anxiety and depression (39). Ultimately, these consequences result in a poor quality of patient care. With this in mind, it may seem counterintuitive that the nurses would feel the loss of no longer being considered nurses or part of the nursing profession. However, they described a keen sense of identity loss, which has been recognized in other studies (19). Overall, the nurses in this study described being very proud of their nursing careers. Over many decades, they managed to work with other nurses to provide high-quality patient care and they navigated many ethical and moral challenges with creativity and boldness.

It is important to highlight that the retired nurses' ability to recall and reflect, sometimes in great detail, on these complex experiences placed value on these experiences. Memories of ethical issues relevant to their nursing practice with patients, families, members of health care teams, and communities were still very vivid and probably affected them emotionally in a variety of ways. Their ability to remember these ethically and/or morally distressing situations many years later resonates with the concept of moral residue, defined as accumulated and unresolved moral distress (47). Moral distress and its subsequent residue are the result of challenges related to meeting and maintaining commitments to patients and families (48,49). Despite having feelings of loss and distress, the retired nurses in this study continued to see nursing in a positive light, through a lens of opportunity.

LIMITATIONS

The limitations of the study were its small sample size and lack of generalizability of the results. However, the results may stimulate discussion and promote future research to explore the three themes that emerged from the data. Further, participants were asked to recall circumstances and details that occurred many years ago. As such, recall bias may have altered their reflections of the facts across time. Recognition of this potential limitation led the two nurse researchers to focus on the themes of ethical responses more than on the finite details of the individual narratives relevant to particular ethical issues. Finally, although the researchers sought to shed light on these retired nurses' experiences of ethical issues and ethical decision-making across many decades in nursing practice, the researchers also acknowledge that their own nursing experiences and understandings were limited to a much shorter period (i.e., approximately 20 years each in practice). As such, the researchers interpreted the findings through their own lived experiences with the narratives shared by participants and then made connections to the academic literature. The researchers hope that they have honestly and accurately captured the essence not only of the retired nurses' sentiments and concerns but also their strength and wisdom.

RECOMMENDATIONS

Concrete recommendations for next steps include suggestions for nursing practice, education, and research. Participants mentioned the need to more fully integrate clinical nursing practice and academic training to address gaps between textbook ethics (e.g., theory) and ethics in practice (e.g., organizational, clinical, relational). They reflected that the circumstances of loss that they described could be seen as opportunities to create positive change. They encouraged the use of real stories ("*not cookie cutter-style case studies*") as an invaluable means of honouring the memory of a patient or a family and also helping nurses to better navigate challenging ethical issues and decision-making in practice. Specifically, they warned of the gaps between the priorities of managers and administrators, and the priorities of frontline nurses. One nurse said that these reflections made her think of the importance of discussing ethics in practice with nursing students and new graduates as well as encouraging conversations about "*who are we caring for…how are we caring for…what is our responsibility as a professional nurse to care about people.*"

Next steps for research may include a concept analysis of the three themes (i.e., fellowship, ingenuity, and gumption) in follow-up studies to more clearly define these concepts and perhaps develop a framework or model to guide nursing ethics education and/or ethics in nursing practice. Further, this study contributes to a small body of academic literature on ethical issues and ethical decision-making among nurses working in acute care locations in northern Ontario, Canada (42). More studies that address ethical issues in various health care sectors in small communities, and rural or remote locations are needed, particularly to continue to explore the unique relational and multi-layered aspects of health care in these settings (16).

CONCLUSION

This study gave eight retired nurses the opportunity to share their expertise and experiences relevant to the challenges inherent in ethical issues and ethical decision-making. The findings and discussion may be useful to nursing students and nurses currently in practice who are navigating ethical issues and struggling with ethical decision-making. The findings also may serve to validate the feelings and perspectives of other retired nurses, who have felt unheard and/or unrecognized. This study links nursing ethics to the personal moral identity of being a nurse and to being part of a larger whole, as an integrated community of nursing practice.

Participants spoke of retirement in a bittersweet context. On one hand, they felt relief and freedom from the responsibilities of nursing. They no longer felt the pressure of having to strictly adhere to the rules and regulations of a provincial regulatory body. With this new-found freedom they did not fear facing an audit or disciplinary action and chose to speak openly about their ethical concerns. On the other hand, they described deep feelings of grief and loss. In recalling their nursing careers, they acknowledged the many changes that have happened over time. However, they responded with courage. First and foremost, the participants expressed a profound sense of ethical accountability to patients and patients' well-being. They considered this accountability the crux of patient-centred care and a valuable point of reference for ethical navigation and action. The contributions of retired nurses, individually and together, need to continue to be honoured and acknowledged.

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