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THE MORAL ENTERPRISE IN INTENSIVE CARE NURSING

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ABSTRACT

The aims of this thesis were to explore nurses' experiences of stress in the ICU (I), to analyze experiences of moral concerns in intensive care nursing from the perspective of relational ethics (II), to describe the synthesis of the concept of moral stress and to identify preconditions for moral stress (III) and to analyse and describe lived experiences of support in situations characterized by critical care situations and moral stress in intensive care (IV). The design was exploratory and descriptive. Material in studies I, II and IV consisted of interviews with intensive care nurses (10 head nurses and 26 staff nurses) employed in general, thoracic and neonatal intensive care units in five hospitals located in different parts of Sweden. The material in study III data from two studies of professional issues in nursing were used for the analysis: one concerned psychiatric nursing and the other was the previously referred study I. In study I qualitative content analysis and descriptive interpretation was used in the analysis. The main theme 'stress induced by dissonant imperatives' formulated in the analysis. Dissonant imperatives are composed of the four sub-themes: 1) controlled by the working situation – needing to be in control, 2) constrained by prioritisation – wanting to do more, 3) lacking authority to act – knowing that something should be done, and 4) professional distance – interpersonal involvement. In study II qualitative content analysis and descriptive interpretation were used in the analysis. A main theme was formulated, 'caring about-caring for: tensions between moral obligations and work responsibilities in intensive care nursing'. Five sub-themes were formulated 1) believing in a good death, 2) knowing the course of events, 3) feelings of distress, 4) reasoning about the physicians and 5) expressing moral awareness. In the study III a hypothetical-deductive method was used. The findings indicate that moral stress is independent of context-given specific pre-conditions: 1) nurses are morally sensitive to the patient's vulnerability, 2) nurses experience external factors preventing them from doing the best for the patient, and 3) nurses feel that they have no control over the situation. In the study IV an interpretive method was used. The first level of analysis of data identified contextual factors, such as type and purpose of support and working conditions. Thereafter five tentative interpretations were revealed: 1) receiving organised support is a matter of self-determination, 2) whether to participate or to be off duty is experienced mutually as exclusive, 3) dealing with moral stress is experienced as a private matter, 4) colleagues managing moral stress serve as models in stress support, and 5) not being able to deal with moral stress urges one to seek outside support. A comparison of these interpretations identified three major themes: availability, accessibility and receptivity of support. The main interpretation of data was: "lived experience of moral stress support involves an interconnectedness between structural and existential factors". A comprehensive understanding was formulated using the four studies (I, II, III and IV). Moral stress was found to be influential on the caring competence. Conflicts between different competences were found leading to a shift in focus away from the patients leading to a possible decrease in the caring competence. Moreover, the subtle resistance among nurses toward participation in organized moral stress support may obstruct the development of nurses' caring competence. Accordingly, imbalance, due to moral stress, between different competences hinders the development of collectively shared caring competence. Keywords: caring competence, hermeneutics, intensive care nursing, moral stress, qualitative content analysis, stress support.

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ORIGINAL PAPERS

The thesis is based on the following papers, which will be referred to in the text by their Roman numerals:

- I** Cronqvist A, Burns T, Theorell T, Lützén K. Dissonant imperatives in nursing: a conceptualisation of stress in intensive care in Sweden. *Intensive and Critical Care Nursing* 2001; 17: 228-36.
- II** Cronqvist A, Burns T, Theorell T, Lützén K. Caring about-caring for: tensions between moral obligation and work responsibilities in intensive care nursing. *Nursing Ethics* 2004; 11(1): 63-76.
- III** Lützén K, Cronqvist A, Magnusson A, Andersson L. Moral stress: synthesis of a concept. *Nursing Ethics* 2003; 10(3): 312-22.
- IV** Cronqvist A, Lützén K, Nyström M. Nurses' lived experience of moral stress support in the intensive care. In manuscript.

The papers have been reprinted with kind permission of the respective journals.

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INTRODUCTION

This thesis concerns nursing practice in intensive care. In this practice nurse's care but "caring is not unique to nursing, but unique in nursing" (Tschudin 2003, p 1). In this thesis, nursing care is viewed as a process of interaction and co-operation aiming at helping individuals, families and groups to identify and handle their present and potential health and illness related problems, to identify and promote their own health resources, to provide for their daily needs and to support as "good" a life as possible

The topic of this thesis concerns the knowledge of intensive care nurses' moral reasoning as reflected in their day-to-day work. This branch of ethics is called empirical ethics, or more precisely descriptive ethics, and is not grounded in the ethical theories commonly known as normative ethics. Empirical ethics comprises human moral experiences as reflected on in a naturalistic context and does not attempt to unravel a single universally valid standard of conduct (Mandelbaum 1955).

My interest in this research area is a result of my long experience of working in coronary care units both as a staff nurse and as a head nurse during the 1980s and 1990s. During the 1980s there were possibilities to increase the number of staff in favour to less scheduled weekends at work. The working situation was altered during the 1990s determined by financial cutbacks. This clinical experience gave me an insight into the structural problems that were predominant. Discussions about stress due to these economic cutbacks were constantly on the agenda.

Thus, I became interested in gaining an understanding of stress in intensive care nursing, which led me to conduct my first study in this thesis. During the first phase of the research process it became apparent that stress had to do with moral concerns, and later on in the process the question of support came into focus.

BACKGROUND

INTENSIVE CARE

The environment of today's intensive care units is characterised by advanced life-sustaining technology that not only saves lives but also creates a rapid working tempo and the need for immediate decisions that invariably have ethical implications.

Since the introduction of artificial respiration - one of the important technological and medical landmarks of the 1960's - intensive care rapidly became more advanced in Sweden as well as internationally. Initially, a specific number of beds for this type of intensive care were allocated to regular wards on an experimental basis. This "hospital-in hospital" was staffed by physicians and nurses with specific knowledge of ventilation support and body fluids, as well as laboratory technicians. The experiment was successful in several hospitals and subsequently, a single ward was converted into a larger intensive care unit. In its early days the intensive care unit dealt with a wide range of conditions including major trauma, severe acute asthma, acute myocardial infarction, and drug overdoses, all with the same goal - to save lives.

With the advance of medical knowledge and technological innovations, specialised intensive care units became necessary. The larger hospitals structured the intensive care unit into surgical and medical intensive care departments. Other hospitals began with coronary and thoracic intensive care, each with its own admission policy. Mortality rates decreased radically, resulting in the need to allocate financial resources to ensure that all hospitals had intensive care units. Initially, anaesthesiology and intensive care education for physicians and nurses was voluntary, but mandatory education eventually became a necessity.

The years of pioneering work, the successful introduction of epoch-making medical treatment, and accordingly the saving of many lives in intensive care are a sharp contrast to the global cutbacks in hospital budgets during the 1990's (Armstrong-Stassen et al. 1996; Lineweaver et al. 1999; Rodney & Varcoe 2001; Hertting & Theorell 2002; Brown et al. 2003). As a consequence, staff cutbacks and the decrease in number of hospital beds in hospitals were essential cost cutting measures although the volume of care was the same (The Swedish Federation of County Councils 2002; Dunnigan & Pollock 2003). The organisational downsizing has mainly caused a reduction in staff numbers at lower levels, such as assistant nurses and support staff. Another measure to minimise costs was to encourage full-time employees to work part-

time. Further, the shortage of intensive care nurses has been an important issue for those organizing intensive care as the shortage adds on to the already strained situation (Bunch 2002; Rosenstein 2002; National Board of Health and Welfare 2002; Wainwright 2002; Binnekade et al. 2003).

The risks associated with the reduction in the number of nurses caring for critically ill patients are of paramount interest. Although causality is not studied, associations between diminished nursing resources and an increase in catheter related infections (Fridkin et al. 1996; Robert et al. 2000), post operative complications, such as post abdominal aortic aneurysm repair (Provonost et al. 2001; Dang et al. 2002), post hepatectomy (Dimick et al. 2001), and finally, post oesophagectomy (Amarvardi et al. 2000) have been found. Reduction in the number of intensive care nurses leads to an increase in workload and may therefore be a risk factor when evaluating an increase in mortality (Tarnow-Mordi et al. 2000).

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Intensive care nursing is a highly complex area of practice comprising both basic nursing care and “care” of technology. Benner et al. (1999) defined intensive care nursing practice and pointed out several important domains. First, an overarching domain - ‘to have clinical forethought’, meaning anticipating and preventing potential problems - is ever present. Secondly, nurses diagnose and manage life-sustaining physiological functions in patients with unstable conditions while providing comfort for the families of the critically ill. Thirdly, nurses are faced with an ongoing and complicated decision-making process pertaining to death and end-of-life care, which includes assessing and organising a reasonable level of care. This activity challenges their skills of communication and negotiation. A fourth domain is the skills of “know-how” of managing crisis, particularly important when physicians are not available. Fifth domain concerns preventing occupational hazards in the technological environment and ensuring the quality of monitoring, this is also an essential part of practice. Finally, providing clinical leadership in order to coach and mentor others, thus stimulating their professional growth, completes the list of domains in describing intensive care nursing practice. In conclusion, this list of domains shows that intensive care nurses perform a large number of tasks. Walters’ (1995a) study of intensive care nursing illuminates nurses’ complex working situation using two themes: ‘being busy’ and ‘balancing’. Being busy recognises the fact that these nurses concentrate on the

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important technical aspects of intensive care and the rapid pace of their work. Balancing refers to nurses' manoeuvres to simultaneously meet patients' emotional needs while at the same time managing the advanced technology. There is reason to believe that under these circumstances nurses working in intensive care units experience feelings of stress.

Critically ill patients' situation, as faced by the intensive care nurse, can be described in terms of being in an extreme physical and emotional dependency (McKinley et al. 2002). Several factors contribute to the patients' physical and emotional vulnerability, for example, difficulties in communicating needs (Bergbom-Engberg & Haljamäe 1988, 1993; McKinley et al. 2002; Simons & Roberson 2002) and lack of sleep and rest (Holland et al. 1997; Fontes Pinto Novaes et al. 1999; McKinley et al. 2002). Furthermore, intensive care nurses also have to meet the families' needs; the need for immediate information and "to be near" the critically ill patient (Walters 1995b; Wesson 1997, 1998; Bijttebier et al. 2001).

STUDIES OF STRESS IN INTENSIVE CARE NURSING

Almost four decades ago, Menzies (1960) brought forth the idea that stress is an inherent characteristic of the nursing profession. Many nursing assignments are by ordinary standards described as "disgusting, distasteful and frightening" that lead to feelings of "worry, guilt, depression and strain" (ob.cit.). This notion of stress was also emphasized by Gunning (1983), who suggested that stress in nursing is composed of two tensions within the discipline. One tension is described as 'ideological ambivalence', i.e. the lack of consensus among nurses on important professional issues, while the other is the discrepancy between what nurses believe nursing should be and what actually exists in the practice of nursing.

In empirical studies on stress in nursing during the 1970s several factors contributing to stress were identified. For example, stress in general intensive care units seemed to be related to interpersonal communication problems, need for (or lack of) an extensive knowledge base, the ICU environment itself and the requirements of patient care (Huckabay & Jagla 1979; Bailey et al. 1980). When intensive care nurses in an American study were asked to rank the most stressful to the least stressful nursing activities the five most stressful areas were 1) sudden death or relapse, 2) understaffing and overwork, 3) nurse-physician problems, 4) insecurity about knowledge and competence and, finally, 5) shock and impact of sights and smells (Jacobsson 1983).

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In the 1990s research reporting of intensive care nurses' stress was sparse. The studies identified referred to previously described domains, but the stressors presented were related to the organisational pressures of the ICUs environment rather than those involved in caring for critically ill patients (Adomat & Killingworth 1994). During this decade, an addition to the list of stressors as perceived by intensive care nurses was the theme "unnecessary prolongation of life", which was judged to be the second most stressful event after the death of a child, indicating that an ethical dimension had entered the stress arena (Lally & Pearce 1996).

The impact of occupational stress on intensive care nurses' health has not yet been sufficiently explored. In a study of Swedish nurses (n=3500) (Pettersson et al. 1995a, 1995b), it was found that most of the respondents were satisfied with their job while 50% reported that they were so tired after work that they did not want to socialise with their family. However, in that particular study, there were no findings concerning stress in relation to nurses working in the intensive care units.

High stress levels in intensive care nursing is reported by Cartledge (2001) to be the most dominant factor when nurses choose to leave their jobs. Moreover, it was reported in a study of 1973 paediatric critical care nurses in United States and Canada (Bratt et al. 2000) that work related stress is a highly influential variable for job satisfaction, including for example satisfaction with professional status and pay, enjoyment of work and time to do the job.

INTENSIVE CARE AS A MORAL ENTERPRISE

Advanced medical technology creates situations that challenge health care professionals' attitudes towards life and death. In critical care, some of the most significant challenges are, care of patients in prolonged comas sustained by life-support systems, the maintenance of brain-dead organ donors, longer survival of premature or very low weight infants at risk of neurological deficiencies, and the possibility of applying aggressive medical treatment to resuscitate terminally ill patients (i.e. Machado 1996; Araújo Sadala & Berti Mendes 2000; Faber-Langendoen & Lancken 2000; Shotton 2000; Provonost & Angus 2001; Puntillo et al. 2001). In these settings, such as in general and specialised intensive care units, physicians and nurses in charge must take decisions in highly uncertain situations.

According to Baker a situation is viewed as moral when it is clear that the behavior of one individual will affect the well-being of someone else (Baker 1987). Ethical

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decisions in intensive care always concern the well-being of the patients. Thereby it is understood that intensive care is a moral enterprise. Furthermore, the term moral can be described as having conflicting constituents in itself. Moral refers to what you can do (or do) and what you should do, not necessarily compatible with each other. Haan (1989) states that “morality is almost always conflictual”, that is, one’s own interest can be opposed to the others’ interest. Ethical decision-making in intensive care is described as a process (Svantesson et al. 2003) to achieve consensus (Melia 2001; Bunch 2002) and involves skills in communication (Benner et al. 1996, p 300; Fins & Solomon 2001) and the time needed in the clarifying of the clinical picture (Bunch 2000, 2002).

Earlier studies have focused on these ethical situations from a problematic perspective, implying that such situations are always prone to be difficult or conflictual in nature (Söderberg 1999; Bunch 2001; Sørli 2001). A predetermined definition of the term “ethical difficulty” was for example, used as a focus in the studies by Söderberg (1999) and Sørli (2001). There is no consensus if a moral problem is equal to an ethical dilemma. There is support for the standpoint that they are identical (Georges & Grypdonck 2002) as well as opposing evidence suggesting that a problem can be solved while a dilemma cannot, as a dilemma consists of a choice between two equally difficult, or bad, alternatives (Tschudin 2003, p 109). Furthermore, from a nurse’s perspective a moral problem has been described as a conflict between one’s own values and those of others based on one’s own judgment and intuitive feeling (Leners & Beardslee 1997; van der Arend & van der Hurk 1999).

PROBLEM AREA

The literature thus reveals that intensive care units are characterised by heavy workloads, increasing work complexity and ethical concerns related to life and death decisions. Due to the successful treatment of previous untreatable diseases, patients survive at an older age with a more complex health status. Furthermore, intensive care units are confronted by new types of diseases, for example, AIDS (acquired immunodeficiency syndrome), and by the advances in organ transplantation methods, which challenge nursing knowledge and resources. In addition, cost cutting and restructuring activities restrict the resources available to staff while the shortage of intensive care nurses places a heavy burden on those nurses remaining in their jobs.

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Prioritising patient care when understaffed, performing activities for which adequate knowledge and skills are lacking, and conflicts concerning life-sustaining interventions are some examples of moral concerns that may be stressful for nurses. It is thus reasonable to assume a relationship between stress and moral concerns. If that is the case, there is also a need for efficient support related to such situations. Therefore, this thesis addresses the issues of stress, moral concerns and support in that order and the aims, in the following section, will have the same order.

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AIMS OF THE THESIS

The overall aim of this thesis was to analyze and describe experiences of stress, ethical concerns and support in critical care situations in intensive care nursing.

The specific aims of the four studies were

- I** To explore nurses' experiences of stress in the ICU.
- II** To analyze experiences of moral concerns in intensive care nursing from the perspective of relational ethics.
- III** To describe the synthesis of the concept of moral stress and to identify preconditions for moral stress.
- IV** To analyse and describe lived experiences of support in situations characterized by critical care situations and moral stress in intensive care nursing.

OUTLINE OF THE RESEARCH APPROACH

The aims of this study and the type of knowledge related to these aims were considered to require a human science research approach. That which distinguishes a human science approach from other research approaches is the focus on understanding individual experiences and their meaning. The lived experience includes values, feelings, emotions and actions while a human research approach involves description, interpretation and critical analysis (Gadamer 1997). Gaining knowledge of lived experiences is a way of understanding the structures of the meanings of these experiences rather than merely formulating a theory to explain them. The ambition in this thesis was to understand intensive care nurses' lived experiences of stress and moral concerns in the intensive care unit (studies **I** and **II**) and the phenomenon of "support in situations of moral stress" (study **IV**). In study **III** a synthesis of the concept of moral stress was obtained by a comparative analysis of data from two different caring contexts.

The goal of this thesis has thus been to understand intensive care nurses' expressions of stress, ethical concerns and support.

EPISTEMOLOGICAL PERSPECTIVES

Epistemology, as it is used in this thesis, refers to theories of knowledge and specifically how this knowledge is gained (Powers & Knapp 1995, p 51). The epistemological perspectives in this thesis are based on the assumption that humans' lived experience constitutes knowledge. Furthermore, it is presupposed that humans have a fundamental interest in understanding what goes on in the world around them, that is, she/he searches for meanings attached to life.

Openness as an epistemological perspective

The epistemological perspective applied in studies **I**, **II** and **IV** was characterised by openness to a varying degree. In the first empirical study (study **I**) a qualitative content analysis was used and the theoretical guides for analysis were chosen before the analysis process began. In this study the principle of openness was applied to the data collection. The second empirical study (study **II**) was also, to some extent, supported by theory, but the theoretical tool was introduced at a later stage of the analysis. In this

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study the principle of openness was thus applied during both data collection and analysis of data. The third empirical study (study **IV**) was guided by the attempt to interpret lived experiences as openly as possible. Theoretical ideas were not used, and the entire research process was characterised by the principle of openness. As a consequence of the increased openness in the process of analyzing empirical data in this thesis, the epistemology of openness, as described by the German philosopher Hans-George Gadamer (1997), was focused on, in parallel with an awareness of the importance of what Gadamer calls “the otherness” in the data. In *Truth and Method*, Gadamer (1997) makes clear that an interpreter must “be aware of one’s bias so that the text (i.e. the data, author’s comment) can represent itself in all its otherness and thus assert its own truth against one’s own fore-meanings” (ob. cit., p 269).

According to Dahlberg et al. (2001), openness as an empirical research approach is made up of two basic components. The first consists of concentrating on the “thing” being studied while the second is sensitivity to the “thing”. This means that the researcher must be open to lived experiences. Instead of accepting the validity of theories, or indeed any given perspective, we as researchers must try to do justice to the object of examination, “that is, we try to be clear about what it means to be open and sensitive in approaching the phenomenon” (ob. cit., p 97).

Gadamer (1997) describes openness as a wish to see, a wish to understand something in a new way. He holds that openness and sensitivity towards the phenomena being studied is a methodological principle. However, Gadamer warns against believing that method implies “following a marked route”. Thus, according to Gadamer, every research question demands new methodological considerations.

Absolute objectivity, however desirable, is nevertheless an unreachable goal. Researchers, as well as other human beings, have pre-understandings that are the inescapable contexts of their research (Dahlberg et al. 2001). Gadamer (1997) talks about comprehending the pre-understanding and its inherent “history of effect” (ob. cit., p 300) that precedes everything that we try to understand. He declares that pre-understanding, as fore-meaning or prejudice, is an intentional structure which comes into play when we regard something *as* something. Nevertheless, our need to become aware of this is vital “because it is necessary for scientific consciousness” (ob. cit, p 301).

It is thus fair to assume that every researcher’s pre-understanding has a major influence on both data collection and data analysis. The assumption that pre-

understanding affects understanding, and accordingly the interpretations made in data analysis, complicates the issue of how to deal with pre-understanding so that it does not negatively influence the findings. Hence, if one does not recognise one's pre-understanding as such, there is a risk that one will fail to understand or will misjudge the meaning of data in empirical studies.

But there is also another aspect of this research problem. A researcher's clinical experience of the research phenomenon can, for example, contribute to a more developed understanding and accordingly facilitate the presentation of the findings (Thorne et al. 1997). Moreover, in the interview situation, pre-understanding may serve as a "bridge" between interviewer and interviewee, creating an atmosphere of understanding and stimulating reflection. But, in line with Gadamer's perspective on pre-understanding both as a necessity for understanding and as a problem in research, the "bridge" can also lead to the unfolding of tacit knowledge. As a consequence of shared familiarity with the studied situation, the interviewees may withhold information due to the belief that they have nothing relevant to add that is not already known by the interviewer.

According to Fleming et al. (2003), "researchers underpinning their work with the philosophy of Gadamer are required to identify their pre-understandings or prejudices of the topic. Reflecting upon these will enable them to move beyond their pre-understandings to understand the phenomenon and so transcend their horizon".

Measures were thus taken during the research process to counteract possible research biases due to pre-understanding. Firstly, prior to each interview, the interviewer (AC) stressed that the interviewee would be given time to reflect and that she/he should disregard the interviewer's own experiences as a nurse. Secondly, regular discussions about possible meanings in the data were held among the research team, and efforts were made to find what Gadamer (1997) calls "the otherness" of the research phenomenon. In this process pre-understanding was called into question many times during the analysis.

Verification of hypothesis

One study (III) was, however, guided by other principles. A hypothetical-deductive approach, applied to describe meanings in the data (interview texts) was employed for the synthesis of the concept of "moral stress". In this study the principle of openness was replaced by efforts to verify a hypothesis.

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The formulation of the hypothetical-deductive approach in study **III** was borrowed from the philosophical work on hypothetical-deductive methods by the Norwegian professor Dagfinn Føllesdal and co-workers (Føllesdal et al. 1993). They describe the application of the method to areas such as natural science, historical research and interpretation of literature. Although the description of the hypothetical method does not explicitly discuss its relevance for studies within the realm of health care science, the method proved suitable due to the fact that data in study **III** consisted of meaning-carrying text. Føllesdal et al. describe the applicability of the hypothetical-deductive method in terms of texts, works of art and actions (ob. cit., p 135).

Deduction means to infer from what has preceded and thereby draws on previous knowledge in order to extract new knowledge, as is the case in deductive theory (Morse & Field 2002, p 6, p 198). Prior to deduction, hypotheses are constructed by reasoning and form steps in the logical inference process. These hypotheses are generated from the researcher's knowledge, from other researchers' works and from the intuitive knowledge of the area under study. The hypotheses are then tested or verified by applying them to data (interviews in study **III**) not necessarily originally collected for that purpose (Føllesdal et al. 1993). This interpretation process will provide substance for the next step in the analysis where conclusions are drawn. Conclusions can be articulated as one or several new hypotheses but can also be presented as preconditions, as in study **III**. According to Føllesdal et al., the preconditions should include some overlapping aspects of the consequences of the original hypothesis (ob. cit., p 117).

Approaches to ethical inquiry of relevance of this thesis

Traditional ethics is usually classified according to focus of inquiry, the method of inquiry, theory, and principles. The terms, or labels, used to distinguish the different levels of investigation are; normative ethic, descriptive and meta-ethics. Although these levels interact in applied ethics, it is necessary to make a distinction between these, (when the research focus is on practice) because there is a considerable difference between the questions raised; "what ought to be" "what is" and "why".

Normative ethics examines norms or standards and defend a system of principles and rules that should be used to determine what actions are right or wrong (ought to be). The International Code of Nursing Ethics (Fry & Johnstone 2002) is an example of the application of normative ethics in a practice discipline. Non-normative ethics, i.e., descriptive and meta-ethics do not claim to determine what ought to be, but instead,

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endeavour to describe what persons actually do. Descriptive ethics investigates and explains the moral phenomena (“what is”), for example, moral reasoning or moral action. Characteristically, meta-ethics analyses moral language and concepts used and the logical arguments to defend positions. Meta-ethics adopts a stance of “new discovery” because the analysis is an attempt to transcend previous theories.

There are two main epistemological approaches to investigate human morality, the moral philosophical approach and the empirical approach. The common method of moral philosophical inquiry is the use of arguments in making moral judgements. The epistemological position is that what is morally right must be defended by sound and logical arguments. One type of argument used, which is relevant for health care professionals, is the “appeal to authority”. Authority can either be an institution, person or a hypothetical person such as the “patient” (Ladd 1978). The type of arguments can be distinguished by the ethical theory used, for example, utilitarianism and the principles within the theory (Beauchamp & Childress 2001). In nursing, for example, the principles of autonomy, justice, beneficence and benevolence are “universal” guides for ethical decision making but contextual in that they are applied in different ways in a given situation (Fry & Johnstone 2002)

The empirical approach in nursing ethics research is relative new in relationship to moral philosophy. Cited in “Ethics in Nursing Practice” (Fry & Johnstone 2002) the first recorded nursing ethics research study was from 1935, in which an analysis of nurses’ ethical problems encountered over a three-month period revealed 110 questions about ethical behaviour. However, nursing ethics research did not begin to publish results until the beginning of the 1980s. The most common focus for research was moral development, moral reasoning, and moral decision making in nursing practice (see for example, Ketefian & Omond 1988). Of interest was how nurses perceive ethical problems in practice. The empirical method of research during this time period falls within the framework of normative ethics, data-collection was often based on nurses’ responses to hypothetical situations and analysed according to a specific theory of ethics. These responses were often given a numerical value in order to indicate different levels of moral cognition and behaviour as well as differences between professional groups.

More recently, nursing ethics research seems to have shifted both its focus for investigation and its methodology. This type of ethics research explores the basic moral norms within nursing practice by a critical and careful examination of moral

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arguments (Jametown & Fowler 1989). Several studies, especially from the European countries, show an increased interest in understanding ethics in nursing practice with a focus on nurses' experience of ethical problems (Söderberg 1999; Sørli 2001). The designs of these studies are predominantly inductive and descriptive, since the ambition is to understand questions concerning "what is". Consequently, qualitative methods of data-collection and analysis are used to describe and understand the experiential aspect ethics in nursing. A hermeneutical approach raises the investigation to a meta-analysis level.

The epistemological approach to ethical inquiry in this thesis was developed from the aim, i.e. exploring moral concerns in the intensive care unit from the perspective of intensive care nurses. In that sense, the epistemological interest was oriented towards how these nurses experience, reflect and reason about their experiences and what meanings they attach to their experiences. The main moral phenomena in focus were critical care situations that the nurses themselves identified containing a moral constituent.¹

A philosophical approach that takes humans' experiences into consideration in ethical inquiry (Mandelbaum 1955) seemed appropriate because the aim was to be as close to the lived experiences (of the participants) as possible. Consistent with descriptive ethical inquiry, the application of a predetermined theory would interfere with this aim (Tschudin 2003, p 45; Holm 1997, p 23). Another rationale to this approach is the view that ethical judgements do not occur in a vacuum. They are influenced by attitudes in society and by the general social environment in which individual health care professionals live and by the organizational features of the health care institutions in which they are employed (Holm 1997). Thus, many of the moral issues faced by intensive care nurses are not specific isolated events, for example an extraordinary medical case, but permanent features of the relationships and structures within which nurses, patients and co-workers exist (Reed & Ground 1997, p 95).

¹ The terminology in the field of ethics is somewhat confusing. In the literature the terms ethics and moral are often used interchangeably. 'Ethics' comes from the Greek word *ethos* meaning character while the term 'moral' comes from the Latin word *moralis* meaning custom or manner. In day-to-day language or in the literature there is no firm distinction between the two. Thus, to refer to the term *ethical* on a theoretical level in relation to principles and theories and the term *moral* as the manifestation of what is right and wrong, good and bad, on a practical or action level is an oversimplification. Accordingly, in this thesis the two terms, ethic and moral are used interchangeably.

METHODS

Research Context and participants in studies I, II and IV

The participants in the project were employed in general, thoracic and neonatal intensive care units in five hospitals located in different parts of Sweden. High technology, intensive work pace, limited budgets and frequent reorganisations of the care structure were common features of these contexts. At the time of the study all intensive care units were filled beyond their capacity, and the shortage of specially trained and experienced intensive care nurses further aggravated this strained work situation. As a consequence, newly employed and inexperienced nurses were often required to take full responsibility for decisions and carry out tasks at an early stage of their training before they had sufficient training.

Ten head nurses representing ten intensive care units in Sweden were contacted by telephone and asked to participate in the study. In accordance with purposeful sampling, an attempt was made to select participants from as many different ICUs as possible in order to obtain variation in working experience (Sandelowski 1995, Denzin 1994, p 230, 441).² The head nurses were also asked if they could provide contact with staff nurses who might also be willing to participate. The participants were given oral and written information about the purpose of the study, a guarantee of confidentiality during the analysis, and anonymity in the publication of data. In turn, the participants gave their informed consent. All 36 nurses agreed to participate. The participating nurses' main area and position at the time of the study are presented in Table 1. Their years of experience as nurses and experience in their actual position at the specific ICU are presented in Table 2. A majority of the nurses were female, only two were male. The nurses' years of experience varied from 1 to 32 years. All nurses at the general intensive care units and thoracic intensive care unit had a specialisation (formal competence) in intensive care. Similarly, almost all nurses at the neonatal intensive care units had specialisation (formal competence) in paediatric care.

² This methodological approach strives for variation in the research phenomenon, which has significance for the applicability of the findings. This methodological approach does not allow comparisons between contexts, which require other research designs.

Table 1. Principal area and position of the respondents ($n=36$).

	Head nurse	Staff nurse day shift	Staff nurse night shift
ICU	7	13	4
THICU	1	2	1
NEON	2	3	3

Abbreviations: ICU, general intensive care unit; THICU, thoracic intensive care unit; NEON, neonatal intensive care unit.

Table 2. Staff nurses' and head nurses' professional experience.

	Mean (SD)	Median
Staff nurses ($n=26$)		
Years since basic nursing training	11.5 (± 7.9)	10
Years in present unit	6.5 (± 5.8)	4.5
Head nurses ($n=10$)		
Years since basic nursing training	25 (± 6.1)	25
Years in present position	13.2 (± 2.6)	14.5

Data Collection

Interviews

Qualitative research interviews with 36 nurses have been used as data in studies **I**, **II** and **IV**. The purpose of such interviews is to gain access to the day-to-day experiences from the subjects' own perspective (Kvale 1996, p 27). The interviews were characterised by openness as well as willingness to listen, to see and openly understand the lived experiences of the interviewees (Dahlberg et al. 2001). Hence, data consisted of descriptions of specific situations, not general opinions.

The opening question, which was: "Can you tell me about your working situation at this ICU?" was intended to guide the interviewee's thoughts in the direction of the

areas of particular interest in studies **I**, **II** and **IV**. After the initial question, areas corresponding to the research questions in studies **I**, **II** and **IV** were addressed, after which the researcher introduced further questions in order to obtain descriptions of lived experiences of critical care situations pertaining to stress (**I**), ethical concerns (**II**) and experiences of support (**IV**). Having posed the questions, the interviewer handed over the initiative to the respondent and followed his/her responses in an open-minded way. At this stage of the interview process, further questions aimed at clarification, such as “can you give me an example?” or “can you describe this in greater detail?” were put to the participants.

Each interview lasted between 40 and 90 minutes and was conducted immediately before or after work. Most interviews took place in a private room adjacent to the ICU, two were conducted in a university office and two in the respondent’s home, in line with his/her wishes. All interviews were audio-taped and transcribed verbatim.

The recorded interviews were listened to prior to each analysis. This approach is supported by conversation analysts, who recommend that recordings should be listened to repeatedly, in order to enrich the analysis process and avoid being limited by the original transcript (Silverman 2003, p 353). Kvale (1996, p 27) states that both the written text and the tape-recording constitute data for interpretation. Listening to the recording several times leads to the impression of reliving the interview and makes the listener more aware of the respondent’s tone of voice, pauses etc, thus the responses may take on a deeper meaning.

Material in study III

In study **III** qualitative data collected for the purpose of this thesis (study **I**) was compared with data collected in a similar study of moral concerns, as experienced in psychiatric nursing (Magnusson and Lützén 1999). The findings from study **I** in this thesis are presented more specifically on page 28 (Summary of findings) and briefly presented here. This study aimed to conceptualise stress within the context of intensive care nursing. The main theme ‘stress induced by dissonant imperatives’ was the overarching concept formulated in the analysis. Dissonant imperatives comprises four sub-themes: 1) controlled by the working situation – needing to be in control, 2) constrained by prioritisation – wanting to do more, 3) lacking authority to act – knowing that something should be done, and 4) professional distance – interpersonal involvement. The study of psychiatric nursing aimed to identify and analyse the ethical

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problems involved in providing home care to patients with long-term mental illness (ob. cit.). Data consisted of focus group interviews with nurses who worked with and thus had experience of such patients. The findings revealed that the nurses often experienced themselves as intruders in the patient's home. Unsure of being welcome in the patient's home on the one hand, and their professional obligation to provide care on the other were contradictory aspects for this group of nurses in their provision of home care. The nurses often had to invent their own strategies for handling the situation, while standing outside the patient's locked door. The main theme formulated was 'intrusion into patient privacy', which describes nurses' moral sensitivity to conflicting ethical and professional implications. Sub-themes were 'intruding in the home of the patient', 'experiencing fluctuating boundaries', 'respecting or transgressing the right to privacy', and 'situating mutual vulnerability'. In both studies raw data, main themes and sub-themes were used for this analysis.

Analyses

Qualitative content analysis

Content analysis, when it first appeared in the 1950s, was used as a quantitative measure by sociologists to study people by extracting patterns, order, sense, and the meanings attached to life experiences from written materials (Berelson 1952; Manning & Cullum-Swan 1994, p 464). The analytic tool was to count the specific constituents of the content, and the process ended when numerical results were presented.

In 1982 Fox presented two levels of content analysis: manifest and latent (Fox 1982). The analysis was also rooted in the realm of the quantitative tradition, based on counts, and scientific rigor was mainly discussed in terms of inter-rater reliability, face and concurrent validity. At the manifest level the analysis was "a direct transcription of the response in terms of some coding" and at the latent level the researcher tried to interpret what is implied or meant (Fox 1982). This was however conducted without epistemological reflections. Fox emphasised that, in latent level analysis, several different types of coding could be relevant, depending on the researcher's personal perception of the research situation and problem area. Without epistemological reflection there could be no discussion about the similarities to pre-understanding. Additional criteria, namely homogeneous, inclusive, useful, and mutually exclusive categories, were proposed in order to enhance the validity and reliability of the coding.

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Morgan (1993) described a shift from quantitative to qualitative content analysis although the analysis was still based on counts. Quantitative content analysis seeks to answer questions about what and how many, while qualitative content analysis addresses why and how the patterns came into being. Furthermore, Morgan claims that the goal of qualitative content analysis is to unravel patterns and interpret the reason for them, not unlike the grounded theory approach (ob. cit.).³

In 1995 Berg, an American sociologist, put forward a claim that one of the main purposes of qualitative content analysis is to produce a grounded theory (Berg 1995, 2004). Berg's perspective on the methodology of grounded theory is based on the work of Glaser and Strauss (Glaser and Strauss 1967; Strauss 1987, 1990) and consequently on the symbolic interactionism perspective, as articulated by Blumer (1969).

Due to its flexible methodology, qualitative content analysis offers many advantages for nursing research, as highlighted by two nurse researchers, Downe-Wamboldt (1992) and Cavanagh (1997). They emphasise that the goal of qualitative content analysis is to enhance the quality of the analysis by relating the categories found to the (nursing) context studied. A prerequisite of the qualitative approach is that the categories constructed should be mutually exclusive due to the statistical procedures required. Furthermore, they claim that qualitative content analysis can lead to hypothesis testing and theory development.

In conclusion, the theoretical/philosophical orientation of qualitative content analysis originated in the positivistic tradition. As the method developed over the course of two decades, researchers emphasised issues of meaning and interpretation, and it has thereby become essential to include epistemological reflections relating to the interpretations in order to increase the validity of findings. As these principles have been adhered to in this thesis, the analysis moved beyond the 'ordinary' qualitative content analysis.

Studies I, II and IV

Data consisted of both detailed and short answers from the thematically designed interviews. In study **I** all data (complete interviews) was used in the analysis, since it became apparent, by listening to the interviews, that the phenomenon of stress

³ Grounded theory is a methodology for an inductively generated theory based on a constant comparative method (see for example Glaser and Strauss 1967; Strauss 1987, 1990).

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permeated the entire material. In view of the fact that the interviews covered several domains it was necessary in study **II** (and also in study **IV**) to identify relevant passages, guided by the research questions, which subsequently constituted the data for further analysis.

The qualitative content analysis used in studies **I** and **II** and, in particular, the coding process in this thesis was guided by Berg (1995) and Coffey and Atkinson (1996). The overall analysis process was influenced by Thorne et al.'s (1997) interpretive approach. Thorne et al. (1997) recognised that clinical knowledge and formal research conducted in a defined area are both valuable as a foundational fore-structure for a new inquiry in nursing research. Moreover, strategic immersion in the field studied is beneficial during the coding phase of the analysis when classifying and creating linkages, as it facilitates the generation of sound knowledge that is relevant to practice. Predetermined strategies, for example pre-determined codes, should be avoided in order not to inhibit the analysis process.

Coding is described by Coffey and Atkinson (1996) as an analytic strategy and a heuristic device, and three main procedures are emphasised: 1) identification of relevant phenomena (carried out by means of listening to the tape-recordings in studies **I** and **II**), 2) collecting examples of those phenomena (in studies **I** and **II** coding of the transcribed text units), and 3) analysing these in order to find commonalities, differences, patterns or structures.

The final level in the content analysis process conducted in this thesis concerns how to reach a theoretical understanding. This final level constitutes the highest abstract level in the analysis.

In studies **I** and **II** qualitative content analysis was used to analyse the data obtained from the interviews. Similarities between the analysis processes in both studies were that the analyses were performed in different steps and described by means of several levels. The labelling of data at the different levels is presented as sub-themes and main themes although the main themes are end products (see Table 4, p 28). The labelling of sub-themes is "experience near", which implies a close relationship to the experience described, whereas the main themes are less concrete, indicating a higher level of abstraction and interpretation.

In study **IV** the analysis was also performed and described in different steps, resulting in tentative interpretations, comparative analysis and main interpretation.

Tentative interpretations are “experience near” while the main interpretation constitutes a more abstract level.

Interpretations

In qualitative research, questions about interpretations are considered hermeneutical questions. Hermeneutics is, however, not a unified tradition, and it is referred to in the plural form by Palmer (1969), who asserts that hermeneutics is a philosophy of understanding that includes different approaches and conflicting perspectives. In the present thesis, the tradition of treating hermeneutics as a systematic method of interpretation (Føllesdal et al. 1993 p. 133) has been used in study **III**, while the perspective of seeing hermeneutics as the art of understanding lived experiences (Dahlberg et al. 2001; Fleming et al. 2003) has been used in studies **I**, **II** and **IV**.

In the third study (**III**), a hypothetical-deductive approach to the interpretation of meaning (Føllesdal et al. 1993) guided the performance of the synthesis of the concept of moral stress.

Concerning studies **I**, **II** and **IV**, interpretations in the analysis aimed at understanding lived experiences. This approach, especially in study **IV**, is based on lifeworld hermeneutics, which is a phenomenological grounding for the understanding of hermeneutics (Dahlberg et al. 2001). When the researcher arrived at a preliminary understanding of the data, a new dialogue with the transcribed interviews began. This stage included the search for a deeper, underlying and sometimes even hidden meaning. The task was to find ideas and messages in the interviews that might not be initially evident.⁴

The preliminary interpretations were tested according to validity criteria originally introduced by the Swedish professor in pedagogy, Arne Trankell (1972), and further developed by his colleague Per-Johan Ödman (1992). According to Ödman (1992), the trickiest question pertaining to hermeneutics in view of its focus on lived experiences is interpretation criteria. These criteria concern the reasons for the decision to choose or exclude interpretations. According to Ödman, this can be described as the validity problem of interpretive studies. The crucial questions in studies **I**, **II** and **IV** can be described as: from what perspectives should the plausibility of the interpretations

⁴ A researcher’s interest in finding hidden meanings in data is often referred to as the French philosopher Paul Ricoeur’s hermeneutical tradition. According to Ricoeur (1976) hidden meanings, or as he would say “the surplus of meaning” is of significant interest in the analysis of interpretation.

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concerning the nurses' lived experiences of stress (I), ethical concerns (II) and support (IV) be judged?

In this thesis the focus was upon intentional meaning (lived experiences) as opposed to the intersubjectively controllable "reality". According to Trankell (quoted in Ödman, 1992), two criteria are useful in this process. The first could be summarised as follows: If a preliminary interpretation leaves an essential part of the data unexplained concerning this specific meaning, the interpretation cannot be accepted as a valid description of the lived experience contained in the data. This criterion is in fact a warning against any interpretations arrived at too easily and an urge to test all preliminary interpretations against all data of general importance to the research questions. Furthermore, there must be no contradictions in the data if a preliminary interpretation is to be accepted. Nevertheless, a preliminary interpretation that is not in total agreement with the researcher's pre-understanding is probably more valid than an interpretation that does not reveal any new understanding at all. New understanding, not in total agreement with pre-understanding, is in fact the phenomenon which Gadamer (1997) calls "the otherness" in data.

In the last step of each analysis, another criterion was used for validating interpretations, namely: If a main interpretation is to be accepted as a valid description of the lived experience referred to in the data, it must be the only one that gives a complete and reasonable explanation of the available information (Trankell 1972, quoted in Ödman 1992). This criterion makes it necessary to continue the process of analysis until it is possible to identify the most reasonable, fair and productive way to understand overt or hidden meanings in the data.

Most important is that all parts in the interpretation structure are consistent with each other. This means that there is a congruency between the tentative interpretation and the main interpretation (and reversed).

The use of theory in this thesis

As previously described the epistemological approach in this thesis was characterised by a varying degree of openness, that is, how and when theories or theoretical constructs were used. In studies I, II and III a decision was made to use different kinds of theoretical frameworks and constructs in the studies. These consist of different theoretical constructs such as a theoretical model (study I), a concept (study III) and a

“school of thought” (study **II**), which are presented in Table 3. As previously stated, efforts were made in study **IV** to keep an open mind during the analysis process by avoiding the use of a predetermined theory or model.

Table 3. Overview of the theoretical support in studies **I**, **II**, **III** and **IV**.

	Theoretical framework	Analytic tool
Study I	Cognitive-phenomenological-transactional view of stress	Cognitive dissonance
Study II	Relational ethics	Care about – care for
Study III	Moral sensitivity, stress	----
Study IV	“Strive for openness”	----

Analytic tools were used in the analysis of studies **I** and **II** as presented in Table 3. The theory of cognitive dissonance (Festinger 1957), was used in study **I** at an early stage of the analysis process similar to a sensitising concept. Briefly, the theory describes cognitive dissonance as an incongruent relationship between cognitive elements, for example perception, insight and knowledge of what to do on the one hand and what is actually done on the other. The reason for using this theory was that earlier studies on stress had mainly focused on stress situations from a “one angle dimension” as expressed in abstract statements, such as, interpersonal communication problems and need for (or lack of) an extensive knowledge base (see e.g. Huckabay & Jagla 1979; Bailey et al. 1980; Jacobsson 1983, Adomat & Killingworth 1994; Lally & Pearce 1996). The decision to use an analytic tool, in accordance with the theory of *cognitive dissonance*, suggests that contradictions may exist in the individuals’ lived experiences. This appears to be a new approach to the study of stressful situations.

Another analytic tool was used in study **II**, the notion of *care about – care for* (Shogan 1988). The notion was originally developed as a pedagogical perspective on moral motivation in which *care about* emphasises the genuine concern for another person and *care for* is the task-oriented dimension of care. This tool was used for a different purpose in the final stage of the analysis. The purpose was to raise the findings from the concrete “experience near” level to a higher conceptual level in order to obtain theoretical understanding. The main theme was created (**II**) by incorporating the notions of *care about – care for*.

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In the following section, these theoretical frameworks: the cognitive-phenomenological-transactional view on stress (study **I**), relational ethics (study **II**) and moral sensitivity (study **III**) will be presented.

Cognitive-phenomenological-transactional view of stress

Bailey and Clarke's (1989) cognitive-phenomenological-transactional (CPT) model describes stress and coping in the form of a three-angle structure. The model builds on Lazarus and Folkman's work on stress and coping, which mainly considers the environment as the source of stress and the individual as the target (Lazarus & Folkman 1984). The CPT model contains the assumption that thought, memory and the meaning of events to the individual experiencing them are the central mediators or immediate causal agents in determining stress. The phenomenological view takes into account that the evaluation of the event may have a different outcome for each person and, therefore, evaluation is highly individual. Furthermore, according to Bailey and Clarke, individual stress and coping are situated in the transaction between the experiencing person and the environment as they perceive it.

In study **I** this perspective provides a theoretical framework for the view of stress in the study and, accordingly, influences the formulation of interpretations.

Relational ethics

Relational ethics can be viewed as a theoretical construct at the developmental stage and is composed of several theorists' ideas and thoughts and can thereby be considered as an emerging school of thought.

Relational ethics is an action ethics existing in the moral space created by one's relation to oneself and others (Bergum 2004). Relational ethics is based on dialogue in the shared experience between two or more individuals (ob. cit.). When viewing ethical actions from the perspective of relationships, the attention is not on traditional ethical theory or principles, nor on virtues or problems. Within the moral space (as in relational ethics) we do not assume that the other person has the same wishes and needs as oneself. Relational ethics is sometimes referred to as the ethics of care (Tschudin 2003, p. 19). In 1982 Gilligan "initiated" the new school of thought concerning the ethics of care (Gilligan 1982). According to Noddings, the ethics of care is "rooted in receptivity, relatedness, and responsiveness" (Noddings 1984). Similarly, Manning described the ethics of care as consisting of five elements: moral attention, sympathetic

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understanding, relationship awareness, accommodation and response (Manning 1998, p 105). Moral attention is to “recognise” that the person receiving care is a living being, a whole person and not fragmented into objective body parts. Sympathetic understanding concerns the ability to “recognise” the other person and their world as they themselves see it. Relationship awareness indicates that we know that different kinds of relationships exist. Accommodation refers to being aware of everyone involved in the caring situation and finally, response is the logical outcome of the attention given. These elements are manifested as a willingness and an openness on the part of the caregiver to acquire insight into the health-related reality of the recipient of care, thereby constituting what Kuhse (1996, p 151) described as a dispositional notion of care. This type of caring relationship is not limited to the nurse-patient dyad, but also includes the relationship between nurses and other nursing staff members, physicians and co-workers.

In study **II** this perspective provides a theoretical framework for the study.

Moral sensitivity

The concept of moral sensitivity as developed by Lützén (1993) is based on moral issues in psychiatric nursing. Lützén defines moral sensitivity as a “personal attribute involving the ability to recognize a moral conflict, a contextual and intuitive understanding of a person’s vulnerable situation and insight into the ethical consequences of decisions made on behalf of another person” (Lützén et al. 1995b; Lützén et al. 1997). Moral sensitivity highlights the trusting patient-nurse relationship and, accordingly, the nurse should have a moral motivation to do ‘good’ or act in the best interest of the patient. Within this relationship it is assumed that the nurse must take responsibility for her actions. A further assumption associated with the concept is the conviction that medical, nursing and contextual knowledge are required when dealing with ethical situations (ob. cit.).

In study **III** this perspective comprises the moral components in the synthesis of moral stress.

Hypothetical-deductive analysis

In study **III** a hypothetical-deductive approach (as previous described on page 10) was taken to the analysis in order to perform the synthesis on the concept of moral stress. The analysis can be described using four levels. First, a hypothesis was formulated

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based on the qualitative data from two independent studies on professional issues in nursing. The hypothesis formulated was that stress has a moral component. One study identified ethical problems experienced by nurses providing home care for patients with long-term mental illness (Magnusson & Lützén 1999). The other study was the first study included in this thesis, which conceptualised stress within the context of intensive care nursing (study I). Secondly, the moral components were explained and thereafter an interpretive analysis of the main theme and the sub-themes from the study of stress in intensive care nursing (study I) was carried out in order to identify the components in the data. Thirdly, tests of the appropriateness (or fit) of the concept of moral stress were performed by using the raw material from both studies, although the study on nurses' provision of home care to patients was not designed to address issues of stress. The consistency between the concept and raw data was sought in the material as were statements that would disagree with the concept. The fourth level consisted of an attempt to identify the preconditions for moral stress.

This study is both a continuation of the analysis of study I but also an attempt to aggregate findings from two separate studies exploring professional issues in nursing. To aggregate findings from several independent studies with similar research questions may enhance the generalizability of the original studies and may produce fairly solid concepts for a theory (Estabrooks et al. 1994). The hypothetical-deductive approach in this analysis is similar to a secondary analysis as described by Thorne (1998). Secondary analysis was primarily a method developed to re-analyze existing data that had been collected for other purposes. Different types of secondary analysis are described by Thorne (ob. cit.) but the type closest to the analysis in this study (III) is the one of analytic expansion.

ETHICAL CONSIDERATIONS

In studies I, III and IV the nurses were informed verbally as well as in writing about the purpose of the study and that confidentiality and anonymity would be ensured during the analysis and publication of the findings. The nurses themselves chose the location for the interview. They were also informed that participation was voluntary and that they could withdraw from the interview at any time if they so wished. The respondents consented to the audio-taping of all interviews.

Studies I, II, III (half of the material) and IV were reviewed by the Ethics Committee, Faculty of Medicine, Uppsala University, Uppsala, Sweden, and no formal

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application was deemed necessary (Reg. no. 99414). In study **III** textual data were used without the consent of the original respondents. Methodologically this is akin to what Thorne (1998) described as a secondary analysis and consequently has similar ethical issues as the present study. As the inquiry in this study concerns the analysis of text (translated from Swedish into English) as opposed to individuals, anonymity could therefore be maintained. Moreover, in the analysis we do not report any findings that could threaten the participants' integrity. The original studies used in this analysis were reviewed by the Ethics Committee, Faculty of Medicine, Uppsala University, Uppsala, Sweden, (half of the material) and by the Ethics Committee at Huddinge University Hospital AB, Huddinge, Sweden, approved (Reg.no. 279/98) (the other half of the material).

SUMMARY OF FINDINGS

Table 4. Overview over the main themes, sub-themes, main interpretation, comparative analysis and tentative interpretations in study I, II and IV.

Study I	Study II	Study IV
Main theme Stress induced by dissonant imperatives in intensive care nursing	Main theme Caring about-caring for: tensions between moral obligations and work responsibilities in intensive care nursing	Main interpretation Lived experiences of moral stress support involve an interconnectedness between structural and existential factors
Sub-theme 1 Controlled by the work situation-needing to be in control	Sub-theme 1 Believing in a god death	Comparative analysis Availability, accessibility and receptivity of support
Sub-theme 2 Constrained by prioritisation-wanting to do more	Sub-theme 2 Knowing the course of events	Tentative interpretation 1 Receiving organised support is a matter of self-determination
Sub-theme 3 Lacking the authority to act-knowing that something should be done	Sub-theme 3 Feelings of distress	Tentative interpretation 2 Whether to participate in organised support or to be off duty is mutually exclusive
Sub-theme 4 Professional distance-interpersonal involvement	Sub-theme 4 Reasoning about the physicians' doings	Tentative interpretation 3 Dealing with moral stress is experienced as a private matter
-----	Sub-theme 5 Expressing moral awareness	Tentative interpretation 4 Colleagues managing moral stress serve as models in stress support
		Tentative interpretation 5 Not being able to deal with moral stress urges one to seek outside support

STUDY I

The first paper presents the analysis of the interviews with intensive care nurses with the aim to conceptualize stress from their perspective of working in intensive care units. From the 36 interviews, 295 statements comprising stressful situations were identified. The main theme 'stress induced by dissonant imperatives' was the overarching concept formulated in the analysis of the interviews (see Table 4). Dissonant imperatives are

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circumstances or situations, in which nurses are simultaneously exposed to two or more options that are contradictory in nature. These dissonant imperatives create a conflict for nurses because they feel that it is impossible to disregard any of the imperatives in order to attend to the other. All imperatives have equally negative consequences at the expense of the other. Dissonant imperatives are composed of the four sub-themes as seen in Table 4: 1) controlled by the working situation – needing to be in control, 2) constrained by prioritisation – wanting to do more, 3) lacking authority to act – knowing that something should be done, and 4) professional distance – interpersonal involvement.

The sub-theme ‘controlled by the working situation – needing to be in control’ explain situations when nurses found their work uncontrollable in terms of never knowing when the nursing care would be interrupted due to the unpredictable nature of treatment and care in the ICU. Several factors contributed to this feeling of uncontrollability, for example, a new admission needing immediate attention or fluctuations in personnel resources due to sick leave and the shortage of experienced nurses. The opposite feeling to lack of control was the nurses’ expressed need to be in control. To be in control was expressed as “being ahead”, for example knowing ahead when the patients were to drop in blood pressure and attend to it.

The sub-theme ‘constrained by prioritisation – wanting to do more’ explain when nurses felt they were forced to make difficult prioritisations due to the lack of resources and heavy workload. Nurses had to prioritise the administration of advanced intravenous drugs that required close monitoring, thus obliging them to remain at the patients’ bedside for a long period leaving the basic care undone. Accordingly, they felt violated because they knew how they wanted (and been trained for) to care for their patients.

The theme ‘lacking authority to act – knowing that something should be done’ concerns situations where nurses knew that the patients were suffering and that the treatment needed to be changed, but there were no physicians available. The options of action for the nurses were either to exceed their authority and change the medication themselves, or watch the patient suffer unnecessarily.

The theme ‘professional distance – interpersonal involvement’ concerns the balance between showing a professional attitude towards the patients and relatives and not becoming too personally involved in the situation. A professional attitude means to approach the patient with a caring disposition, a willingness to “see” the patient as an

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individual with special needs. Caring for patients over a long period of time meant that the nurses closely followed the patients' and relatives' emotional ups and downs related to the success or failure of the treatment, and accordingly they felt the need to keep a distance.

STUDY II

The second paper presents the analysis of intensive care nurses' experiences of moral concerns from the perspective of relational ethics. The general overview of the 36 answers resulted in responses that failed to encompass examples of ethical situations, responses that portrayed ethics as integrated in practice and responses that contained specific examples of ethical experiences. The findings consist of five sub-themes and a main theme as seen in Table 4. When contrasting the five sub-themes to the theoretical notion of *care about* and *care for*, a main theme was formulated, 'caring about-caring for: tensions between moral obligations and work responsibilities in intensive care nursing' (see Figure 3). *Caring about* rests on moral ground and assumes a personal ability to know what is morally good to do in a caring situation. In this study it was expressed as a genuine concern for the patients through feelings, beliefs and insight into patients' vulnerability. *Caring for* is task-oriented nursing care that is assigned and controlled by, for example, employers and physicians, and can be considered to be a moral obligation to fulfil work responsibilities. Tension occurs for the nurses when *caring about* and *caring for* a patient cannot be achieved at the same time. Four sub-themes reflect this type of tension and a fifth indicates that the balance is partly maintained.

The first sub-theme 'believing in a good death' refers to the nurses' idea about what a 'good death' is and its desirability. Comments on death and dying comprised the patients' right to die, how to die and possible resistance to allowing patients to die. Tension occurs for the nurses when they cannot give support for the patients to have a good death because of the main purpose of intensive care, which is to save lives.

The second sub-theme 'knowing the course of events' reveals the nurses' intuitive feeling of knowing that something is going to happen in a specific situation, for example, knowing that a critically ill patient will not survive. "Knowing" that the patient would not survive was perceived as an argument for discontinuing the treatment and, when it nevertheless continued, the nurses experienced frustration. By continuing the treatment the patients were not allowed to die, as incongruent with what the nurses

perceived as ‘good care’. Instead the nurses had to carry out the treatment opposed to their own knowledge and standpoints.

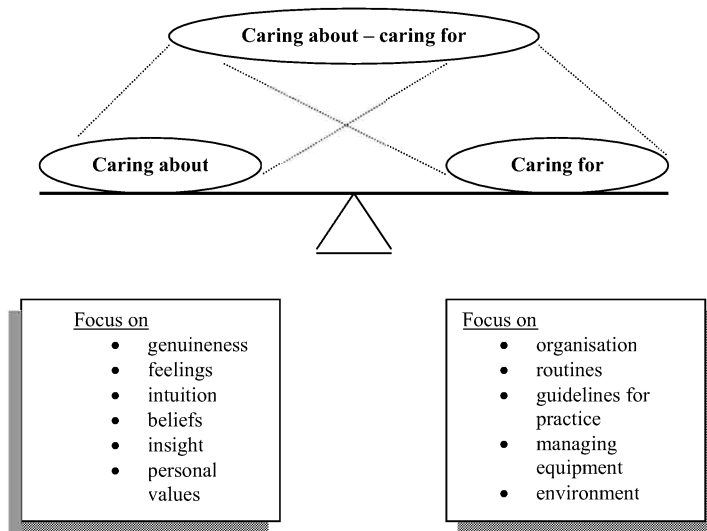


Figure 1. Caring about - caring for: tensions between moral obligations and work responsibilities.

‘Feelings of distress’, being the third sub-theme, indicates that the nurses were frustrated when they reflected on situations with ethical concerns. They described frustration when trying to “make sense” of the intensive care, especially beginners, and when feeling that they had opposing views on what actions to take with treatment as compared to the physicians. The tension existed between what the nurses should do as their work responsibilities and what they morally should do involved distressing feelings. Most nurses in the study referred in their reflections on situations with moral concerns to actions taken by the physicians as described in the fourth sub-theme ‘reasoning about the physicians’ doings’. Criticism was directed at the continuation of treatment, which seemed of no benefit to the patients. The nurses did not always agree with the orders given and claimed that even among themselves the physicians had

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different opinions. In this theme, the tension is overtly due to the nurses' awareness that they disagree with the physicians' decisions.

The final sub-theme 'expressing moral awareness' refers to the nurses' ability to discuss complex caring situations from different perspectives. This type of reflection was conducted by posing rhetorical questions such as, 'What use is doing surgery on an 85-year-old person?' and then providing the answer themselves: 'There is a lot of old patients that have felt quite well after surgery so it's worth while trying.'

STUDY III

The third paper presents a synthesis of the concept of moral stress. The hypothesis initially formulated was that stress contains a moral component if that is the case, it is appropriate to talk about moral stress. Moral components in this study were mainly of three kinds. The first comprises emotional and cognitive faculties of human beings that contribute in identifying moral situations (e. g. moral sensitivity). The second includes the moral experiences constituting a historical dimension. The third moral component can be considered as a product of the first and second components and consists of a moral view composed of moral principles, clarified moral dilemmas and ideas of the good in life.

The moral components identified in the study of stress in intensive care nursing (study I) are stated as follows.

- Moral sensitivity was identified in, for example, the sub-theme 'lacking authority to act – knowing something should be done'. This means that the nurses expressed an awareness of the fact the prescribed treatment was not sufficient to alleviate the patient's pain. Another example of nurses' moral sensitivity was that several of them were concerned that the patients were not "allowed" to die in peace and with dignity.
- Moral experience was expressed in all of the sub-themes because they are based on nurses' lived experiences of stressful situations.
- Moral view was identified in the nurses' reflections on what constitutes good care and what is required to achieve this goal, for example, in the theme 'constrained by prioritisation – wanting to do more'. In this theme nurses expressed that they knew what the patients needed, thus contributing to what is considered to be 'good care'.

Finally, three preconditions leading to moral stress were identified: 1) nurses are morally sensitive to patients' vulnerability and lack of autonomy, 2) nurses experience that external factors prevent them from doing what they think is best for the patients, and 3) nurses believe that they have no control over the specific situation.

STUDY IV

The fourth paper presents the analysis of head nurses' ($n=10$) and staff nurses' ($n=26$) lived experiences of moral stress support. The analysis identified a variety of contextual circumstances as seen in Table 5.

Table 5. Overview of the contextual circumstances: type of support, purpose of support, critical care situations and working conditions

Circumstance	Type	Example
A. Type of support	Formal/informal	Peer support meetings/individual
	Regular/irregular	Group sessions with group leaders (head nurse, counsellor, social worker, priest or psychologist)
	Miscellaneous	Written instructions Lectures (in-service) in crisis management, ethics, psychology
B. Purpose of support		Ventilate what happened Express point of view Support for emotional reactions
C. Critical care situations	Societal issues	Dramatic events in society involving hospital resources
	Patients issues	Patient with extraordinary medical condition needing special resources Provocative and/or aggressive relatives
	Employment issues	Group of personnel received notice to quit of termination of employment
D. Working conditions	Type of employment	Full- or part-time, day or night shifts employment (staff nurses)
	Working period	Morning-/evening-/night shift, during the whole week (staff nurses)
	Type of time-planning system	Established working schedule (six or ten weeks) Individually planned schedule

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These findings indicate that there is no consensus among intensive care nurses about the nature and purpose of types of support.

The next step in the analysis was to interpret the lived experiences of moral stress support. Five tentative interpretations were revealed (see Table 4): 1) receiving organised support is a matter of self-determination, 2) whether to participate or to be off duty is experienced mutually as exclusive, 3) dealing with moral stress is experienced as a private matter, 4) colleagues managing moral stress serve as models in stress support, and 5) not being able to deal with moral stress urges one to seek outside support. The major themes in the tentative interpretations, as identified in the comparative analysis and the contextual circumstances, were availability, accessibility and receptivity of support. The two components *availability* and *accessibility* were determined by the type and purpose of support, working conditions and the head nurses' involvement in organizing support. The third component, *receptivity* refers to the individual nurse's awareness of the need for support and the ability to receive the support available. This component can vary according to nurses' different views on support, previous experiences and the disposition to receive support. In this study it was interpreted that the nurses might have a subtle resistance towards organized group support. The three components are interrelated meaning that they influence each other and, in different combinations, facilitate or hinder nurses' ways of handling stressful events.

The main interpretation was "lived experience of moral stress support involves an interconnectedness between structural and existential factors" and appears to be an interpersonal process. Availability and accessibility can be described as structural factors such as management and organisational matters, which are the responsibility of the head nurse, who at the same time needs to show sensitivity towards nurses' need of support. Receptivity, for the individual staff nurse, refers the awareness of the need of support and willingness to accept the support offered. A subtle resistance in organised group support would violate efforts in organising support meetings. However, it seems that nurses also have to trust colleagues and head nurses in order to obtain support. Thereby, the experience of support is due to trust, confidence, security, and perhaps also self-esteem. If such elements characterise the climate or atmosphere in a support group, the possibilities of supporting each other are good. If however, the opposite

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proves to be the case and such attributes are not present in the “supporting climate” the situation may be dominated by distrust and insecurity.

REFLECTIONS ON FINDINGS

The findings from the studies indicate that 1) dissonant imperatives seem to induce stress (study **I**), 2) intensive care nurses are captured in a conflict between moral obligations and work responsibilities (study **II**), 3) this type of stressor can be labelled moral stress (study **III**), and 4) when organising support in critical care situations structural and existential demands needs to be met (study **IV**). In lieu of these findings there is reason to believe that moral stress influences the development and utilisation of caring competence.

Moreover, assessing patient needs and providing care in complex situations requires different types of competence. Competence in nursing care can be described as a caring competence that is essentially personal, an integration of experience, knowledge and skills. Johansson (1989, 1996) for example, suggests that caring competence is a further development of a broader human competence in which intellectual, emotional, physical, social, existential, aesthetic dimensions are viewed to be necessary aspects of human life. It is suggested that professional care providers should have access to all domains in order to be a competent care provider. According to Johansson caring competence should continuously be subjected to discussion in order to develop the very core of it otherwise there is a risk it will remain as a tacit knowledge (ob. cit).

The findings in this thesis indicate that nurses' competence will enhance the moral enterprise in a health care setting. Accordingly their work as moral agents may be facilitated. Intensive care nursing as a moral enterprise and intensive care nurse as a moral agent will be discussed below. Further, a way of elaborating the area of nursing competence, role expansion, will also be discussed below as well intensive care nursing and autonomy.

IMPEDIMENTS TO THE MORAL ENTERPRISE

Impeding factors to the moral enterprise in the ICUs are several. Two of the most prominent in this thesis are lack of time and factors related to the interdisciplinary work (studies **I**, **II** and **IV**). Of course there is a time pressure present in all caring situations because nurses working there have to anticipate that a new patient may arrive at any time or another patients' condition will suddenly deteriorate. The lack of time does not only affect the direct patient care (concerning prioritisations in study **I**) it also may

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influence if and how nurses perceive moral concerns. For example, the threshold for the recognition of the problem could be raised as well as neglecting the problem without further deliberation (Holm 1997). However, deliberation takes time and the time required increases, especially in complicated medical cases, that do not “fit” in the medical guidelines. Moreover, in intensive care nursing there has been no tradition of actively reflecting nursing care with colleagues.

Factors related to the interdisciplinary work are related to the historical traditions of medicine and nursing including the traditional gender relationships and the hierarchical nature of health care organizations. Nursing history is a history of nurses’ subordinate relationship to medicine (Kuhse 1996, Miers 2000). The contemporary role of intensive care nursing has developed with the addition of tasks from medicine and is by no means liberated from the traditional gender inequalities. Different perceptions on ethical situations between nurses and physicians in the ICU may also obstruct the moral enterprise. Physicians perceive the situations from a decision-making perspective and nurses have to execute and live with the decisions made (Söderberg & Norberg 1993; Oberle & Hughes 2001). What not has been addressed in the studies of different perspectives concerning ethical situations is that different views *per se* are not a problem although there seems to be a desire to reach consensus. The desire that the intensive care team achieve moral consensus has been claimed to be in the interest of giving good patient care (Melia 2001; Bunch 2002). Thus a question can be raised if it is realistic to achieve consensus among all personnel in intensive care? Disagreement may be a start to a constructive discussion, which may lead to a development of competence.

Reports on interventions promoting “ethical consensus” in intensive care are scarce. In a recently published randomized study the effects of ethic consultations on nonbeneficial life-sustaining treatments were evaluated (Schneiderman et al. 2003). A reduction of hospital days was noted and the participating physicians, nurses and relatives agreed that these consultations were helpful in addressing treatment conflicts.

Another strain within the interdisciplinary work in the intensive care is that there is no clear cut between the roles of physicians and nurses referred to that there is a blurring of disciplinary boundaries. For example, experienced nurses take on new tasks especially when there are inexperienced physicians on duty (see the next section concerning the expansion of the nursing role). Nurses handle this situation in different ways and it involves skills in communication (Benner et al. 1996, p 280).

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Impediments to enhance the moral enterprise are seen in all of the four studies (**I**, **II**, **III** and **IV**). Stress as it is described in study **I**, dissonant imperatives are the main stressors identified. These imperatives create a conflict for nurses because they feel that it is impossible to disregard any of the imperatives in order to attend to the other. Thereby, all imperatives have equal status, or more precisely, have equal negative consequences at the expense of the others. The effect of this conflict is experiences of stress because it exceeds the nurses' psychosocial and emotional resources (Lazarus & Folkman 1984). The moral dimension is present in these types of conflicts when patient care is involved and when the nurses experience that they ought to do something. Nurses' moral motivation to act in a way that is good for the patient complicate these conflicts because they feel that they cannot achieve this because of other imperatives. This conflict is illuminated especially in the sub-theme 'constrained by prioritization – wanting to do more' (study **I**). Nurses were forced to prioritize among the nursing assignments often resulting in leaving the basic nursing care left undone which were not congruent with what the nurses judged good care to be. The sub-theme 'lacking authority to act – knowing something should be done' (study **I**) is another example on a conflict with moral constituent. Nurses were aware of knowing what was the best to do for a patient, for example in situations with patients not getting enough pain medication, and at the same time they were aware of legal restrictions of what they were not allowed to do. Nurses in these situations were faced with two choices: either overstep their formal competence and act according to their clinical knowledge or, wait for the physician while standing by watching the patient suffer.

The presence of moral concerns in the findings of study **II** is beyond doubt. It was found that nurses' need to balance moral obligations and work responsibilities, as formulated in the main theme. This situation can be described as consisting of conflicting imperatives, on one hand a moral obligation, the individuals' genuine concern to care for another, and on the other work responsibilities, the professional assignment to supply care the individual are contracted with. Tensions occur within the nurse when there is not enough time to care about a patient, according to the nurses' moral obligations, and nurses' responsibility to fulfil their requirements related to their positions as being nurses in the intensive care.

Moral stress, as shown in study **III**, is present when nurses are morally sensitive to patients' vulnerability and perceive that they have no control over the situation. To be morally sensitive and at the same time aware of moral obligations can be perceived as

conflicting especially when there are circumstances that restrict what you actually can do. It has been suggested that clinical supervision increases nurses' awareness of the ethical dimension in patient care (Severinsson & Kamaker 1999). But it is unclear if nurses within the supervision group get support in having a "realistic" amount of sensitivity so they will not end up being more stressful than before. Thus, a question has to be raised is: Can a nurse have too much moral sensitivity?

In study **IV** the aim was to analyze intensive care nurses' experience of stress support in relation to critical care situations and moral stress and a variety of interventions aiming to support nurses was reported. These findings yielded that there were no structured support aiming to meet moral stress. By not having the opportunity to discuss ethical concerns, in order to enhance reflection, may have an impeding consequence to the moral enterprise.

THE INTENSIVE CARE NURSE - A MORAL AGENT

It is understood that nursing care is a moral enterprise (see for example Gadow 1980, Noddings 1984, Benner et al. 1996, Kuhse 1996, Tschudin 2003). Thus, intensive care nursing, as studied here, can be seen as a moral enterprise. To enhance the moral enterprise the presence of moral agents is a necessity. Moral agency in nursing care includes the interaction of personal qualities as well as the rational justification of decisions made. Justifications are based on professional codes of ethics, that is, the decisions are justified in the best interest of the individual patient leaning on relevant and factual knowledge. Moral agency in nursing can be viewed as having two central components; the capacity to identify an ethical issue and the rational process to make decisions about it. Not-with-standing the many factors influencing these decisions, such as personal values, culture and religion, the capacity to recognise, not only a moral problem, but also the moral nature of nursing is a necessary condition for competent moral agency (Lützén 1997). Central to the individuals' capacity to identify an ethical situation is the emotional understanding (Nortvedt 1998) similarly in Johanssons' words "emotional competence" (1996). The emotions are important when nurses are to grasp a patients' experience of illness and when reaching an understanding of patient realities. According to Nortvedt this so called emotional understanding has two interrelated features: one affective and one cognitive (Nortvedt 1998). The former, the affective, implies the possibilities "to be moved" as an immediate affective response upon another person's affective state and this have consequences for the nurse-patient

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relationship. Nurses in this thesis display such an ability to be moved by the patients' suffering. In study **I** the nurses met patients in pain and the nurses were concerned about the inadequacy of pain treatment. The cognitive feature of emotional understanding is how nurses interpret the situation involving the patients' actual condition and treatment. In the above example with patients in pain, nurses dealt with why not the pain medication were efficient enough and how they could, with or without trespassing their authority, increase the efficiency of it.

To enact moral agency there is a necessity for nurses to have a "language of ethics". Benner et al. (1996, p 162) suggests that an expert nurse has developed a moral voice and thereby they are more powerful when arguing for their patients best and when demanding that the system change in order to be more just. To be able to argue in such situation there is a need to recognize that there exist ethical situations. According to Johansson (1996) this ability could be referred to as existential competence.

In study **II** the majority of the intensive care nurses were able to relate to such ethical situations. But there were some nurses who did not have any examples on ethical situations to share. It is unclear if these nurses did not see situations as morally relevant or lacked the ability to reflect on moral issues. According to Heath (1998) nurses vary in their verbalizing skills but this should not be a barrier to reflection. However, why nurses exhibit this so called moral muteness is not clear and needs to be explored. What further complicates the situation is that reasoning abilities is claimed to be a central part in nursing care and reflection is thus vital for the development of clinical nursing knowledge and ethical judgement (Benner et al. 1996, p 115) especially together with colleagues (Ekebergh 2001).

What does this mean for a nurse who does not have these abilities? According to Rubin (1996, p 172) nurses who do not reach the expertise level in nursing have problems in recalling significant caring situations. To conclude, emotional and existential competences need to be combined with intellectual competence in order to accomplish reflection (cf. Johansson 1996).

Moral agency is shaped by moral knowledge. According to Sarvimäki (1995) a morally integrated person should exhibit theoretical-ethical knowledge, moral action (how to) knowledge, personal moral knowledge (motivation to act) and situational moral knowledge (moral awareness). Knowledge of ethical problems increases the awareness of patients' vulnerability in practice and in combination with nurses' moral sensitivity greater demands will be created for fairness and justice in order to guarantee

the quality of patient care. In a situation when resources are lacking, as was the case in the ICUs in this study, and nurses should provide care in accordance with ethical principles, they may paradoxically be caught in a conflict between their sensitivity for the patient and not being able to supply good care (study **I**, **II** and **III**).

The cumulative effect of moral stress or to face critical care situations with moral components is recognised as a serious concern. When left with no possibilities to reflect on such situations nurses (humans) may compromise their basic values and principles. This lingering effect is called moral residue and “sears the heart” (Webster & Baylis 2000, p 233; Mitchell 2001). Nurses at risk of compromising their commitments and principles are those who are uncertain about what is right and what actions ought to be taken. Humans who recognise that their values and principles have been compromised typically experience moral residue that mainly takes two forms. One form is when the person comes to clarity with what he or she will or will not tolerate or co-operate with in the future. The other form is when the person adapts by constantly shifting his or hers values according to what is perceived to be the “dominant value” that day (Webster & Baylis 2000). The intensive care nurses in this study (study **I**) were concerned and felt stress when they were forced to leave the basic care undone due to heavy workloads and other priorities. In these situations, which occurred frequently, they violated their ideas and values concerning “good” care and accordingly were forced to “do the second best” for their patients. Similarly in study **II** the nurses expressed ideas about the “good death”, old people allowed to die and to die peacefully with dignity, was in contrast to how patients actually died. In those situations it can be speculated if the nurses experienced moral residue and if so, in what form.

The awareness of moral residue may yield greater clarity and insight and strengthen one’s ability to handle complex care situation and to do better next time. This can be dealt with in organised forms, for example group discussions that have an emphasis on situations with ethical concerns. The intensive care nurses in this study did not have regularly occurring group sessions where discussions about ethics were held to possible counteract effects of the “moral exposure” (study **IV**).

EXPANSION OF THE NURSING ROLE

According to the findings in this thesis intensive care nurses are exposed to moral stress. One way of reducing tensions due to moral stress, in situations when there is a collision between actual and formal competence between two health care personnel

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(nurses versus physicians), is for the nurse to take on new duties and not to continue to always be dependent on a physician. Taking on tasks previously assigned to the medical profession is a question of expanding or extending the nursing role in intensive care. The debate whether to expand or extend the nursing role is somewhat confused since there is no consensus of the definition of the two terms (Briggs 1991; Bowler & Mallik 1998). The distinction made between the terms lean on the explanation that an extended nursing role includes acceptance of new tasks as delegated by the medical profession and an expanded nursing role is based on a deepening of the caring component. These distinctions seem not to be valid because some researcher uses the two terms interchangeable (Briggs 1991).

The acceleration of technology and medical treatment has meant that in intensive care the boundaries between medical and nursing roles are blurred. This is especially true in situations when a recently introduction of a new medical treatment, for example intensified insulin therapy in critical ill patients, are becoming a routine (Bradly 2002). What previously, in such situation, has been the physicians' responsibility; ordering b-glucose tests and the adjustments of insulin dosages according the outcome, can suddenly become the responsibility of the intensive care nurse although the nurses execute it using medical guidelines designed for that specific treatment situation in a given intensive unit. This type of specialized skills is one example that the intensive care nurse takes on as an extension of medicine. Other examples are inserting arterial and central lines, requesting X-rays and performing elective cardioversions. There are variations across hospitals as well as countries what tasks are delegated to nurses to execute (Hind et al. 1999). What is new to a particular intensive unit may be common practice in another. Commonalities of the extended tasks are that they are repetitive, mechanistic, automatic and predictable (Hunt & Wainwright 1994).

But there are other questions to be asked. One is: What preferences do intensive care nurses have in discussions about taking on new tasks? In the short run the nurses may feel that they are relieved by not being forced and take the time to locate a physician to get an order. But if they already have an overfull working situation they may be reluctant to take on further tasks to be responsible for, thus ending up with being more stressed than before. Nurses can have different opinions about what and what is not to be undertaken by nurses in the intensive care especially less experienced staff hesitates in extending their role (Bowler & Mallik 1998; Hind et al. 1999). Another question to be asked is what else could be seen as influencing the preferences nurses have? Or

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more specifically: Nurses who willingly take on new tasks, as an extension to the medical profession, what values can be at stake when doing that? Some nurses can be drawn to the status that physicians have and while adopting some aspects of the physicians' role they may believe that they enhance their own status. As reported in study II the intensive care nurses talked about physicians' doings. It seems fair to put the question whether this focusing on the physicians is an expression for an attraction to the medical profession?

The effects of appreciating technical medical skills predominantly over valuing nursing care may have pivotal consequences, as was the case in an acute care unit (Nyström 2002). The unit had been in focus for complaints from patients concerning the nursing care. After an investigation on reasons why, it was found that nurses working there predominantly valued medical technical tasks and accordingly were drawn to that type of assignments. Nurses perceived that some of the patients visiting the emergency care unit were not "real" ECU-patients and they were not concerned of why and how these patients needed to be met. One explanation was that the nurses giving nursing care seemed to be un-reflected when doing so.

The formalisation of the extension of intensive care nurses' role is in its developmental stage subjected to debate. There is a variety of terms to describe any expansion of nurses' role beyond initial authorization such as nurse clinician, advanced practitioner, clinical specialist, clinical nurse specialist, nurse practitioner and advanced practice specialist (Keane & Richmond 1993; Naylor & Brooten 1993; Bullogh 1992). Much of the literature used to explore issues of role expansion in intensive care nursing originates from the USA and UK and suggestions made have not been established in Sweden although there is a growing interest (Ball 1997; Delametter 1999; Dawson 2001).⁵

There are several issues to be dealt with when expanding the nurses' role. Issues about legislation, education and accountability needs to be addressed when constituting a new formalised professional role.

As discussed above in critical care the debate of expanding the nurses' role has so far concerned medical technical skills as an extension of medicine. The debate has now started to comprise whether nurses also should prescribe medicines in the intensive care

⁵ Recently in Sweden, at Skövde University College, an advanced education (80 p) has started where district nurses with two years of work experience are becoming nurse practitioner authorized to make medical decisions.

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(Dawson 2001). This type of dependent prescribing is considered when a physician makes the diagnosis but another professional group can then modify the prescription. The prescriptions in focus for debate are, for example, oxygen therapies, intravenous fluids, electrolytes, sedation, topical antifungals and oral analgesia. Several questions can be raised concerning this type of role expansion. It is however important to recognize that this type of development, role extension, does not support the intensive care nurses in developing their caring competence. The findings in this thesis indicate that there exist obstacles in nursing practice when nurses are to develop their caring competence. Without debate about caring competence, nurses are at risk to preserve undesired features of the nursing role.

INTENSIVE CARE NURSING AND AUTONOMY

Moral stress probably influences the way intensive care nurses exercise their autonomy. But what is autonomy? Is it appropriate to talk about autonomy in intensive care where there seems to be a lot of factors inherent in that type of care which dictate what the nurses should do? At first, competence is viewed as being a prerequisite to autonomy. Since competence, as described above as a personal capacity, autonomy can be ascribed to a person. Ballou (1998) identifies 6 themes, inherent in the concept of autonomy: self-governance, decision-making, competence, critical reflection, freedom, and self-control. All of these themes points to an individual (behavioural) approach to autonomy, omitting the important issue about the context in which the individual acts. Bishop and Scudder suggest that nurses have their own particular kind of authority that comes from the control of the day-to-day care of the patients (Bishop and Scudder 1990 p.133). To be in control of care can also be expressed as freedom to organise the care. Cash (2001) suggests that it is more appropriate to talk about clinical autonomy as a characteristic of a role, for example being a nurse that has authority. Cash further suggests that clinical autonomy is constructed within a particular situation, a contractual space, and thereby not immediately transferable to other contexts. Autonomy also includes accountability for decisions made concerning patient care.

Further, nurses' preferences for autonomy have a significant part in the way they judge their job satisfaction. Nurses with much preference for autonomy seem to react negatively if their job do not include presence of such job characteristics and reversed nurses who have a little preference for autonomy find themselves content in a more task

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oriented nursing care system with limited autonomy (Landeweerd & Boumans 1994). It is assumed that more authority to make decisions leads to a higher degree of autonomy leading to professional extension and professional growth.

Moral stress in this thesis was expressed as “not to have control” over patients, assignments and the whole situations (study I). “Not to have control” is in distinct contrast to have the freedom to perform the care required (Ballou 1998) or the control of day-to-day care (Bishop & Scudder 1990). Thus it is therefore reasonable to conclude that nurses in this study were limited in their autonomy. Although autonomy was not investigated in this study and accordingly the intensive care nurses’ preferences concerning autonomy is unknown, it can be speculated if such limited autonomy influences these nurses’ job satisfaction or choices of leaving the job. Although there is a lack of definitional precision on autonomy several authors suggest that there is a positive relationship between autonomy and job satisfaction (for example Dwyer et al. 1992; Blegen 1993; Landeweerd & Boumans 1994; Finn 2001). Restricted autonomy is reported as a major cause to job dis-satisfaction and presumable have an impact on nurses’ job turnover and absenteeism (McCloskey 1990). All 10 intensive care units in this thesis reported shortage of experienced intensive care nurses. Of course, there are several factors contributing to this situation but there is reason to believe that issues of autonomy have a significant part in why nurses choose a specific speciality of care. Questions of how autonomy is perceived in intensive care nursing, what are the preferences for autonomy and if there is no possibility to execute autonomy what are the consequences needing to be addressed. Finally, how is autonomy related to the development of the caring competence?

MORAL STRESS AND CARING COMPETENCE – A COMPREHENSIVE UNDERSTANDING

The findings in this research, based on the analysis of the experiences of nurses working in various intensive care units, exemplify the moral enterprise of nursing. In order to reach a more comprehensive theoretical understanding of the findings in this thesis, Ellström's (1997) theory of occupational competence will be applied in order to explain the relationship between moral stress and the participants' general concerns about the patients' care and conflicting responsibilities.

Ellström (ob.cit), in his study of changes in work life and the demands on occupational competence, suggests that a distinction can be made between competence as an "attribute" of the individual and as a "qualification" or requirements of the work or task. Occupational competence refers to the relationship between the capacity (knowledge and intellectual skills) of an individual (or a collective) and the requirements of the work. The employer can either explicitly or implicitly request specific qualifications, according to Ellström.

Ellström's theory of occupational competence includes five different meanings of competence (fig 2). The relationship between these meanings distinguish three views of occupational competence; competence as an attribute of the individual, competence as job requirement, competence-in-use.

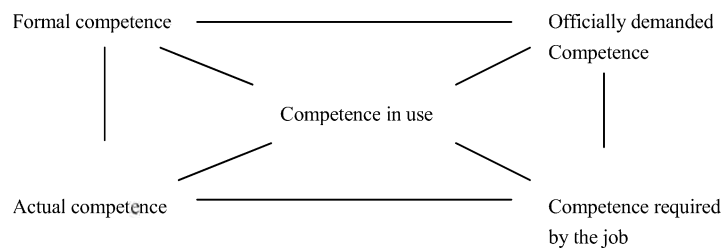


Figure 2. Different meanings of occupational competence. (Reprinted by permission from the *Journal of European Industrial Training*)

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Competence as an attribute of the individual person is referred to as a potential capacity to accomplish a certain task or a job and involves dimensions such as personality traits, different types of knowledge, perceptual motor skills, attitudes, motivation and social skills. Here Ellström makes a distinction between the formal competences a person has and the actual competence acquired in a specific job situation. These distinctions can be exemplified in nursing, for example, to have a “formal” competence is to obtain an advanced educational diploma in intensive care nursing and thus meet the required competence to work in intensive care nursing. To have an “actual” competence in the intensive care unit can be defined as the nurse’s skills and knowledge, i.e., the potential capacity to successfully use advanced technology in emergency situations.

Occupational competence defined as *job requirements* is the official demand for competence as a basis for recruitment and the competence actually required by the job. The correspondence of these two may be disturbed, for example if there is a shortage of persons who meet both requirements.

Competence-in-use, according to Ellström, is neither primarily an attribute of the individual(s) nor an attribute of the job. This type of competence illuminates the interaction between the individuals and their work, focused on the competence that becomes evident in their work performance. Competence-in-use can be seen as a dynamic factor mediating between the potential capacity of the individual and the requirements of the job. These factors may either enhance or limit the extent to which the individual uses his or her actual competence. Individual factors such as self-confidence or lack of self-confidence are equally of importance as are job related factors such as the organisation of the work.

CONFLICTS BETWEEN DIFFERENT COMPETENCES

In study I, the intensive care nurses seemed to have difficulties in utilising both their formal and their actual competence due to high pressures of work and the unpredictable requirements of intensive care nursing. Contradictory competence demands are exemplified in the sub-themes *controlled by the work situation-needing to be in control* and *constrained by prioritisation- wanting to do more*. These sub-themes clearly point to a conflict between the nurses’ formal (educational requirement) and actual

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competence (potential capacity). The consequence may be that the nurses do not fully use their actual competence.

The sub-theme *lacking the authority to act- knowing that something should be done*, indicates a conflict between the physicians' and nurses' competence. This conflict arises when the nurse's actual competence due to experience is advanced and the physician's formal competence in medicine is more advanced but exhibits limited actual competence. An often-occurring situation is when a patient is in pain and the experienced nurse who "knows" her medication and what to suggest must obtain an order from a physician to do so. The outcome in such a situation depends on many factors, especially the physician's presence and how well nurses argues for their suggestions. In this situation, a type of negotiation occurs between the competence of the physician and the intensive care nurse. Hence, conflicts between the actual formal competence of the individual nurse and competence required by the job may hinder nurses in the utilization of their whole competence. The nurse, in order to avoid conflicts, may instead concede to the physician's pain treatment.

SHIFTS IN COMPETENCE FOCUS

In study **II**, a contradiction between the individuals' competence (formal and actual) and the competence required by the work situation could be seen. This is exemplified in the two sub-themes *believing in a good death* and *knowing the course of event*. In both sub-themes nurses perceive that "something is wrong" with the care they are required to carry out (work responsibilities). When these participants had another view than the physicians' had about what should be done, it was expressed as a "gut feeling" (interpreted as moral obligation). Examples of this type of view are the expressed opinions "that it is wrong not to let patient die" and "let nature have its course". Situations in which these views were expressed, nurses felt they needed to prioritise assignments they were required to perform. Thus, "only" competence as a job requirement was asked for.

When the physician orders these assignments an important consequence is that the nurses' focus shifts from the patient to the physician. This shift is displayed in the sub-theme *reasoning about the physicians' doings* (study **II**). The shift in focus means that the nurses' caring competence may not develop because they do not maintain an active concentration on caring assignments. On the other hand, in the sub-theme *expressing moral awareness* the physicians "doings" are questioned, for example, is it right for a

patient who is dying to be kept alive by advanced technology? Hence, conflicts between the nurses' competence and work required competence lead to shifts in focus of competence. This shift may influence the caring competence negatively. Nurses who have a moral awareness reflect on the caring situation and thereby they may influence how to maintain and perhaps also increase their caring competence.

MORAL COMPONENTS IN MORAL STRESS - A FORM OF COMPETENCE

Moral components in the syntheses of moral stress in study **III** are moral sensitivity, moral experience and moral view. Moral sensitivity can be seen as a personal capacity comprising an individuals' ability to recognise moral conflicts and an understanding of a patients' vulnerability and insight into the ethical consequences of decisions made on behalf of the patient (Lützen 1995b).

Ellström (1997) argues that competence is an individual's potential capacity to accomplish a certain work assignment. This capacity includes cognitive factors, such as an intellectual awareness of the moral nature of a specific situation, but also affective and personal factors such as attitudes, values and motivation. Although moral sensitivity, moral experience and moral view as described in study **III**, are created in interaction with others, it is an individual characteristic and a potential capacity to deal with moral problems in nursing. In other words, the ability to identify, analyse and deal with moral problems can be viewed as an actual (moral) competence. Thus, moral stress can be seen as an aspect of actual competence. This form of competence is not explicitly asked for by the employer. In the findings of this thesis there is an indication that the intensive care nurses themselves are not aware of whether the employers are neglecting this form of competence or not.

Competence-in-use means that the intensive care nurses manage situations when they perceive that a treatment procedure is not compatible with a patient's needs. The nurse's perception can be described as a moral sensitivity and lead to moral stress if not resolved. Yet, an exaggerated trust in one's ability of what one really can do may have the effect that the sensitivity of own limitations is weakened. There is a risk that nurses may act adversely because they do not turn to colleagues for help. On the contrary, to have an "excess" of moral sensitivity may result in going beyond their capacity in caring for a patient. As a consequence, the nurse may feel exhausted and loose control in making reasonable decisions concerning his or her working situation and the nursing care. Thus, moral stress, if leading to positive actions, constitutes a form of actual

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competence, influencing the balance what really can be done and what is possible to do in nursing care.

OBSTRUCTION TO THE DEVELOPMENT OF COMPETENCE

In order to have a functioning moral stress support, problematic structural and existential factors need to be identified and attended to (study **IV**). The findings in study **IV**, suggest that some nurses have a subtle resistance to participate in organised group support. Reflection on experiences of moral stress may result in increased competence in dealing with new situations for the individual nurse. Reflection on moral experiences together with colleagues can be seen as an essential activity for developing caring competence. This type of reflection may also be useful in helping less experienced nurses to deal with moral stress. For this to occur it is necessary to have an open atmosphere in the ICU. In situations with well-functioning organised support nurses might not only increase their moral competence, but also strengthen their self-esteem and trust in managing critical caring situations. According to Ellström, these affective dimensions are significant for a professional persons' competence. Hence, subtle resistance towards organised moral stress support may obstruct the development of nurses' competence.

IMBALANCE BETWEEN COMPETENCES

The final part of the comprehensive understanding could be stated as: the imbalance, due to moral stress, between different competences hinders the development of collectively shared caring competence. According to the suggestions above, moral stress influences nurses' utilized competence. There are conflicts between different competences that is, between actual and formal competence of the nurse and between the nurses' competence and physicians' competence. The latter conflict may result in a change of focus for the nurse's competence, from the patient to physician. Thus, the different competences in this thesis seem not to be integrated in what Ellström label 'the competence-in-use'. Most significant, some nurses avoided competence-stimulating activities such as organised group support. According to Ellström the 'competence-in-use' should be a combination of both formal and actual competence, i. e. the individual dimension. But it should also include the competences required by the employer and the work situation.

The moral enterprise in intensive care nursing

A comprehensive understanding of the four studies (I, II, III and IV) in this thesis is that there is a lack of such combination of competences in the intensive care units that were studied. When the different competences are not integrated and utilized in the specific work situation, the nurses appear to experience this as contradictory. In critical care situations, when ethical decisions are to be made, and the physicians' have the main responsibility, the nurses' total competence will not be required, only their formal competence to execute orders. This seems to lead to an increased interest in the physicians' doings and to a lesser extent, an interest in developing caring competence. Further, it may be a common view among nurses that the only competence required in provision of care is the formal one. When nurses experience a lack of recognition of their actual competence, the motivation to pursue the development of competence may thus decrease and this can lead to professional distrust.

Additionally, it seems fair to assume a gap between the competence required by the work and the competence actually asked for. This hinders the development of collectively shared competence (body of caring knowledge) among the nurses in the ICUs. If only formal competence is required, there is probably a risk that the actual competence decreases. A professional atmosphere that is dominated by subtle resistance towards group support may be in itself a warning that the actual competence among the nurses is declining. The nurses may experience that they have no choice whether to focus on the patient or the physician. If the focus changes from patient care to the physician, nurses will be unable to help each other to increase their caring competence by paying attention to issues about the nursing care and actively support discussions with colleagues. An ideal situation exists when both competences are equally valued, formal and actual, and that the demanded competence harmonises with what competence the work requires. But without ambitions to acknowledge the different competences there will be obstacles to the development of the collectively shared caring competence as well as obstacles to come to terms with moral stress.

According to Johansson's (1989, 1996) model for caring competence, it is constructive to understand the issue of professional competence in intensive care nursing as a further development of a more broadly human competence. The intellectual domain of competence deals in this thesis with the necessity to have enough formal competence to fulfil both medical assignments and caring interventions. For caring interventions the nurses must attempt to understand overt or hidden meanings in statements made by patients and their relatives. The emotional domain of competence

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deals with maturity and self-esteem of the nurses as well as their self-confidence. The social domain of competence is necessary to deal with issues together with physicians, colleagues, patients and relatives. In discussions with colleagues it is important to be generous and willing to share experiences, even if there is a risk to disclose weak spots in the professional image. Otherwise such experiences may be looked upon as personal, not professional. The existential domain of competence also includes courage to understand the importance of interpersonal relations when confronted with human suffering.

The findings, the reflection on findings and the comprehensive understanding seems thus to disclose that moral stress is not only a problem. It can also become a driving force to stimulate moral awareness and reflections about how to handle difficult care situations in clinical settings. Increased moral awareness in intensive care can be related to Johansson's (1996) existential domain of competence. Such considerations can probably serve as support to develop a collectively shared caring competence in intensive care nursing thus moving beyond the individual level of competence. The advancement of practice in intensive care nursing, from advanced beginner to an expertise practice, is dependent on the development of reflection in a clinical situation (Benner et al. 1996, p 114).

Consequently, nurses that are solely left on their own to reflect might be hindered in their development of caring competence (Ekeberg 2001). Thus, the most significant in the process of maintaining competence and for the development of it is reflection together with others. Reflections together with colleagues can be seen as an action to enhance the moral enterprise in intensive care nursing.

METHODOLOGICAL REFLECTIONS

This thesis has thus been a combination of research approaches all aiming to understand intensive care nurses' work situation in terms of moral stress, ethical concerns and support. The research methods that were chosen were sensitive for human experiences. This combination of research approaches was found to be relevant when taking into consideration that the disadvantages, inherent in each approach, were made apparent and accordingly appropriately met.

The effort to conduct a qualitative content analysis, in this thesis, is mainly a descriptive procedure. It brought to the fore a need to pose a question whether the findings might be a product of something already existing in the researchers' pre-understanding or not. It seems fair to put the question if it is possible to conduct a manifest qualitative content analysis of data knowing that humans are momentarily searching for meanings in statements made by other humans and thus are constructing reality? According to the theory of intentionality⁶ you are bound to fail if trying to conduct a pure descriptive procedure. To use a pre-existing theory (study **I**) may facilitate the process of producing a new understanding when trying to control possible undetected effects originated from the pre-understanding. On the other hand, using a theory in such way may limit understanding of data, that is, reading data with a narrowed focus and important meanings in data can be missed.

The strive for research openness in study **II** and especially in study **IV** brought forth the significance of reflecting interpretations with other researchers. In all studies, **I**, **II**, **III** and **IV** the interpretations were regularly discussed with the co-authors and those represented different domains of knowledge such as nursing, sociology and medicine. This combination of varying scholars allowed for interdisciplinary critique. Uncontrollable influences of pre-understanding were thereby hopefully minimized. If not taking that type of precautionary step the pre-understanding, coming from a professional experience in intensive care nursing, would perhaps have had an uncontrollable grip on the process of interpretation. For clarity, the concept of openness has been used in such a way that pre-formulated hypothesis or pre-existing frames of

⁶ According to Gadamer (1997) it becomes clear that "with intentionality we get a more and more radical critique of the 'objectivism'" (p. 243).

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interpretations have not been used (study **II** and **IV**). This was one way of trying to find valid interpretations. Another way was to try out the interpretations, which was described previously (page 21).

In contrast to openness (**II** and **IV**), in study **III** the use of the idea of verifying a hypothesis was carried out.⁷

However, there were also several similarities concerning the methodological courses of action in the process of analysis between the two approaches. Interpretations made with the idea of openness were tried out against data when estimating the quality of the interpretations (validity). This step in the process of analysis, in study **II** and **IV**, which aimed at finding the most meaningful interpretation, was in fact similar to the hypothetical-deductive method when trying to verify the hypothesis in study **III**. That is the hypothetical interpretation is tried out when the researchers tries to falsify it.⁸

The similarities between applying the idea of openness in a study and using a hypothetical-deductive method could be explained from the fact that the manoeuvres done can be related to that they display an entering into the research process at different levels.

In this thesis each method has been complete in itself and conducted as if each method stands alone. This standard has enabled each study comprising all studies to be published independently. However, in order to arrive at a new whole a comprehensive understanding, study **I**, **II**, **III** and **IV** were laid out in the process of it. The process of formulating a comprehensive understanding concerning moral stress and caring competence can be described as a form of structure at a different abstract level than in the interpretations in the separate studies. Hence, the comprehensive understanding concerning caring competence comprised all earlier interpretations. It could thus be seen as an “umbrella” for understanding competence that guides the reader through the former interpretations and contributes a further understanding of the phenomenon being studied. The strength of this procedure is the fitting of the results from each study into a comprehensive outcome.

⁷ Of course there is a necessity to be open for the possibility that the hypothesis cannot be verified, but this is not a Gadamerian type of openness.

⁸ According to (Trankell 1963) and Gustavsson (1996) this process reminds of Poppers idea that scientific knowledge increase with falsifying not valid hypothesis.

SUMMARY AND CONCLUSIONS

Intensive care nursing is characterised by a multitude of assignments surrounded by advanced technology, high working load, shortage of nurses and daily ethical concerns. According to this thesis, in critical care situations dissonant imperatives seem to induce stress. Dissonant imperatives create conflicts for nurses because it is impossible to disregard any of the imperatives to attend to the other and have equally negative consequences. The intensive care nurses were found to be captured in a conflict between moral obligations and work responsibilities adding on to the already strained working situation for them. Accordingly, the type of stressor prominent for intensive care nurses in critical care situations was moral stress. Furthermore, structural and existential demands needed to be met when organizing support in critical care situations when the intensive care nurses were to handle moral stress.

Moral stress was nevertheless found to be influential on the caring competence. Imbalance between different competences hinders the development of collectively shared caring competence. Conflicts between different competences were made the nurses to shift focus from the patients leading to a possible decrease in their caring competence. Moreover, the subtle resistance among nurses toward participation in organized moral stress support may obstruct the development of nurses' caring competence.

The most important conclusion of this thesis is that moral stress neither can nor should be totally eliminated in the ICU. Accordingly it is necessary to handle it in such way that it will be beneficial to the development of the individual as well as the collectively shared caring competence. Thus, moral stress is not only a problem. It is can also become a driving force to stimulate moral awareness and reflections about how to handle difficult care situations and thus may lead to improved caring competence. In order to accomplish this, there is a need for an organisation where reflection and discussion are stimulated and where different kinds of support interventions has its natural position in the daily work in the intensive care.

CLINICAL IMPLICATIONS AND FURTHER RESEARCH

Moral stress as it is discussed in this thesis comprises several dimensions. All of these dimensions can be used in clinical settings in group discussions in order to increase an understanding of possible stress related problems at the specific unit. Further, the structural and existential factors of organising moral stress support can provide an understanding for head nurses when organising support interventions.

Suggestions for further research is here presented comprising mainly three areas.

- Elaborate the concept of moral stress (it is assumed that there might be different types of moral stress needing to be addressed differently).
- Development of a questionnaire to measure the severity and occurrence of moral stress in different settings as well as estimating if, and what health consequences may be related to moral stress.
- Develop interventions that aim to support nurses when handling moral stress in critical care situations and take into consideration individual, cultural and organisational aspects. To evaluate and test these interventions.

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SUMMARY IN SWEDISH

INTENSIVVÅRDSSJUKSKÖTERS KANS MORALISKA VARANDE OCH GÄRNING

Medicinska och teknologiska landvinningar har under de senaste decennierna öppnat nya möjligheter för behandling av mycket svåra medicinska tillstånd. En följd av denna utveckling är att all sjukvårdspersonal i ökad utsträckning medverkar vid vård av kritiskt sjuka samt i beslut som på något sätt berör frågor om liv eller död. Sådana beslut kan t.ex. handla om att påbörja eller att avsluta behandling, eller att avstå från hjärt-lungräddning. Komplicerande i denna situation är de idag krympande ekonomiska resurserna. Intensivvårdsavdelningarna utgör således en plattform för många svåra beslut, ofta med en etisk komponent.

Intensivvårdssjuksköterskorna förväntas dessutom utföra flera helt olika uppgifter samtidigt, t. ex. att intensivövervaka en patient och parallellt med detta bemöta känslomässiga reaktioner i samband med svår sjukdom. Det är rimligt att anta att denna komplexa och mångfacetterade arbetssituation kan innebära ett stort mått av stress för sjuksköterskorna.

Ett övergripande syfte för denna avhandling har därför varit att få kunskap om sjuksköterskors erfarenheter av stress, etiska situationer och stöd i samband med kritiska vårdssituationer inom intensivvård.

Kunskapsteori och metodologi

De empiriska analyserna i delarbeten **I**, **II** och **IV** har inneburit varierande grader av öppenhet inför såväl uppenbara som mer eller mindre dolda innebörder i data. Teoretiskt stöd användes tidigt i den första analysen (delarbete **I**). Här begränsades det öppna tillvägagångssättet till datainsamlingen. I nästa analysarbete lades det teoretiska stödet in senare (delarbete **II**). Här präglades således både datainsamling och analysarbete av metodologisk öppenhet. Det tredje analysarbetet utgick också från sådana principer, denna gång helt utan teoriansknytning (delarbete **IV**). Innehållsanalyser och tolkningar har utvecklats med hjälp av den hermeneutiska kunskapsteori som betonar vikten av att vara öppen, följsam och sensitiv inför datas olika innebörder. Detta förhållningssätt innebär bl.a. att forskaren problematiserar sin egen förståelse så att den inte får utöva okontrollerat inflytande över forskningsprocessen.

Delarbete **III** bygger på en annan form av hermeneutik. Denna utgår från hypotetiskt deduktiva principer tillämpad på meningsbärande material.

Delarbete 1

Dissonant imperatives in nursing: a conceptualization of stress in intensive care in Sweden.

Syfte

Att begreppsliggöra intensivvårdssjuksköterskors erfarenheter av stress.

Metod

Explorativ och tolkande design. Avsikten var att identifiera betydelsefulla komponenter och begrepp. Trettiosex sjuksköterskor från 10 allmän intensivvårds-, thoraxintensivvårds- och neonatalvårdsenheter i Sverige deltog i studien. Materialet bestod av intervjuer med öppna frågor avseende stressande arbetssituationer, och det analyserades med hjälp av en kvalitativ innehållsanalys kompletterad med tolkning. Analysen utfördes i fem nivåer med gradvis ökande abstraktion, och resulterade i ett huvudtema samt fyra underliggande teman. Som tolkningsstöd tidigt i analysarbetet användes begreppet "kognitiv dissonans".

Resultat

Som huvudtema formulerades: *Dissonanta imperativ (motstridiga tvingande omständigheter) samverkar vid uppkomst av stress hos sjuksköterskor inom intensivvård.* Huvudtemat bestod av fyra underliggande teman. 1) *Dominerad av arbetssituationen - behov av kontroll* Sjuksköterskorna kände sig dominerade av situationer med hög genomströmning av svårt sjuka patienter. Samtidigt uttryckte de behov av att ha kontroll över sina arbetsuppgifter. 2) *Begränsad av prioriteringar - önskan att göra mer* Sjuksköterskorna hann sällan med att utföra alla sina arbetsuppgifter på grund av hög arbetsbelastning och vanligen prioriterades den basala omvårdnaden bort. 3) *Sakna auktoritet att handla - vetskap om att något borde göras* De erfarna sjuksköterskorna uppfattade ibland att de hade en högre reell kompetens än de beslutsfattande läkarna. De hamnade i trångmål när deras uppfattningar inte överensstämde med läkarnas. 4) *Professionell hållning - personligt engagemang* Sjuksköterskorna upplevde att det kunde vara svårt att hantera patient/anhörigkontakten då personligt engagemang kunde leda till orealistiska förväntningar på kontakter utanför arbetstid.

Delarbete 2

Caring about-caring for: tensions between moral obligations and work responsibilities in intensive care nursing.

Syfte

Att analysera intensivvårdssjuksköterskors erfarenheter av etiska situationer.

Metod

Explorativ och tolkande design. Trettiosex sjuksköterskor från 10 allmän intensivvårds-, thoraxintensivvårds- och neonatalvårdsenheter i Sverige deltog i studien. Materialet bestod av intervjuer med öppna frågor avseende etiska situationer. Analysarbetet baserade sig på kvalitativ innehållsanalys kompletterad med tolkning, och det utfördes i fem nivåer med gradvis ökande abstraktion. Analysen resulterade i ett huvudtema och fem underliggande teman. Som stöd i analysens senare del användes ett pedagogiskt begrepp: moralisk motivation (care about-care for).

Resultat

Sjuksköterskornas utsagor delades in i tre grupper: svar utan exempel på etisk situation, svar som beskrev att "etiken var närvarande hela tiden" och svar som gav detaljerade beskrivningar på etiska situationer. Ett huvudtema formulerades: *Caring about - caring for: tension between moral obligations and work responsibilities in intensive care nursing.* Detta tema beskriver, hur en moralisk spänning uppkommer när sjuksköterskan inte har möjlighet att fullgöra sitt arbetsansvar och sina moraliska

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plikter samtidigt. Underliggande teman som identifierades var a) föreställning om en god död, b) vetskap om händelseutvecklingen, c) känslor av obehag, d) resonerande om läkarnas göranden samt e) moralisk medvetenhet.

Delarbete 3

Moral stress: synthesis of a concept.

Syften

Att beskriva syntesen av begreppet moralisk stress samt att identifiera förutsättningar för uppkomst av moralisk stress

Metod

En hypotetiskt-deduktiv metod tillämpad på ett meningsbärande material (text). Materialet bestod av två oberoende kvalitativa studier som beskriver sjuksköterskors professionella villkor. Den ena studien belyste sjuksköterskors moraliska problem inom psykiatrisk vård (15 sjuksköterskor), den andra belyste sjuksköterskors stress inom intensivvård (36 sjuksköterskor).

Resultat

Eftersom liknande moraliska komponenter identifierades i de två studierna formulerades tolkningshypotesen att stress innehåller en moralisk komponent samt att moralisk stress uppkommer när man inte kan följa sin moraliska lyhördhet på grund av externa begränsningar. Förutsättningar för att moralisk stress ska uppkomma är 1) att sjuksköterskor är moraliskt lyhörda för patientens utsatthet, 2) att sjuksköterskor uppfattar att externa faktorer (som t ex brist på resurser) hindrar dem från att göra vad de anser vara bäst samt 3) att sjuksköterskor upplever att de inte har kontroll över situationen.

Delarbete 4

Nurses' lived experience of moral stress support in the intensive care.

Syfte

Att analysera och beskriva hur sjuksköterskor inom intensivvård erfar stöd i samband med spänningsfyllda sjukvårdssituationer och moralisk stress.

Metod

Explorativ och tolkande design. Trettiosex sjuksköterskor från 10 allmän intensivvårds-, thoraxintensivvårds- och neonatalvårdsenheter i Sverige deltog i studien. Materialet bestod av intervjuer med halvstrukturerade frågor avseende stöd i samband med stressande sjukvårdssituationer och moralisk stress. Inledningsvis genomfördes en kontextuell analys av tillgängligt stöd vid tiden för datainsamlingen. Därefter baserades analysarbetet på en hermeneutisk forskningsansats som förespråkar ett öppet tillvägagångssätt med intresset riktat mot existentiella innebörder i data. Deltolkningar abstraherades i tre huvudspår som ledde fram till en sammanfattande tolkning.

Resultat

De fem deltolkningarna var: 1) för att få tillgång till stöd måste man vara aktiv själv, 2) att tvingas välja mellan att få stöd och att vara ledig, 3) att ta emot stöd känns som en privatsak, 4) identifikation med erfarna och säkra kollegor kan fungera som stöd samt 5) vid starka känslor av skuld och skam behövs stöd utifrån. Deltolkningarna strukturerades i huvudspåren: 1) tillgång, 2) tillgänglighet och 3) mottaglighet. Dessa relaterades till varandra och bildade tillsammans med resultatet från den kontextuella

analysen underlag för huvudtolkningen. Huvudtolkningen kom att belysa den existentiella innebörden av att ge och ta emot stöd samt betydelsen av det professionella klimatet och de strukturella resurserna i samband med stressande sjukvårdsituationer och moralisk stress.

Konklusion

Det sammanlagda resultatet visar alltså att stress för intensivvårdssjuksköterskor kan uppkomma på grund av motstridiga tvingande omständigheter samt när den moraliska medvetenheten och de formella förpliktelserna i arbetet kolliderar. Denna typ av stress kan kallas moralisk stress. För att sjuksköterskorna ska kunna hantera detta krävs dels tillgång till olika stödformer, dels att de själva är tillgängliga och aktiva inför de stödinterventioner som erbjuds. Den existentiella dimensionen i att ta emot stöd har inte tidigare belysts, vilket måste tas hänsyn till då man organiserar stöd. Den moraliska aspekten av intensivvårdsarbete tycks alltså ha större betydelse än man tidigare haft kunskap om. Moraliska frågeställningar ser dock ut att saknas i kommunikationen mellan sjuksköterskorna på intensivvårds-avdelningarna.

En sammanfattande förståelse av det komplicerade sambandet mellan moralisk stress och kompetens visar att moralisk stress varken kan eller bör elimineras helt inom intensivvården. En total avsaknad av moralisk stress kan förmodligen leda till slentrianmässig omvårdnad och okänslighet inför patienters och anhörigas lidande. Ett visst mått av moralisk stress ser alltså ut att vara nödvändigt för utvecklingen av omvårdnadskompetens i allmänhet och etisk kompetens i synnerhet. Följaktligen måste den moraliska stressen hanteras på ett sätt som leder till utveckling av både individuell och kollektiv omvårdnadskompetens. För detta behövs en vårdkultur som gagnar reflektion och diskussion. I viss mån följdriktigt måste handledning och andra former av stödsatser bli en självklar del av arbetet.

Klinisk och vetenskaplig betydelse

Föreliggande resultat kan sjuksköterskorna och framförallt arbetsledande sjuksköterskor använda sig av för att förstå en svår arbetsituation. De identifierade begreppen kan användas som underlag i handledning och i diskussionsgrupper.

Sjuksköterskornas arbetssituation har problematiserats ur ett etiskt perspektiv, och begrepp har identifierats. Moralisk stress som begrepp behövs studeras ytterligare då det är rimligt att anta att det finns olika typer som dessutom kräver olika stödformer. Vidare behövs det undersökas förekomst och möjliga effekter på t ex sjuksköterskor hälsa. Avslutningsvis kan resultatet specifikt generera hypoteser med syfte att skapa interventionsmodeller för att motverka moralisk stress.