Master thesis

Exploring moral distress –

a study of how nurses struggle to do what feels morally right

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PREFACE

During our thesis work, we were often asked ‘Why do you write about medicine? How is your topic connected to your study program?’. In autumn 2016, we attended an ethics seminar of our supervisor and started talking about the upcoming thesis work, agreeing that we both wanted to write about ‘something different, connected to ethics and medicine’.

Sonja worked in her father’s practice during schooldays and recognized that doctors’ appointments are not just about anamneses but also about personal life stories, worries and thoughts. When working voluntarily as a first aider for events and supporting paramedics on the ambulance car, she was also faced with dramatic situations – both experiences have taught her how responsible and wearing a medical occupation can be. Accordingly, her interest in getting a deeper understanding of incriminatory and complex situations has grown. Carolin first got to know the field of medicine while writing her bachelor thesis at the medical company *B. Braun*. She enjoyed learning more about how *B. Braun*’s solutions do not only improve medical treatments, but can also save patients’ lives. The ability of doing good and having a significant impact on peoples’ lives by working in the medical industry, are her main motivations for selecting the phenomenon of moral distress for the master thesis.

During our empirical research, we spent time at a child oncology ward and were granted the possibility to meet engaged nurses who told us emotionally about their work. In hindsight, conducting this study enabled us to experience how fragile life is and how important human care is for patients. Performing this research literally also meant learning for life, and we are glad to have chosen this ‘different’ topic. We now wish to enable our readers to enter the lifeworlds of nurses, to understand their feelings and perceptions – thereby, we hope to facilitate in-depth sense-making about moral distress for healthcare professionals as well as for employees from other branches who might experience morally distressful situations.

We would like to thank our supervisor Sverre Spoelstra for always having a sympathetic ear and for providing us with helpful feedback, and our hospital contact persons who dedicatedly granted us access to their wards and introduced us to their colleagues. Likewise, an affectionate thanks to the interviewees and nurses we accompanied for mainly meeting us in their free time and allowing us deep insights into their personal experiences. Furthermore, we would like to thank our families, partners and friends for supporting us in pursuing our goal.

Carolin Bollmann & Sonja Gorke, Lund, 19 May 2017

ABSTRACT

Moral distress in nursing is a widely-acknowledged phenomenon that has been linked to decreased patient care, burnouts and job turnover. Thereby, it is often described by quantitative studies which lack insights in feelings and perceptions of affected nurses. Our thesis approached the phenomenon differently by interpreting narratives. These were identified through a qualitative study in cooperation with two university hospitals. Thus, moral distress is illustrated by depicting its multifaceted appearances. For this purpose, we entered lifeworlds of nurses by conducting interviews and observations regarding the theory of symbolic interactionism and interpreted findings in a hermeneutical way.

Consequently, we analyzed our findings by focusing on nurses' moral foundations, on explanations for and consequences of moral distress as well as on alleviating factors. Firstly, most nurses seemed to appreciate their work as they aim at improving patients' situations by listening to their own gut feeling concerning what is 'right' for the ones they care for. The most mentioned reasons for acting immorally were time constraints as well as constraints by colleagues and patients' parents. Subsequently, nurses often felt stressed, avoided patients and handed their responsibility over to physicians. Moreover, we elaborated on five stories which we assessed as particularly interesting for understanding moral distress: caring for terminally ill patients, experiencing interferences through patients' parents, assessing the decisions of doctors as immoral, suffering from time constraints and finding oneself amidst requirements of physicians and families. As this thesis' aim is to enhance the understanding of moral distress in order to empower nurses to handle it as well as to enable healthcare managers to grasp it, we also elaborate on approaches to tackle moral distress by drawing comparisons to passages from interviews and observations in which moral distress was handled differently.

Subsequently, our discussion explicitly focuses on passionate care in nursing, which comes to light when nurses experience moral distress. Thus, we argue that experiencing moral distress should also be seen positively, since it only arises when nurses have caring moral foundations they want to live up to. Besides, our discussion touches upon the inevitability of fully preventing moral distress. Thereby, we stress the coherence between communication, especially moral courage, and moral distress by outlining the downside of these seemingly easy 'solutions'. Therefore, in contrast to many other studies, our research shows the positive aspects of an in itself negative concept like moral distress and expresses clearly, that it is not evitable, especially not by applying panaceas. Finally, we give a brief recapitulation, accompanied by recommendations for further research.

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1. INTRODUCTION

1.1 THEMATIC OVERVIEW

Presumably almost everyone has experienced a situation in which he or she was sick and simply wished for someone to take care of him or her during this time to get well soon. While dealing with minor illnesses, family members or friends might take on this caring role, but in more serious cases the sick person depends on care provided by hospital staff. Needless to say, every ill person wishes for someone who does the best possible to improve his or her health situation. Nurses are usually associated with these kinds of tasks, as they are supposed to improve the health conditions of patients, help them to recover, lessen their pain and show "… a human response and advocacy in the care of individuals [and] families …" (ANA American Nurses Association, 2017).

However, just like everyone else, nurses also have feelings and live through ups and downs – therefore, their physiological as well as mental health is of great importance as it can influence the care provided to patients (Burston & Tuckett, 2013). Even if nurses are the ones who primarily have direct patient contact and should be able to fully take on this responsible role, they regularly find themselves amidst organizational constraints such as understaffing as well as amidst dependencies on doctoral decisions and requests of patients and relatives (Jameton, 1977; Piers et al., 2012). Consequentially, nurses can experience "moral distress" (Jameton, 1984, p.283), which is an intense and mainly negative form of stress for which the literature often depicts similar explanations and consequences (Hamric, Borchers & Epstein, 2012; Nelson, 2009). As this type of stress is connected to what feels 'moral' to nurses, and therefore to "… the standards of good or bad behavior, fairness [and] honesty … that each person believes in" (Cambridge University Press, 2017a), "nurses feel … moral distress when they perform procedures that they feel are morally wrong and can find no way to avoid" (Jameton, 1984, p.283). Therefore, due to their close relationship to patients and the difficulties nurses find themselves in, we assess them as key figures to get an understanding of moral distress.

Although some people might wonder how the topic of moral distress is connected to the business focus of our faculty, we truly believe that the phenomenon of not being able to do what feels morally right can occur in any organizational setting. Of course, medicine and especially end-of-life-situations might involve distressful situations on a fundamental and dramatic level. However, Jameton (2013), the researcher who defined moral distress, declares it an organizational phenomenon that can arise in every institution. Sales agents, for instance,

might be obliged to market insurances to customers to achieve better success rates for their employer, knowing that the products are futile or even disadvantageous for the client. This can trigger just as much moral distress for business persons as for nurses, and may cause them to leave their occupation.

Yet, why is it important to understand moral distress? Concerning the healthcare sector, in which morality often plays a central role when it comes to what is ‘the right thing to do’ for vulnerable persons, we assess it as crucial to know about how nurses experience moral distress and to what extent it influences their colleagues and patients. The following part therefore provides a brief overview of the purpose, significance, as well as research questions and outline of this thesis.

1.2 PURPOSE

Our purpose is to explore the experiences of moral distress, possible explanations, consequences and alleviating factors in order to raise nurses’ and organizations’ awareness for the concept. We strive for illustrating the different perceptions and feelings of nurses while facing moral distress, which in turn aims at sensitizing others to those complex situations. Furthermore, we intend to call attention to the complexity of the phenomenon by considering it from all angles. Thereby, we participate in a debate about moral distress by silhouetting our study against the existing literature.

1.3 SIGNIFICANCE

Since several quantitative studies (surveying between 150 and 400 nurses) show that half of the interrogated nurses are planning to resign or have already done it due to moral distress as a way of escaping “feeling[s] of extreme worry [or] sadness” (Cambridge University Press, 2017b), we therefore assessed it as important to gain a deeper understanding of the topic in nursing (Woods et al., 2015).

Yet, why should healthcare know about moral distress and promote possibilities to discuss it? We think that on the one hand, it is more human to care for employees than to simply neglect how they feel, on the other hand, it is probably even costlier to ignore moral distress than to tackle it. If nurses suffer from moral distress and therefore leave their occupation, the two nursing professors Garros and Austin found out that time constraints for the remaining colleagues increase – this can lead to even more distress, since nurses feel unable to take time for their patients (Canadian Association of Paediatric Health Centres, 2013). Besides, the process of finding and hiring experienced nurses is very time-intensive and expensive – this

circle hence influences organizations negatively. Thus, our thesis hopefully enables sense-making for nurses: one of the researchers who coined the term 'sense-making' is Karl E. Weick, who defines it as "the making of sense … [about] events" (Weick, 1995, p.4). Our research is of interest for managers since they should aim at having a healthy and content workforce that – preferably – knows how to cope with moral distress.

1.4 RESEARCH QUESTION

To fulfill our research purpose, we concentrated on the empirical inquiry of the question 'Why and how do nurses experience morally distressful situations and how do they handle them?'.

For uncovering the appearances of moral distress, we focused on different aspects which illustrate the moral foundations of nurses, the explanations for and consequences of the phenomenon as well as possible approaches for tackling moral distress. The following sub-questions served as a guideline throughout our study and were used as cornerstones during our interviews and observations:

- How does moral distress arise?
- What does 'morally right' mean to nurses and to what extent do ethical codes influence moral foundations?
- How do they feel when experiencing moral distress?
- Which consequences can moral distress have and to what extent does it turn into a long-term phenomenon?
- How does moral distress affect teams, patients and workplaces and do nurses act differently because of it?
- Is there a discourse about moral distress, so how do nurses describe the communication with colleagues, patients and relatives?
- What would nurses wish for to reduce the phenomenon?

1.5 THESIS OUTLINE

In the context of the upcoming literature review (chapter 2), we provide an overview of the present literature about moral foundations in nursing as well as explanations for and consequences of moral distress. Hereby, we illustrate that the phenomenon has mostly been investigated in forms of quantitative research in healthcare and might have long-term effects

for nurses, healthcare teams as well as for patients and their relatives. Moreover, we introduce the role of ethical codes in the context of moral foundations in nursing as well as the theory of 'ethics of care', which we connect to nurses' understanding of morality.

Subsequently, we touch upon the most common explanations for moral distress in the literature, namely time constraints and relations to doctors and relatives. During our field research, we noticed that the majority of our interview partners works in pediatrics and is therefore subject to additional triggers of moral distress, such as disagreements with patients' parents. Accordingly, our literature review illustrates the current body of knowledge in terms of moral distress in this field. Our overview also depicts that moral distress is a personal concept and might lead to exhaustion and withdrawal from care, or can make nurses raise their voice against immoral actions. Moreover, we name approaches which the literature brings forth to tackle moral distress by touching upon the importance of communication and moral courage. Lastly, we also show that academics attach importance to educational measures for nurses to know about moral distress and to improve their own resilience.

Subsequently, in chapter 3, we elaborate on the epistemology of our study as well as on the applied theories and methods. We outline that we conducted interviews and engaged in observations to enter the lifeworlds of nurses. Moreover, we mention the analytical framework of our qualitative research, which included working with narratives. By introducing our two research sites and characterizing our interviewees, we familiarize our readers with the surroundings and main actors of our study. Finally, we touch upon the reliability and limitations of our thesis.

Afterwards, in chapter 4, the empirical findings of this study are presented and interpreted based on the already in chapter 2 established categories. Our interviewees for the most part aim at limiting suffering, making a difference for patients and generally relying on their gut feeling when it comes to potentially distressful situations. While trying to live up to their moral foundations, they often encounter constraints which are influenced by time pressures, hierarchies between doctors and nurses and difficulties with parents of sick children. This results in consequences which include that nurses feel exhausted, withdraw from caring adequately for patients or pass on the responsibility for patients to others. We also elaborate on alleviating factors for moral distress, which were mentioned by our interviewees, such as regular and informal team communication. Consequently, communication is also the foundation of actively engaging in moral courage by raising one's voice. To conclude the illustration of alleviating effects, this is complemented by the positive effect of feedback and

the relevance of self-care in nursing. Furthermore, we try to make sense of, from our point of view, especially interesting case examples, by interpreting stories that nurses narrated to us and illustrating instances of how moral distress might be tackled.

Thereupon, in chapter 5, our findings are positioned in the context of the given literature based on the four known categories which run through our thesis. Hereby, we especially highlight that ethical codes are less acknowledged in practice than in the literature and that the gut feeling of nurses plays an important role. Besides, nurses' position amidst doctors and relatives is, due to the focus on pediatrics, of particular importance for our research. Yet, we also outline clear differences between the reviewed literature and our findings, as our empirical data for instance shows less evidence of turnover and burnout and more signs of passionate care and moral courage than the current body of knowledge in this field. In the context of chapter 5, we then elaborate on our main insights, which illustrate moral distress in a different light. This is firstly accomplished by focusing on the supposition that moral distress brings passionate moral foundations to light, since nurses who muse about moral can make nursing human. That train of thoughts is followed by making the argument that communication can be an alleviating factor for moral distress, as it is highly relevant to reappraise morally difficult situations and to reduce the arousal of the phenomenon. Yet, communication measures should be implemented with caution as they could also result in negative consequences for nurses, such as increased time constraints. Finally, we elaborate on the topic of moral courage, which seems to be a double-edged sword, since it can help nurses to overcome moral distress – however, it can also lead to interpersonal difficulties and resignation.

In chapter 6, we conclude the discussed research results by getting back to our research questions in thought. Besides, our key findings, which enable us to participate in a debate about moral distress, are summarized: moral distress can also bring positive aspects to light, sometimes already small measures can alleviate the phenomenon and moral distress is also dependent on how every respective nurse handles it. Within all those three aspects, we consider it as important to always see the other side of the coin when it comes to how our findings affect nurses. To finalize our thesis, we give recommendations for further research.

2. LITERATURE REVIEW

2.1 CONCEPTUAL FRAMEWORK

Moral distress has been identified as a growing concern and research focus in healthcare for almost three decades (Johnstone & Hutchinson, 2015; Pauly, Varcoe & Storch, 2012). The concept was first established by Andrew Jameton in 1984 (Jameton, 1984). Since the doctor in charge of a Swedish ward** told us about practical experiences with moral distress and our literature research illustrated numerous related articles, we saw the possibility to gain deeper insights into the topic. Therefore, we engaged in primary and secondary research and hereby learned about the various appearances of moral distress. In the context of our study, we reviewed articles, books, documents and films. Hereby, we concentrated on the following conceptual framework:

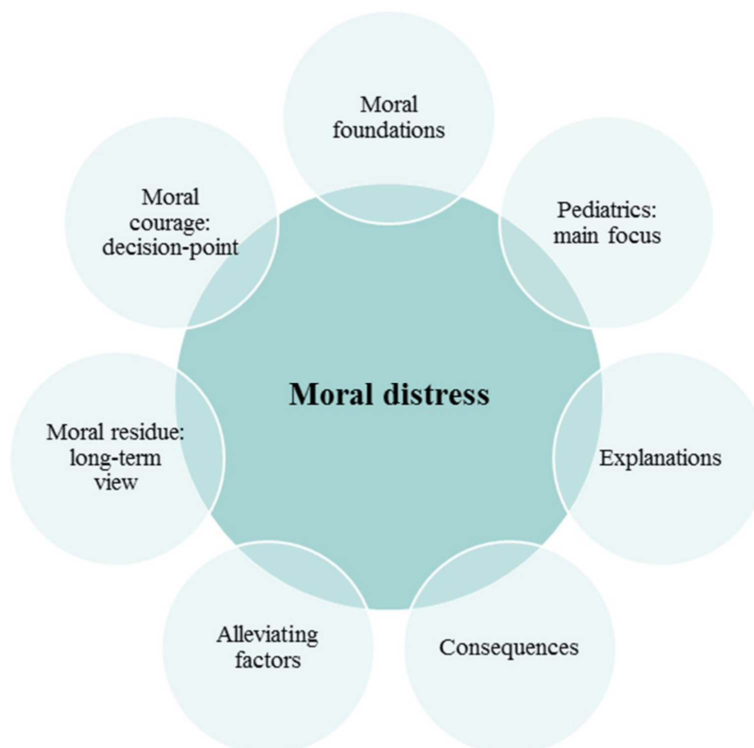

Figure 1 Conceptual framework

Over the months of our research time, we reviewed material about moral foundations in nursing and learned which explanations for and consequences of moral distress the literature depicts, how moral distress can have an impact on nurses in a long-term-view (moral residue)

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[*] The glossary in Appendix 1 aims at enabling an understanding of medical terms that are specifically connected to our research. The terms which can be found in the glossary are marked with an asterisk (*), when they appear for the first time.

and what might happen if a nurse feels the need to actively do something about it (moral courage). In the following, we elaborate on those different aspects and on our study focus in pediatrics*.

2.2 MORAL DISTRESS, MORAL RESIDUE AND MORAL COURAGE

We believe that the literature about moral distress can be divided into two different categories; the dominating quantitative (e.g. Menzel, 1996; Woods et al., 2015) and the underrepresented qualitative research. Besides, one might recognize two camps within the field: one group of researchers accepts the concept of moral distress as a negative feeling and tries to research its appearance as well as its consequences by focusing on nurses (e.g. Corley, 2002; Hamric, Borchers & Epstein, 2012). These researchers, like Rushton, state that nurses experience distress if they "are in situations where they believe that what they are doing is causing more harm to their patient than good …" (Johns Hopkins University School of Nursing, 2017) or that distress can also arise through "… the feeling of not being able to do the right thing" (St. Angelo, 2017). Other scientists state that the concept should be defined more clearly and objectively and that the occurrence of moral distress for doctors and healthcare managers is underexplored (e.g. Johnstone & Hutchinson, 2015; Nelson, 2009).

Studies on the phenomenon have been conducted worldwide – however, Western countries clearly dominate (Oh & Gastmans, 2015). Researchers hereby often concentrate on distressful situations that occur in end-of-life- and ICU*-contexts (McAndrew & Leske, 2015). Regarding occupational groups, almost all reviewed articles emphasize the group of nurses, as nursing is highly connected to moral action (Hamric, Borchers & Epstein, 2012; McCarthy & Gastmans, 2015). Generally, most articles consider the field of healthcare and moral distress has mainly been explored by American authors writing for journals such as the *International Nursing Review* and *Nursing Ethics*. Research about the phenomenon for physicians is still in its infancy (Johnstone & Hutchinson, 2015) and merely some authors like Mitton et al. (2010) or Musto, Rodney and Vanderheide (2015) have started investigating connections to other businesses. The latter for instance found out that healthcare managers can equally experience moral distress – the phenomenon does not only affect nursing.

Moreover, authors disagree about the influence of age and work experience concerning the receptiveness for moral distress (e.g. Borhani et al., 2014; Oh & Gastmans, 2015). Borhani et al. (2014) hereby conclude that moral distress decreases when nurses gain experiences of it throughout their work life. Woods et al. (2015) support this – even if young nurses are better

trained for ethical difficulties, they still show higher moral distress rates. However, Hamric, Borchers and Epstein (2012) contradict the positive influence of age by stating that experienced nurses suffer from higher levels of distress.

If nurses do not tackle moral distress, it can gradually turn into "'moral residue' – … the lingering feelings after a morally problematic situation has passed" (Epstein & Hamric, 2009, p.332). According to Hamric, moral residue only occurs after the actual situation of moral distress as its trigger was resolved but the related feelings still remain (MoralDistressProject, 2013). Those 'leftovers' provide a new foundation for future moral distress – thus, if nurses repeatedly "allowed [themselves] to be seriously compromised [due to moral distress]" (Webster & Baylis, 2000, p.7), their moral residue will constantly increase (Epstein & Delgado, 2010). This is described as the 'crescendo effect' and leads to stronger reactions as nurses are "… reminded of earlier distressing situations" (Epstein & Delgado, 2010, p.3). The existing literature emphasizes the importance of acknowledging moral distress since moral residue can have negative long-term effects on nurses as well as on their patients (Oh & Gastmans, 2015; Wall, Austin & Garros, 2016). Nurses who continue working with moral residue over a long period can feel emotionally numb and frustrated, and experience low job satisfaction, which in turn might lead to a burnout and the complete withdrawal from patient care (Epstein & Delgado, 2010).

Even if moral distress is mainly seen negatively, some researchers also evaluate it as a positive struggle that enables learning from experiences to be better prepared for in healthcare inevitably ever-arising morally demanding circumstances (Burston & Tuckett, 2013; Corley, 2002). Besides, nurses who feel affected by moral distress should not feel less worthy – Garros and Austin even state in an interview that being aware of moral distress can lead to being more sensitive to patients' suffering and needs than colleagues who refrain from questioning the morality of their actions (Canadian Association of Paediatric Health Centres, 2013). Moreover, Jameton (2013) clearly sees a scope of action to escape from moral distress: "Moral distress is a decision point … where ambivalence needs to be resolved toward a choice" (Jameton, 2013, p.303). Therefore, engaging in 'moral courage', which in accordance with the clinical nursing professor Lachman arises when "you feel the fear but speak up anyway" (Nancy Valentine, 2013) can enable a more human and benevolent care, as nurses deeply identify themselves with the patient as a vulnerable human to care for (Corley, 2002). Based on this, some researchers think that nurses are obliged to raise their voice for their patients in order to advocate for them and to alleviate their own moral distress. Academics like Lachman suggest working with the word 'code' in order to facilitate that nurses

remember what it needs to be morally courageous: they should think of “courage, obligations, danger management and expression” (Nancy Valentine, 2013). Thus, Lachman also expresses that nurses should know their obligations, calm themselves down in situations in which they have the feeling that it might be dangerous to revolt and train how to speak up (Nancy Valentine, 2013). Lastly, Rushton adds that managers thereby need to support nurses in finding their voice (Johns Hopkins University School of Nursing, 2017).

2.3 MORAL FOUNDATIONS IN NURSING

First of all, caring is defined as “displaying kindness and concern for others” (Oxford Dictionaries, 2017a). To understand the ethical foundations of caring and to comprehend why being blocked in executing those leads to moral distress for nurses, it is essential to review the literature about ‘ethics of care’. The theoretical mindset, which was established by the ethicist Carol Gilligan, describes morality as a concept of individuals who show a maternal approach for the vulnerable. Therefore, we think that the ‘ethics of care’ are more appropriate for nursing than other ethical theories, since they explicitly focus on the purpose of caring humanly for individuals. For our thesis, we consider it especially valuable to align the ‘ethics of care’ with nurses’ beliefs in order to gain a deep understanding for their actions and feelings towards patients (Gilligan, 1993). Watson (1997, 2015) agrees with Gilligan’s argumentation for a human care through stating that caring is transpersonal and should involve love and respect, which one identifies authentically with. “To act properly in accordance with an ethic of care requires that the four moral elements of care, attentiveness, responsibility, competence, and responsiveness, be integrated into an appropriate whole” (Watson, 2015, p.136). Therefore, acting morally is seen as “an exercise of choice and the willingness to accept responsibility for that choice” (Gilligan, 1993, p.67) – thus, nursing is deeply connected with morality (Keyko, 2014) and nurses should act as “patient advocates” (Oh & Gastmans, 2015, p.15).

This asks for establishing a close relationship to the patient in order to be able to take care of him or her in the best possible way (Gastmans, 2013; Piers et al., 2012). Thereby, it is especially relevant to see the bigger picture and to embrace the patient’s situation with all its variables: caring is more than just curing a patient in a medical way, it is about being attentive, comprehensive and trying to alleviate the patient’s situation (Elliott, 1999). A German nurse expresses her thoughts like this in a TV documentary: “Care is not just to give infusions and medicine – it is about seeing the human. Not the pseudonym ‘patient’… [A] 90-year-old woman has a life, a story, a biography… I think patients deserve respect” (37 Grad,

2015). Halvorsen, Forde and Nortvedt (2008) emphasize that especially soft skills like "… human closeness, empathy, comfort and care …" (Halvorsen, Forde & Nortvedt, 2008, p.724) are essential in nursing for getting to know the patient and his or her needs, followed by an adequate care. As patients find themselves in a vulnerable situation – having to rely on nurses who take care of them – nurses can considerably improve patients' curing by responding to their unique needs and by giving them the feeling of being cared for through engaging in more than merely executing pre-defined duties (Arman & Rehnsfeldt, 2007; Keyko, 2014; Watson, 2015). Therefore, nurses often try to engage in "... unselfish (altruistic) love that is expressed in action" (Arman & Rehnsfeldt, 2007, p.373), thereby making a healthcare setting human (Jameton, 2013).

Lachman (2012) even thinks that moral action is not a voluntary choice, it is part of the professional responsibilities of nurses, as patients expect nurses to be empathetic and to care for their suffering. Empathy thereby refers to "the ability to understand and share the feelings of another" (Oxford Dictionaries, 2017b). Although empathy can be described as walking in another's shoes, nurses should not suffer too much with the patient: Rushton clarifies in a video that it is important that nurses stay healthy to be able to care for others and that their integrity is not compromised (The Schwartz Center for Compassionate Healthcare, 2014). Therefore, it is argued that instead of feeling grief and pain of patients through shouldering all of it, nurses should engage in compassion (Operation Mediation, 2012). According to Rushton, this allows nurses to "feel for patients and be concerned for other's suffering" (The Schwartz Center for Compassionate Healthcare, 2014), but to keep a healthy distance to secure their own health at the same time.

The reviewed literature demonstrates different views on which foundations the relationship between nurses and patients should be established: Laukkanen, Suhonen and Leion-Kilpi (2016) vote for moral decision-making standards to facilitate difficult decisions – especially for intensive care units, where nurses' moral foundations are put to the test since they often feel that patients should not suffer any longer (37 Grad, 2015). In contrast to that, Sabatino et al. (2016) emphasize that ethical action cannot be learned based on ethical codes but should ground on nurses' own assessments and personal values such as sincerity and liability. Besides, Lachman researched that nurses can train to act in morally courageous ways if they are educated by nurses who act as positive role models (Nancy Valentine, 2013). This shows that there is often a conflict between the theoretical ideas of ethical codes and their application in practice – or codes are applied subconsciously by nurses, as their values resemble the regularities (Numminen, van der Arend & Leino-Kilpi, 2009).

Ethical codes aim at laying a foundation for ethical conduct in nursing by summarizing nurses' moral responsibilities (Fida et al., 2016; Iacobucci et al., 2013) – the most prominent code is probably the international 'Code of Ethics for Nurses' (International Council of Nurses, 2012). Acting according to the code is seen as obligatory for nurses and the regularities should be continuously discussed. The main foundation is thereby a respect for human dignity, being one of the worldwide basic human rights (United Nations General Assembly, 1948). Thus, it is especially important that nurses do "… not compromise their professional judgement" (Sasso et al., 2008, p.834). However, moral distress can undermine these ethical foundations, as nurses are hindered in fighting for the patients' dignity. The ICN* code tries to make moral distress in a sense impossible, as it states that "the nurse [challenges unethical practices and] maintains a standard of personal health such that the ability to provide care is not compromised" (International Council of Nurses, 2012, pp.3–4). Yet, to what extent is this realistic? Andersson (2013) researched the usage of ethical codes at a Swedish university clinic and found out that many healthcare professionals do not know the codes profoundly, which especially for new nurses leads to uncertainty in ethically difficult situations, as they lack the long-time experience in nursing. Moreover, ethical education does not seem to take place continuously. Numminen, van der Arend and Leino-Kilpi (2009) confirm this – their study with Finnish nurse educators and students highlights the significance of teaching ethics constantly and interactively. Besides, Iacobucci et al. (2013) explain that nursing codes actually motivate nurses to raise their voice when they perceive a procedure as morally wrong – in their study, the ones who trusted ethical codes more often prevented or criticized unethical behavior of others. However, when nurses have the feeling that they have to live up to regularities that they cannot fulfill, for instance due to time constraints, they might feel even more morally distressed (Vryonides et al., 2015).

2.4 EXPLANATIONS FOR MORAL DISTRESS

Academics who research in the field of nursing name the collaboration with incompetent colleagues, economic restrictions from insurances and the management board (often combined with understaffing (Eizenberg, Desivilya & Hirschfeld, 2009)) and seemingly inappropriate life-prolonging measures as main explanations for not being able to execute what feels morally right (Whitehead et al., 2015; Woods et al., 2015). If these aspects are given, healthcare providers can also feel that they cannot act as advocates for patients (Glasberg, 2007).

Firstly, the healthcare sector is highly pressured by financial constraints, which often affects nurses the most (Fida et al., 2016). For instance, Eizenberg, Desivilya and Hirschfeld (2009) list understaffing as one of the main origins for being forced to disregard own moral beliefs. Nurses nowadays often have the same amount of work or even more tasks – yet, there is less personnel and nursing gets more and more complex, for instance due to new technologies that keep patients alive (Winters & Neville, 2012). Therefore, the upcoming of moral distress is seen as being highly influenced by the broader developments in society and healthcare – there are not enough resources to meet patients' expectations in times of demographic change and life-prolonging measures (Glasberg, 2007).

Nurses also often report that they depend on doctors' and relatives' decisions or act as an intermediary between those two parties – Jameton (1977) names this "nurse in the middle problem" (Jameton, 1977, p.22). Moral distress can hereby for example arise for nurses, if doctors or relatives do not agree on certain treatments. Pauly, Varcoe and Storch (2012) found out that hierarchical structures can lead to the unequal distribution of decision-making power and are therefore known for causing moral distress, since nurses are often the ones who have to execute doctors' decisions. Besides, nurses can also be blamed by patients or relatives for delayed or seemingly inadequate treatment, even if these aspects of care depend on medical decisions the nurses often cannot do anything about (Jameton, 1977; Rasoal et al., 2016). If nurses agree with patients or their relatives that the decisions of physicians are wrong or evaluate the conduct of other colleagues as immoral, they can consequently assess their peers as incompetent (Piers et al., 2012). Interestingly, researchers from the Canadian Association of Paediatric Health Centres (2013) figured out that getting a better understanding about the reasons for decisions can already alleviate moral distress for nurses, even if they would still come to a different conclusion.

Besides, Piers et al. (2012) report that the competences of nurses are often not recognized enough. Nurses regularly feel that they have too little influence concerning decisions that affect the patients (Winters & Neville, 2012). Especially when it comes to biomedicine*, nurses are not informed and included enough (Anderson, Monsen & Rorty, 2000). When reviewing the existing literature, Nelson (2009) concludes that a lack of communication and knowledge-sharing often leads to distressful situations for all involved actors. However, including nurses in difficult decisions and conversations would be helpful as they see the patients very often and can usually assess their condition best (Jameton, 1977). Yet, nowadays, nurses are generally still seen as being responsible for interpersonal relationships and caring tasks, whereas physicians have the leading role, especially when it comes to

medical decisions. Thus, nursing has quite a low-skill image in media and the public attention, which can lead to frustration for nurses (Sabatino et al., 2016).

2.5 MORAL DISTRESS IN PEDIATRICS

While reading about the phenomenon of moral distress, we especially noticed that most of the literature focuses on nurses working in adult healthcare settings; only a few studies and articles concentrate on pediatric units. Af Sandeberg et al. (2017) for example state that Swedish pediatric cancer care units lack research on moral distress. Similar to the previously mentioned explanations for moral distress, academics name different views and attitudes among colleagues, incompetence and hierarchical issues as well as work overload and end-of-life decision-making as the most likely sources of moral distress at pediatric wards (Austin, Kelecevic & Goble, 2009; Dyo, Kalowes & Devries, 2016). Although the field of pediatrics clearly faces a shortage of sufficient research about moral distress, a few main themes, which differ from the ones occurring in adult care, can still be identified. Disputes about resuscitation*, futility of care*, stopping nutrition and hydration as well as conflicts between the medical staff and parents regarding life-sustaining measures are common explanations for moral distress in pediatric wards (Austin, Kelecevic & Goble, 2009).

Several authors draw attention to the emotional component and burden of caring for seriously ill children, for instance at a pediatric oncology unit (Prentice et al., 2016; Pye, 2013). The accomplishment of painful treatments on a terminally ill child as well as medical and technological advancements that allow prolonged life-sustaining measures is often described as the 'futility of care'. It causes pediatric nurses to experience moral distress as they sometimes assess the situation of the patients as palliative, but nevertheless have to keep the children alive (Austin, Kelecevic & Goble, 2009; Pye, 2013). An important aspect is also that nurses do not merely have to care for sick children, but also watch "… families suffer through the cancer experience …" (Pye, 2013, p.251). Therefore, pediatric nurses constantly struggle with living up to the growing demands and wishes of the patients' families regarding treatments at the pediatric unit, which often causes nurses to feel powerless, frustrated, and angry about interferences (Wall, Austin & Garros, 2016). Sarkoohijabalbarezi, Ghodousi and Davaridolatabadi (2017) confirm the particular role of relatives in pediatrics by referring to the close relationship between nurses, ill children and their parents – and define this as a main trigger for moral distress when it comes to pediatric nurses: "... nurses play effective roles in reducing stress* and unhappiness of patients and families while assuming a caregiver role…

during [the] hospitalization of children" (Sarkoohijabalbarezi, Ghodousi & Davaridolatabadi, 2017, p.2).

Furthermore, Pye (2013) differentiates between the burden of doctors and nurses at pediatric units by arguing that although doctors struggle with decision-making, nurses are burdened with actually carrying out the decision made and living with its consequences, since they are the ones who are primarily in direct patient contact (Jameton, 1977). Next to this, pediatric nurses often find themselves caught in dependencies on doctoral decisions which are increasingly based on economic aspects and less on what is best for the patient (Wall, Austin & Garros, 2016). To sum up, our literature review clearly revealed that parents of sick or especially terminally ill children constitute an additional trigger for moral distress in the everyday work life of pediatric nurses.

2.6 CONSEQUENCES OF MORAL DISTRESS

Associated with the pre-mentioned explanations for moral distress are consequences that personally affect nurses and finally have an impact on their patients and the whole healthcare system (Pauly, Varcoe & Storch, 2012). As moral distress is seen as an "embodied concept" (Musto, Rodney & Vanderheide, 2015, p.94), it is experienced very personally – nurses feel sadness, anger and frustration when being confronted with moral distress, which is why the phenomenon is seen as mainly negative (Wilkinson, 1987). Besides, moral distress is researched as a very intensive concept that does not necessarily occur every day (Oh & Gastmans, 2015). Yet, its symptoms show similarities to the burnout phenomenon that is characterized by "… exhaustion and depersonalization …" (Oh & Gastmans, 2015, p.24). When nurses experience moral distress, they might also treat the patients inadequately and aggressively. Interestingly, Lachman found out that every nurse reacts differently to moral distress – they either seem to "implode or explode like a bottle of champagne" (MoralDistressProject, 2013). Thus, not all nurses feel consequences for their own well-being – sometimes they also react with anger, which affects their colleagues or patients and their relatives (MoralDistressProject, 2013). Moreover, even if they think that their own acting was morally wrong, they tend not to admit that or do not feel guilty about their misconduct (Fida et al., 2016; Papastavrou, Andreou & Vryonides, 2014). Usually, studies depict three main consequences that follow these feelings:

Firstly, nurses repeatedly try to avoid morally difficult situations and thereby neglect their duty to provide comprehensive caring, which ultimately impairs patients (McCarthy & Gastmans, 2015). If nurses are subordinated in hierarchy, they often adapt to these

circumstances, do not raise their voice against immoral actions and think in a more medical, technical way (Anderson, Monsen & Rorty, 2000). Besides, nurses who feel that they cannot influence physicians' or relatives' decisions, which impact their patients and therefore their nursing work, often feel powerless (Keyko, 2014). If nurses do not engage anymore (as they think that they nevertheless do not have the power to change something for the better), Rushton concludes that they are no longer attentive to the patients' needs (The Schwartz Center for Compassionate Healthcare, 2014). This can have negative consequences, as nursing becomes less social and there is less mutual support among colleagues. This is especially problematic if disengaging becomes normal and other colleagues follow this way of acting (Fida et al., 2016).

Secondly, moral distress can cause nurses to think about work when they are at home, as they wonder if they have done the right things during their shift (Papastavrou, Andreou & Vryonides, 2014). If they are overall discontented with the morality of their work, they frequently change their occupation in order to escape from moral distress (McAndrew & Leske, 2015). For instance, when staff shortages occur, nurses have to set priorities, which leads to an unequal care for patients – this often feels wrong compared to the wish to care for patients equally (Papastavrou, Andreou & Vryonides, 2014).

Thirdly, if nursing is understaffed and there are severe time constraints, "… failure[s] to carry out all needed nursing interventions …" (Winters & Neville, 2012, p.20) arise. The basic caring tasks like activating the patient, taking care of his or her hygiene and engaging in a conversation are disregarded if there is not enough time to execute them, and nurses and patients are therefore unable to establish a relationship (Halvorsen, Forde & Nortvedt, 2008; Papastavrou, Andreou & Vryonides, 2014; Winters & Neville, 2012). Nurses thereby feel unease as they know that it would be morally right to enable the patients to feel better as soon as possible and to take time for speaking to patients and relatives (Vryonides et al., 2015). Moreover, neglecting hygienic needs of patients reduces their dignity and can lead to severe health implications (Winters & Neville, 2012). Likewise, a Norwegian study implies that understaffing "… resulted in early discharge, delayed admission and reduced monitoring of patients" (Halvorsen, Forde & Nortvedt, 2008, p.720), so it has severely negative consequences for them. The study also depicts that sedation is sometimes used to keep patients calm in order to cope with all the patients that need help at the same time (Halvorsen, Forde & Nortvedt, 2008). If nurses do not have enough time to engage in appropriate care, patients can become even sicker and illnesses can be prolonged – moreover, studies show a higher mortality rate linked to the lack of delivered care (Vryonides et al., 2015).

Consequently, if nurses feel that they have to prioritize patients, they often blame doctors for not being present enough or managers for not seeing the understaffing and the need for interpersonal care, in order to clear their own conscience (Vryonides et al., 2015). However, nurses can also respond to time constraints by trying to work more in order to compensate for personnel shortages (Winters & Neville, 2012) – yet, this may lead to feelings of exhaustion and tiredness (Halvorsen, Forde & Nortvedt, 2008). Researchers like Garros and Austin agree that moral distress can affect nurses very deeply by influencing their emotions and leading to physical problems (Canadian Association of Paediatric Health Centres, 2013). Even if nurses usually try to hide their exhaustion from their patients, higher sickness rates are often unavoidable (37 Grad, 2015). When they cannot cope with distressful situations anymore and leave their occupation due to moral distress, the situation gets even worse, as their colleagues then have to offset their workload. Thus, a vicious circle emerges and hospitals have to invest more budget into the training of new colleagues than they save because of less staffing (Winters & Neville, 2012).

2.7 POSSIBLE APPROACHES TO TACKLE MORAL DISTRESS

The literature states that moral distress should be tackled on different levels: nurses are to some extent able to care for their personal health, healthcare organizations can engage for a work environment that prevents moral distress as far as possible, the institutions which represent the nursing profession are able to provide advice and the society should adjust its picture of nursing and acknowledge it more (Burston & Tuckett, 2013).

Firstly, a work environment that can reduce moral distress mainly includes the possibility of open, respectful and supportive communication about morally distressful situations (Burston & Tuckett, 2013). Dodd et al. (2004), as well as Garros and Austin, clarify that this does not mean that conflicts do not arise, but that there is a good way to talk about them (Canadian Association of Paediatric Health Centres, 2013). Nurses according to Finder also often report that the exchange of thoughts with their colleagues to reappraise morally difficult situations helps them to cope with moral distress (MoralDistressProject, 2013). Musto, Rodney and Vanderheide (2015) therefore suggest to introduce regular de-briefings and storytelling in order to broach the issue. Hereby, Corley (2002) and Anderson, Monsen and Rorty (2000) see it as essential that healthcare professionals of different levels cooperate with each other and also include patients and relatives into their team communication. All in all, communication about moral distress should be supported by the management in order to take full effect (Janssens et al., 2015).

Secondly, nurses should be enabled to raise their voice if something feels morally wrong to them (Keyko, 2014; Pauly, Varcoe & Storch, 2012). The literature hereby suggests to create a positive work environment that facilitates moral courage and is therefore considered as a possibility to tackle moral distress (Musto, Rodney & Vanderheide, 2015; Nelson, 2009). When actively interfering in the decisions of physicians, nurses show "ethical assertiveness [which] is defined as actions to enter or facilitate ethics deliberations in which nurses have not been included, whether through personal initiative, … [or] advocating patients' wishes to others …" (Dodd et al., 2004, p.17). A study conducted by Dodd et al. (2004) illustrates that this is much more common among nurses than the wish to be engaged in the development of ethical guidelines or in ethics committees that debate about "moral principles that govern a person's behavior or the conducting of an activity" (Oxford Dictionaries, 2017c).

Nurses especially interfere doctors' decisions when they feel that they know the patients more closely than the doctors do and can therefore assess what is best for the patients (Dodd et al., 2004) – thus, it is essential to enable nurses to passionately engage for their patients in order to achieve a good care for sick persons (Anderson, Monsen & Rorty, 2000). That is connected to the approach to let nurses work more independently, so that they do not slide into the situation of being obliged to do what feels morally wrong to them. Atabay, Cangarli and Penbek (2015) describe nurses as key actors in healthcare environments as they are the ones who are mainly responsible for the care of sick individuals and function as their central contact person – however, they feel that nurses do not have adequate room for maneuver. By providing them with more autonomy in decision-making, moral distress symptoms might be reduced (Fida et al., 2016; Piers et al., 2012). This does not mean that nurses should feel forsaken – if anything, it matters that they are supported by their head nurses (Laukkanen, Suhonen & Leino-Kilpi, 2016): positive feedback from superiors seems to enhance nurses' work engagement and alleviates negative attitudes to the occupation, which is necessary to make nurses feel confident enough to raise their voices for their patients (Fida et al., 2016).

Thirdly, Corley (2002) suggests that nurses must be educated on moral distress to not be deeply affected by it. In this context, the nursing coach LeAnn Thieman narrates in a video about a study, in which nurses were questioned about moral distress and only some of them underwent a moral distress training. The latter showed more signs of the phenomenon than the ones who did not attend the coaching. From her point of view, this even supports the thesis that moral distress trainings are important, as she thinks that all of the nurses experienced moral distress – however, the nurses participating in the training were just more aware of being affected by it (LeAnn Thieman, 2015). Rushton adds to this that learning about moral

distress is important in order to know how to tackle it (The Schwartz Center for Compassionate Healthcare, 2014). The literature therefore proposes ethics education as crucial (Burston & Tuckett, 2013; Pauly, Varcoe & Storch, 2012). Janssens et al. (2015) suggest working with case studies in order to educate healthcare professionals about moral distress and to prepare them for situations in which it might arise. After having conducted a quantitative study, they concluded that interrogated employees generally associated case trainings as highly relevant for their everyday work life.

Fourthly, next to ethical education, Watson (1997) also asserts that nurses have to care for themselves in order to be able to care for others. Hereby, Rushton especially names the concepts of resilience and mindfulness as important (The Schwartz Center for Compassionate Healthcare, 2014). Healthcare organizations can support nurses in training resilience, which "… refers to the ability to recover or healthfully adapt to challenges, stress, adversity, or trauma…" (Rushton, 2016, p.112). Besides, in accordance with Rushton, mindfulness concepts "… can help to regain stability in morally distressful situations… and consider the body, the feelings and emotions and the thoughts, attitudes and beliefs of nurses… [in order to get to the thought that 'the] experience of my patient's pain is not my own pain'" (The Schwartz Center for Compassionate Healthcare, 2014).

After reviewing literature that is related to our research focus in this chapter, the next one outlines the research philosophy and methodology of our thesis in detail.

3. RESEARCH PHILOSOPHY AND METHODOLOGY

3.1 RESEARCH PHILOSOPHY

EPISTEMOLOGY

Regarding our thesis, we did not aim at identifying the 'truth' about moral distress – as Popper (2002) formulates it: "We do not know: we can only guess" (Popper, 2002, p.278). We therefore concentrated on rich and emotional narratives of morally distressful situations that nurses told us about, since they are stories of personally experienced situations, and therefore not objective, informative descriptions of a given truth. Hereby, we evaluate storytelling as highly suitable for healthcare surroundings, since "… unconscious fantasies and emotions" (Lökman, Gabriel & Nicolson, 2011, p.29) are considerably present in this field (Lökman, Gabriel & Nicolson, 2011). Thus, stories are useful instruments "… to explore otherwise tacit organizational meaning systems" (Tietze, Cohen & Musson, 2005, p.49). By listening to the narratives of nurses, we sought to gain knowledge about moral distress and experience nurses' actions and feelings firsthand (Dutton & Dukerich, 2006; Gabriel, 2004a). However, we had to be cautious not to incriminate our interview partners too much as difficult situations were hereby undergone again. We therefore think that getting to know emotions asks for a dialogue that allows different levels of freedom and guided interrogation (Kvale, 1996). Besides, we assessed a trustful relationship and the allocation of adequate speaking time as important to recognize feelings.

During our thesis, we exemplify how nurses handle moral distress and try to illustrate why some experience it less. Since the method of interpreting stories is mainly about inquiring explanations (Gabriel, 2004b), we interrogated the dialog partners intensively about why they assessed situations in a specific way and why they acted as they did. As we spoke to ten nurses, we think that we could compile a bunch of experiences which clarify similarities and differences in the perception of moral distress. Although we intended to discover personal perceptions of moral distress, we are aware that they might have been biased as they want to present themselves in a good light and therefore tried to cast a critical eye on the nurses' statements. We sought to question statements that for instance seemed to condemn certain colleagues or structures by interrogating nurses about what they actually thought of and wished for in those distressful situations.

We evaluate our research as a "give-and-take[-situation]" (Dutton & Dukerich, 2006, p.24), as we forward our findings to the contact persons of the hospitals we cooperated with. Following Gabriel's (2004a) narrative approach, which implies that stories can enable sense-making, the

analyzed stories about moral distress might be gainful for nurses and could serve to tackle the phenomenon within clinics (Burston & Tuckett, 2013; Tietze, Cohen & Musson, 2005).

RELATED THEORIES

In order to gain knowledge about moral distress, we worked with the post-positivist tradition of 'hermeneutics' through analyzing and interpreting empirical data. As introduced in the epistemology section, our interpretation of personal narratives thereby focuses on one form of hermeneutics, which in itself is a multi-faceted research philosophy (Prasad, 2005). Besides, a hermeneutical approach includes paying attention to the context of texts, so we continuously tried to question how the situational circumstances in which the nurse found herself in contributed to her experiences of moral distress that she told us about (Prasad, 2005).

Corresponding to Prasad's (2005) description of the theory of "symbolic interactionism" (Blumer, 1969, p.1), which claims that situations only have a signification if individuals interpret them, there is more than one reality (Alvesson, 2017b; Hanson, 1965). We must also consider the possibility that moral distress might be an 'umbrella concept' for different experiences and feelings and that there is no 'one moral distress' as such. By applying the theory of symbolic interactionism and entering the "lifeworlds" (Husserl, 1996, p.45) of nurses, we started a "journey into the unknown" (Gherardi, 2004, p.34), since the world can be seen in a new light when diving into the ever-changing meanings of experiences (Kvale, 1996; Prasad, 2005). The theory of symbolic interactionism is nowadays increasingly used in organizational studies and we think that its application complements the hermeneutical focus of our study well, as it is not only related to the interpretation of "ordinary lives in everyday local situations such as … work …" (Prasad, 2005, p.23) from the individual's point of view, but also to the analysis of interactions between different parties. Therefore, this theoretical mindset seems appropriate for investigating how nurses define their own role and how they make sense of experiences, as well as for studying the interplay between nurses and physicians or patients' parents (Cronk, 2017; Prasad, 2005).

Moreover, our study relies on Jameton's theory of moral distress – his definition of the phenomenon clarifies that nurses are constrained in engaging in compassionate nursing. As we think that his description of moral distress corresponds best to our empirical findings, which exactly reveal these feelings of being blocked in what feels right, we assess Jameton's theory as most suitable. Besides, our findings often depict what Jameton names 'nurse in the middle problem' (Jameton, 1977).

Finally, we rely on Gilligan's 'ethics of care' to understand the attitudes that nurses apply for assessing the morality of their own actions and of colleagues' deeds. As the literature of moral distress mainly focuses on explanations for and consequences of the phenomenon, we think that it is gainful to also illustrate the moral foundations of nurses in depth. Thereby, our study stands out from previous research, as we analyze moral foundations based on an ethical theory. Ethical theories like Utilitarianism, Deontology or Virtue ethics seem less appropriate for our study. Utilitarianism sees morality as bringing contentment for many people (Spoelstra, 2016) – we think that in care the enhancement of a very individual patient situation is important. Deontology includes that morality should be based on rules (Spoelstra, 2016) – we assess this as unrealistic for nursing, as every patient's situation is different. Lastly, Virtue ethics encompass that one should treat others as one wants to be treated oneself (Spoelstra, 2016) – we evaluate this as part of nursing, but still think that the maternal approach of the ethics of care suits nursing better.

3.2 RESEARCH METHODOLOGY

FIELD RESEARCH

OVERVIEW OF RESEARCH SITES

So far, we have elaborated on our thoughts about how we thought to gain knowledge about moral distress – in the following, we focus on the tools that we used to put our epistemology in practice. To research the concept of moral distress in healthcare, we cooperated with two university hospitals, one in Sweden and one in Germany. A physician established the contact to the Swedish clinic, which was founded approximately 250 years ago and has about 10.000 employees. In Sweden, nursing is a subject of study (Morand, 2016), whereas nurses in Germany undergo a vocational training. The German university hospital was founded in the beginning of the 19th century and has about 9.000 employees. A nurse friend of Carolin who works at the clinic arranged interviews with interested colleagues for us.

As the hospitals are quite similar (when it comes to their connection to a university and to their size) and German is our mother tongue, we decided to work with both university clinics in order to be able to conduct ten interviews. Thereby, it was interesting to see that even if nurses in Sweden have more freedom to influence caring tasks and pain medication, there was no real difference in what nurses experienced as moral distress factors, because doctors and patients' parents still have more decision-making power when it comes to medical decisions. In the course of our research, a focus on pediatrics resulted from the fact that most of the nurses we interviewed work in pediatric wards. The patients' relatives – especially the

children's parents, play a significant role in causing moral distress, for instance when nurses are blocked in doing what feels morally right because the parents express different wishes (Sarkoohijabalbarezi, Ghodousi & Davaridolatabadi, 2017). Moreover, working with children seems to cause the strongest feelings of moral distress, eventually because of the "… special conditions and vulnerability of children… " (Borhani et al., 2014, p.7).

INTERVIEWS

We researched moral distress by conducting a qualitative study and interviewing ten nurses in a semi-structured way – this type of interview seems to fit the exploration of lifeworlds best, as it enables an open conversation about experiences (Kvale, 1996). The conversations took place in informal surroundings or via *Skype* to enable free expressions of personal experiences. All interviewee names have been changed for confidentiality reasons. The nurses were merely told the purpose of the study (to explore moral distress) – however, there was no strict interview guideline. We posed questions that we developed freely (based on a literature review and conversations with our contact persons at the hospitals). During the interview period, these queries were then adapted to every interviewee. All interviews took about one hour and were recorded digitally.

Our interviewees were all female – therefore, throughout our thesis, we consistently speak of 'she' when referring to a single nurse. Furthermore, half of the interview partners came from Sweden, half from Germany and they differed in age as well as in how they expressed themselves. The following table provides a short overview of the nurses we interviewed for our study, while complete descriptions can be found in the appendix (Appendix 3: Overview interviewees):

Name	Specialization	Workplace	Country	Years of work experience	Type of communication	Language / Body language
Agnes	Pediatrics and epilepsy	Neurology reception	Sweden	35 years	Personal interview	very self-secure
Clara	Pediatrics	Pediatric surgery	Germany	5 years	Skype interview	direct, lively, open-hearted, joyful, positive
Ella	Pediatrics	Pediatric oncology	Sweden	n.d.	Observation	calm, thougtful
Emma	Pediatrics	Pediatric surgery	Germany	3 years	Skype interview	self-secure, communicative, motivated, reflective
Filippa	Pediatrics	Pediatric surgery and urology	Germany	2 years	Skype interview	insecure, satisfied, positive
Ida	Pediatrics	Neurology ward	Sweden	4 years	Personal interview	self-secure / nervous
Ines	Pediatrics	Pediatric oncology	Sweden	10 years	Observation	self-secure, thoughtful, positive
Ingrid	Pediatrics	Pediatric oncology	Sweden	33 years	Observation	self-secure, passionate, loving
Leia	Pediatrics	Pediatric oncology	Sweden	10 years	Skype interview	self-secure, thoughtful, realistic, ambitious
Maja	Pediatrics	Pediatric emergency	Sweden	13 years	Personal interview	self-secure, calm
Matilda	Pediatrics	Pediatric oncology	Sweden	11 years	Observation	self-secure, thoughtful, calm, positive
Sara	Pediatrics and family nursing	Pediatric surgery	Germany	31 years	Skype interview	self-secure, sprightly, compassionate
Thea	Infection	Infection ward	Sweden	2 years	Personal interview	very passionate, positive
Vera	Pediatrics	Pediatric surgery	Germany	1 year	Skype interview	self-secure, thoughtful, calm, lightsome but realistic

Table 1 Overview of interviewees

OBSERVATIONS

Due to a limited research time, we concentrated on two “shadowing observations” (Rennstam, 2017b, p.25), in order to understand what it generally means to be a nurse, including group dynamics, wearing situations and tensions in nurses’ work surrounding. The observations were conducted at the Swedish university hospital we cooperated with on the 30th and 31st March 2017. We visited the child oncology inpatient* and outpatient* wards and entered the work lives of pediatric nurses – in the end, all experiences were documented in written form.

On the first day, the doctor in charge showed us around at the ward. We then joined a meeting of physicians, a team meeting among nurses and physicians and a break at the staff room. As the ward was very busy on that day and the nurses wanted to be able to explain some things to us, we came back the next day and split up – Sonja observed nurses at the inpatient ward, Carolin joined nurses at the outpatient ward. The inpatient ward accommodates patients for a longer time, sometimes up to several weeks, whereas the outpatient ward treats patients who are at home and merely visit the hospital for treatments. We both each accompanied two

nurses during their patient visits, observed the preparation of medications, joined their breaks and had time to talk to them face to face.

DESK RESEARCH
DOCUMENT STUDY AND VIDEO ANALYSIS

Desk research was conducted regarding the 'ICN Code of Ethics for Nurses', which likewise concern nurses in Sweden and Germany (International Council of Nurses, 2017). Besides, we reviewed a study about ethical codes that was send to us by our contact person at the Swedish clinic (Andersson, 2013).

Moreover, a video research was conducted based on the search terms 'moral distress' and 'nursing'. Seven videos were consequently reviewed – their speakers and interviewees define and explain moral distress, narrate how the phenomenon affects nurses, their colleagues and patients; and speak about how to tackle it (mostly by engaging in moral courage). Most of the times, nursing professors are thereby interviewed about the phenomenon.

ANALYTICAL FRAMEWORK

After transcribing the interviews, we noted comments to remember stories, repetitions as well as strange, contradictory or missing information (Ryan & Bernard, 2003). Consequently, we also transcribed how interviewees spoke and acted to be able to interpret all communication elements. Thereby, the ethical consideration that it might be doubtful to criticize the expressions, body language and observed activities of nurses who unburdened themselves for our study, was part of our analyses (Kvale, 1996). Nevertheless, by paying attention to unmentioned information and inconsistencies, we intended to maintain a reflexive perspective (Alvesson & Sköldberg, 2009).

To code the empirical data, we then used the "cutting and sorting technique" (Ryan & Bernard, 2003, p.94) which sorts information by collecting similar topics and building corresponding groups (Rennstam, 2017c; Ryan & Bernard, 2003). By using thematic overviews, we worked with "initial and focused coding" (Rennstam, 2017c, p. 9) – first, we labeled interview findings, then we found comprehensive codes for these labels to reduce the content to the most important data (Rennstam, 2017c). Thereof, we created different tables as overviews of mentioned ethical foundations, explanations for moral distress, consequences for nurses, teams and patients as well as interviewees' suggestions for how to alleviate moral distress:

Figure 2 Analytical framework

Our analysis took place throughout the whole research stage and adapted to every interview's individualities (Kvale, 1996). Hereby, accurateness should not outplay interesting findings, so we aimed at depicting the most common appearances and outcomes of moral distress as well as at selecting stories which we assess as notably insightful for understanding the phenomenon (Rennstam, 2017a; Tracy, 2010). By reviewing the interviews repeatedly, we also engaged in "intra-source critique" (Schäfer, 2017b, p.21) to improve our interpretations. Finally, in the context of our discussion, we positioned our research in relation to the existing literature by showing similarities, differences and possibilities for mutual knowledge enhancement (Rennstam, 2017c).

RELIABILITY AND VALIDITY

First of all, since this thesis was written in pairs, we believe that the exchange of ideas between the two of us enhanced the quality of collecting and analyzing empirical data. We thereby perceived it as advantageous that we have diverse backgrounds and approached topics differently.

Secondly, to assure the validity of our research, we previously defined our research purpose, questions and epistemology and presented those components to both our Swedish hospital contact and our thesis supervisor. This foundation then served as a scope and further guideline throughout our thesis. Regarding our field research, we decided to cooperate with two university clinics to increase the number of possible interview candidates. Thereby, focusing mainly on pediatrics may at first be seen as a reduction of validity – however, as the existing literature about moral distress lacks research in the field of pediatrics, we assess this focus as gainful. Generally, since we were not employed, paid, or connected to neither of the two hospitals, we believe that we were uninfluenced to steer the research in a direction which might be favored by the clinics.

Thirdly, considering the reliability of our field research, we assess our approach of conducting ten interviews as justified, since our intention was not to perform a representative study with a huge amount of data, but to focus on an in-depth data collection. Therefore, instead of using a strict interview script, we allowed flexibility and openness by adjusting our questions to the individual situation and needs of the respective nurse (Appendix 2: Interview guidelines). By

ensuring confidentiality to the interview participants, we once more tried to grant validity since we think that this increased the probability of open answers (Kvale, 1996; Tracy, 2010). As Lachman describes it when being interviewed, nurses normally like to express and share their feelings about moral distress (Nancy Valentine, 2013) – we had the same impression: the nurses we spoke to always seemed to express themselves very openly. Moreover, by conducting observations, we gained real life experience and could put ourselves in pediatric nurses' positions to the greatest possible extent. Hereby, we assess it as helpful that we do not have profound medical knowledge or work experience at a hospital ward, as we think that we therefore could observe processes and group dynamics more openly.

Fourthly, taking different interviews as a foundation, our thesis presents practical examples to show the credibility of our judgments. Yet, as "audiences make meanings" (Tietze, Cohen & Musson, 2005, p.64), our interpretations were conducted with creativity and openness, but merely depict our viewpoint of the nurses' narratives. Therefore, we try to explain the interpretations of nurses' experiences in detailed clarity and liveliness, so that the readers of this thesis are able to evaluate them and might also contradict some of our assessments: we evaluate this as valid and important, as our aim is to outline the narratives in depth, precisely to enable individual sense-making (Ryan & Bernard, 2003; Tracy, 2010).

Lastly, by connecting those empirical examples with the literature, we aim at showing the credibility of our judgments. Lund University's online search engine, LUBsearch, hereby seemed to be a trustful data source for literature, as it summarizes various search platforms and contains an enormous amount of secondary data (Lund University, 2017).

RESTRICTIONS AND LIMITATIONS

First of all, nursing lacks time for knowledge-sharing, so it was difficult to conduct ten interviews (Dutton & Dukerich, 2006; Gabriel, 2004b). In general, the possibility of selecting nurses was limited, as we assessed it as questionable to coerce someone to participate in a study which explores personal feelings, if that person feels unable to contribute own experiences or does not want to share them. Connected to that, one could assess it as one-sided that all the German nurses we interviewed came from the same department. However, as they told us about diverse morally distressful experiences, we do not evaluate this as critical. Moreover, we interviewed several young nurses, who appeared to be very positive about their work and did not really seem to suffer from moral residue. When it comes to the Swedish nurses, this was surely also owed to the fact that the younger nurses felt more versed and self-secure when it comes to conducting an interview in English. We merely interviewed

female nurses, as only women contacted us due to their interest in participating in our study. Besides, at the ward we visited, only one nurse was male. We accepted this limitation and assess our sample as qualitatively representative, since the vast majority of nurses are female (Grant, Robinson & Muir, 2004).

Secondly, as interviewees were mainly requested by head nurses and department heads, a certain bias can be assumed. Nurses might have been skeptical to report experiences openly, as they could have feared difficulties with superiors (Dutton & Dukerich, 2006; Schäfer, 2017b). Furthermore, in alignment with Alvesson's (2017a) recommendation, we consider that the nurses' stories might sometimes not have depicted moral distress but rather alleged examples for stress. Besides, they might have been fragmentary or unconsciously modified to present their narrators in a better light.

Thirdly, the observed reality at the child oncology wards might not be exemplary. As we observed the wards on a calmer day, we felt that the stress level was rather low. Moreover, the ward seemed to do things properly that some other nurses reported as main explanation for moral distress – there was, for instance, a good communication culture between nurses and doctors. We acknowledge that the impression we had from our observations might be blurred and that it would have surely been interesting to see how the healthcare professionals act and interact on a stressful day. Yet, we also think that the days at the ward enabled us to experience some positive examples for how moral distress can be minimized, for instance by relying on a good team communication, which we in turn assess as gainful for our thesis.

Lastly, our lack of medical knowledge as well as our inability to speak Swedish might have sometimes challenged the understanding of empirical data (Dutton & Dukerich, 2006). This holds especially true for the meetings during the observations at the clinic, as they were held in Swedish. Therefore, we could observe how the nurses and physicians interacted with each other and how the general atmosphere was, but not exactly what they were talking about. Finally, our positive attitude towards the medical field might have led to a "confirmation bias" (Schäfer, 2017a, p.20), as we have searched for evidence that moral distress is not a merely negative concept (Marshall & Rossman, 1999; Tracy, 2010).

4. EMPIRICAL FINDINGS – HOW NURSES EXPERIENCE MORAL DISTRESS

Previously, we clarified why and how we conducted our research – this chapter goes beyond this by presenting our empirical data. We firstly elaborate on moral foundations of nurses, followed by explanations for and consequences of moral distress, and finish with factors that might alleviate the phenomenon. Thereby, a few main themes could be identified and are illustrated through interview quotes. Moral foundations seem to be the decisive factor for nurses to experience moral distress in the first place as they define what nurses perceive as morally right and wrong. Our empirical data shows that nurses follow their own assessments when aiming at helping patients holistically and at engaging for analgesia*. Secondly, time constraints, hierarchical structures and disagreements concerning medical decisions, as well as interferences of patients' parents mostly caused nurses to feel compromised in living up to their foundations. This in turn leads to manifold consequences such as that nurses turn away from patients, lighten their own responsibility or are negatively affected by taking experiences home. Lastly, nurses also stated that communication and self-care in many respects can reduce moral distress. The four above mentioned parts of our analysis serve as an overview and pave the way for the stories of five nurses, which present our findings in a more profound way.

4.1 'I KNOW WHAT IS BEST FOR THE PATIENT'

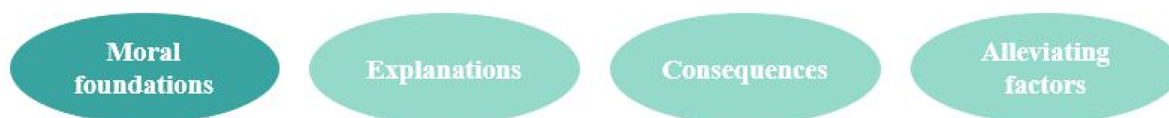

Figure 3 Section overview 4.1

To understand why nurses experience moral distress when they feel that they cannot do what seems morally right, we assess it as important to comprehend exactly what 'doing the right thing' means to them. For this reason, we reviewed the 'ethics of care' as part of our literature review since this framework discusses moral principles for dealing with vulnerable persons who are in need of love and respect – just as sick patients require passionate care from nurses (Watson, 1997, 2015). Although our interviewees were not explicitly aware of the 'ethics of care', they clearly told us about their moral beliefs which explain how and why they treat patients as they do. Throughout our study, we therefore try to link their statements to the principles that are to be found in the theoretical mindset of the 'ethics of care' in order to give

our interpretation of the stories and actions of nurses a basis for orientation. Thereby, three main foundations – making a difference for patients' situations, relying on the own gut feeling, and limiting suffering – were identified and are subsequently analyzed. We further elaborate on the correlation between those moral foundations and moral distress in section 5.2.

Firstly, making a difference for patients by slipping into their shoes seems to be the main foundation for engaging in nursing. Thereby, a close relationship with patients and relatives is established, in which nurses seem to deeply care about their patients' comfort and recovery:

> I try to take care of them the same way as I would like to be treated by a nurse. (Thea)

> Of course, I think about what I could do to help the child, to make it feel better... There is nothing better than watching a sick child becoming healthy again. (Emma)

In order to make a difference for patients' situations, nurses especially emphasized the importance of seeing the patients' situation holistically. Thereby, they stated that the personal environment of patients should be considered, as it can play a crucial factor during the recovery process:

> I think the patient is more than just the disease... Taking care also includes to listen… So I really try to see the patient as a whole human being. (Thea)

> If we do good for the parents, we do good for the child we think... You have somehow a 'double responsibility'. (Maja)

Secondly, when it comes to what they assess as morally right for their patients, it became clear that nurses seldom identify with codes of ethics – instead, they act accordingly to their 'gut feeling' and experience:

> Oh god, [laughs] I cannot really remember the ethical code and what is actually part of it... It is more my feeling and my experience that I use. (Filippa)

Concerning the assessment of how patients feel and how their illness is developing, nurses often know patients better than doctors do, as they see them regularly during the day. This close relationship seems to further support nurses in trusting their gut feeling regarding morally 'right' care and in their estimation when patients' suffering has to be limited. For instance, nurses regularly expressed that they see it as one of their main tasks to guarantee that patients do not have to be in pain or should not receive futile care in end-of-life-situations:

> I have to set priorities. If someone is in pain, he or she receives a pain medication first. (Clara)
>
> I had a patient… , she is terminally ill [deep breath] … There is no part in her life that she might find enjoyable – … it would be better not to do the reanimation. (Ida)

To conclude, the main elements of our interviewees' moral foundations were the following:

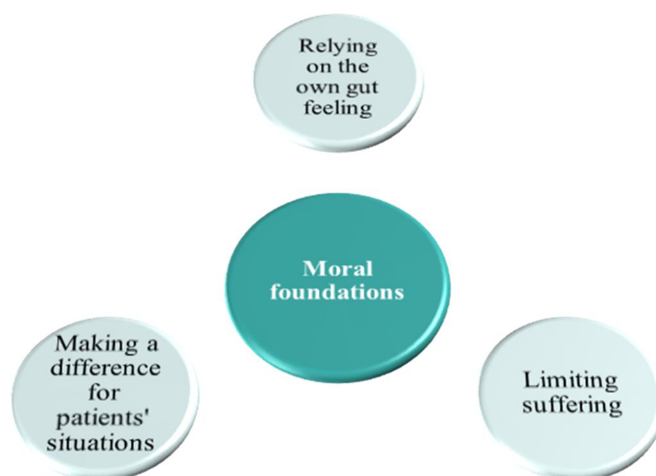

Figure 4 Conclusion of moral foundations in nursing

4.2 'I WOULD DO IT DIFFERENTLY, IF I ONLY COULD'

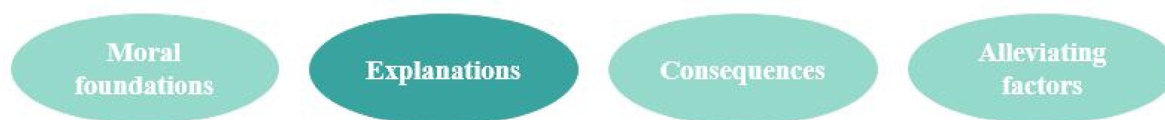

Figure 5 Section overview 4.2

To understand the phenomenon of moral distress, we tried to comprehend the various reasons why nurses feel distressed. Time constraints, interferences of patients' parents as well as hierarchical decision-making were the dominating explanations for moral distress while interviewing our nurses, and are presented hereinafter.

First of all, all nurses named understaffing and thereof resulting time constraints as a main trigger for moral distress, since time pressure seems to prevent nurses from living up to their moral foundations. The increased caring effort that seems to have developed over the last years, due to medical progress, further intensifies nurses' perception of this issue:

> [Situations in which you know what would be morally right, but you cannot do it] exist… they mainly occur during situations of time pressure. (Vera)

> … The kids … are much sicker than they were 10 years ago. It feels like you have less time for every patient, but you need to do the same amount of work. (Ida)

The previous quotes highlight that the situation of understaffing might not be easily resolved, but traces back to wider societal reasons, such as growing life-expectancies. As a result, nurses feel unable to listen to patients and parents as well as to explain treatments in detail. On the other hand, nurses can feel even more distressed when they nevertheless take the time to do so:

> Today one of the patients was crying and I wanted to stay to comfort her but I did not have the time because I had so many other patients. (Thea)

> You … always find yourself in some kind of a conflict, as you know that there is still a lot to do, but you feel that [listening] does good to the parents. (Vera)

Nurses also mentioned that an increased economical focus in healthcare forces them to compromise their moral foundations, since they therefore have to prioritize patients. At worst, the rising economic pressure might lead to less human nursing and neglection of care:

> We do not have enough personnel… We just keep running from one child to the next one and try to cross off things from our to-do list. (Emma)

> … I know that we only get money for one week from the insurance and then I try to hurry up to release the patient within this time frame. At this point I really feel that I am in a moral conflict. (Vera)

A sobering notion is that understaffing, and consequentially time constraints as explanation for feeling morally distressed, were named by all interviewed nurses. During the first day of our observations at the child oncology, we could as well experience that the ward was overcrowded and that nurses did not have time to explain things to us, whereupon we returned one day later. The ward meetings we attended were repeatedly interrupted by phone calls and the coming and going of colleagues. We assess this as critical, as the respective colleagues thereby missed out on information. However, time constraints during our observation only occurred to a limited extent, which was for instance visible when a nurse took additional time for a patient who was very sick and whose grandmother was crying at the bed. Yet, we acknowledge that this impression might be misleading, as we deliberately had to observe the ward on a day which was less stressful. On the other hand, we realize that the nurses at the ward could have also taken advantage of our presence by showing how morally distressed

they feel to draw attention to things that should be changed for alleviating their distress (for instance the implementation of better staffing) – however, they did not do that.

Next to time constraints, we came to know another aspect which can increase moral distress distinctly. As our study was mainly conducted in the field of pediatrics, the nurses we interviewed and observed regularly found themselves amidst doctors and parents and somehow acted as a 'communication channel'. Since nurses are normally easier to approach at the ward, they have to handle requests and problems, but cannot directly resolve them:

> ... As a nurse, you end up in the middle. You have the doctors on the one side and you have the parents on the other and it's sometimes as if they both speak through me... (Ida)

> It is a very stressful situation for us that [patients] have to wait for such a long time and we have to meet their complaints… We can go half way and then we cannot do anything more... (Maja)

Furthermore, patients' parents can block nurses' desire to engage in what feels morally right to them:

> If it is the fourth day after the surgery, … at some point, we say 'we could leave [out] one painkiller' – we just have a feeling when this is adequate. But they insist on pain medication, even if the child laughs and plays. And, well, I think from a professional viewpoint [this] would in fact not be right... (Clara)

However, in the context of our observations, we could not observe moral distress caused by patients' parents. Instead, we experienced quite the opposite, thus a good cooperation with parents. The nurses there told us that they feel much appreciated by the parents, and that most parents are very grateful for the nurses' work. Nevertheless, we think that it would have been interesting to witness how a nurse reacts if she experiences a morally distressful situation with parents as well as to explore possible long-term consequences if such situations add up.

Lastly, when it comes to the cooperation with physicians, nurses often reported hierarchical decision-making as another main explanation for experiencing moral distress. A common problem seems to be the lack of understanding for decisions made by doctors and the feeling of inferiority to them:

> I felt helpless and tried to understand why on earth [the doctors] would send [the patient] to surgery again. It did not make any sense back then and it still does not make sense today… (Emma)

> … sometimes the drainage* is removed, although I openly stated that I do not agree. (Vera)

In contrast to that, the oncology ward we visited gave a different picture by conveying the impression that there are only few hierarchies. During the ward meeting and team breaks, it attracted our attention that the doctors and nurses mingled. We did not have the feeling that there were formations of small groups and all observed nurses emphasized the equal discussions between physicians and nurses:

> We have no doctors on high horses. I really like them, we have a great atmosphere. (Ingrid)

However, we acknowledge that this positive picture could also have been influenced by the wish to convey a good impression during our presence. Moreover, one nurse shared with us that the focus of nurses and doctors is sometimes very different: doctors' discussions take place on a high medical level, while nurses usually take the broader picture into account, which can lead to disagreements within the team.

To summarize, the main factors that led to moral distress for our interviewed nurses were the following:

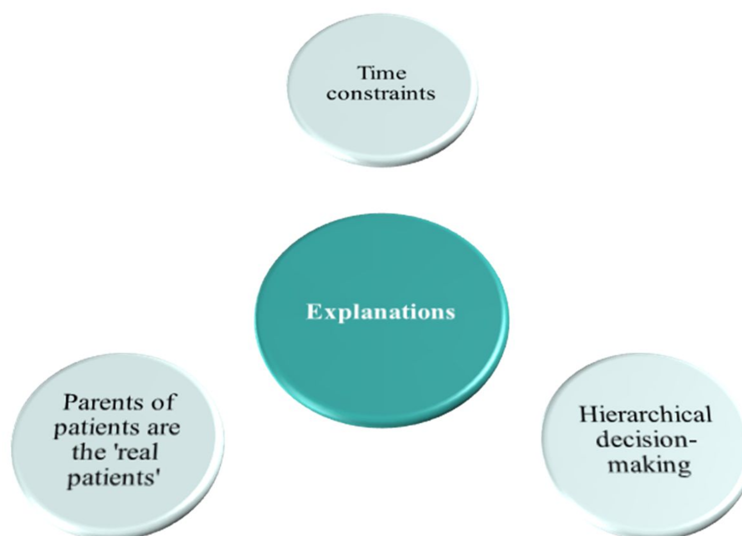

Figure 6 Conclusion of explanations for moral distress

4.3 'I CANNOT STAND THIS ANYMORE'

Figure 7 Section overview 4.3

After analyzing which moral foundations nurses act upon and what hinders them from living up to them, we now demonstrate possible outcomes of moral distress. The effects we encountered were manifold, but could be grouped into three major categories: nurses might be negatively affected, light their own responsibility and turn away from patients as well as only engage in minimum care.

Firstly, if nurses experience moral distress, this entails consequences for nurses themselves and for their further development. To gain a deeper understanding of these effects, we consider being aware of the correlations and differences between stress and moral distress as important. If nurses must repeatedly compromise their integrity as stress prevents them from living up to their moral foundations, moral distress is transformed into moral residue. Consequently, some of them feel negatively affected and take work experiences home:

> … Sometimes we do not have time for [making patients and their families feel comfortable]… And then you have to neglect your own moral values because it simply does not work… And sometimes I feel that these situations add up… (Vera)
>
> It is awful… I do not take separate patients home but the whole situation in my job… (Agnes)

Yet, some nurses also see moral distress as a sign that they still care about the patients' well-being:

> When something bad happened at work or to the patients you take it home and think about it… But if you dream about patients or think about them at home, I think it also shows that you care and that you really want to help. (Thea)

On the other hand, even if nurses can do what feels morally right, working night shifts or long hours and engaging in work that includes physical exertion can be perceived as stressful. Therefore, our study illustrates that turnover rates in nursing are also influenced by 'regular' stress:

> ... You have to work [in shifts and] to be present on the weekends and on bank holidays. I think it is very exhausting to work as a nurse for your entire life. (Filippa)

> It is not that I am depressed because of a child which maybe will die… but I feel like… totally exhausted. (Sara)

Secondly, resulting from feeling negatively affected due to moral blockades, nurses frequently accept the physicians' superiority and thereby withdraw from acting as patient advocates:

> It happens that I disagree with doctors but then I think 'Well, they have studied medicine, they have a lot more expertise than I do, so they know what to do'. (Filippa)

During our observation, we witnessed a situation in which a chemotherapy for a baby could not be started, as an x-ray* showed that the incision* was placed wrongly. When Ella, the caretaking nurse, entered the patient's room, the parents had not yet been informed about the result of the x-ray and directly approached her about the further treatment of their son. We hereby assessed Ella's reaction as interesting, as she neither lied to the parents, nor told them the full truth – she just stated what she could do, taking blood samples, and left the parents with the information that the doctor will answer their questions. Ella thereby escaped a morally distressful situation, assigning the responsibility to the doctor, even if she was the first confidential person for the family and knew about the misplaced incision.

Lastly, as a consequence of time constraints or uncomfortable situations with patients' parents, nurses might reduce their engagement for patients' needs by merely providing basic care, by avoiding the patients' rooms or by not taking care of patients in a timely manner:

> … When there is understaffing, you can only take care for the basic needs... [Thus, sometimes] an antibiotic can only be given an hour too late… I think that is almost careless... (Vera)

> You try to not enter the room at all or to avoid the parents on the corridor – you simply do not feel like explaining it for the sixth or seventh time. (Clara)

During our observations at the child oncology, we could not observe that nurses turned away from patients. However, turning away can also occur in more subtle ways:

> I try to be warm-heartedly, but I also try to build a wall – not a too high wall [laughing]… I really have to distinguish between work and private life. (Ines)

All in all, the consequences of moral distress which were most often mentioned by the nurses we interviewed were the following:

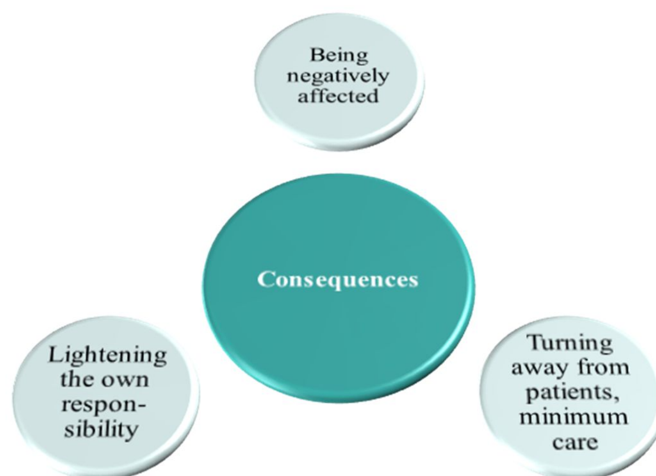

Figure 8 Conclusion of consequences of moral distress

4.4 'I WANT TO DO SOMETHING ABOUT IT'

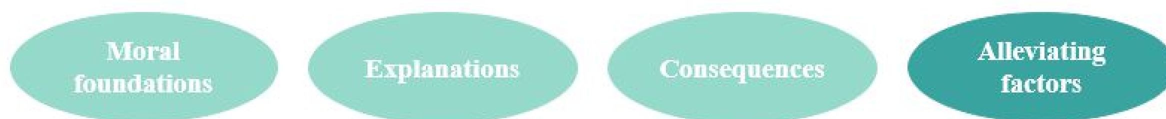

Figure 9 Section overview 4.4

After mentioning moral foundations, explanations for and consequences of moral distress, we consequently elaborate on factors our interviewees referred to as alleviating the phenomenon. Regular and informal communication, engaging in moral courage as well thinking positively and engaging in self-care thereby play an important role. In the following, we focus on measures that nurses can actively contribute to, as we are aware that broader solution approaches for the healthcare sector would go beyond the scope of our thesis.

Firstly, our interviewees had the feeling that a collegial work surrounding is the foundation for an open communication culture, which in turn was perceived as helpful. If distressful situations can be talked through, the experience of moral distress seems to have a less negative effect:

> … I work with a great group of colleagues because you can always talk to them… I feel that that is a very positive atmosphere. (Ida)
>
> Maybe the other nurse has the [same] problem [with the patient] or feels the same way, but if you do not talk about it, you cannot share your feelings. (Thea)

So, how should communication be implemented in the everyday work life of nurses? In this context, the interrogated nurses assessed formal trainings as less important in relation to regular team communication:

> … You occasionally talk with the colleagues. But there is no set meeting… I think that sometimes it would be quite good to meet at the end of a shift and to reflect about [experiences]. (Filippa)

The ward that we visited puts exactly this into practice: all the nurses meet at the end of their shift and have the chance to talk about their day, about problems that aroused and difficult situations with parents or doctors in an informal way. The head nurses are also present since they need to know about those challenges to discuss them with physicians afterwards. A good communication with doctors was generally assessed as the most important factor to avoid doing what feels morally wrong:

> I also talk to my boss [, the doctor in charge]. That is very good… They take us seriously. (Leia)

As already mentioned in section 4.2, we felt that the flat hierarchy between the observed physicians and nurses enabled a regular and open communication culture. We further elaborate this in section 5.3. But is it enough to simply maintain a good communication in order to avoid moral distress? Next to regular and informal communication, our interviewees also showed active engagement in moral courage in relation to physicians as well as to relatives in order to reestablish their moral foundations:

> I discuss [the medication] with the doctor [and also] have some possibilities … to change [it]. I tell him what to do and not to do. It is an agreement between the doctors and me. (Agnes)

> I just told the parents that what I have to do with the patient is important… You try to resolve this through making it reasonable, through explaining them why I do what I do. (Vera)

By practicing moral courage, nurses express their disagreement and doubts, and thus take a stand for what they perceive as a better treatment for their patients. We believe that this engagement should be looked at more closely, since it might be an alleviating response to moral distress, but also has its risks, which is why our discussion pays particular attention to moral courage in section 5.4. Yet, if nurses generally assess it as meaningful to advocate for their patients, what empowers them to do so? Our interviewees for instance evaluated it as helpful to see the positive aspects of nursing as well as to get positive feedback about their own accomplishments:

> It is a very nice occupation … as you can actively engage in the well-being of the parents and the patients. (Filippa)

> … A former patient came by to say hello ... This was simply amazing to see how well she is doing now and that this is because of us… We work a lot and it feels great to get something back. (Emma)

Though, are positive attitudes of nurses, which are reinforced by thankful feedback, enough to cope with situations in which moral distress cannot be completely ironed out? Our interview partners shared that they also need to care for themselves in order to protect their inner balance in situations that feel morally wrong – even if this might bring along emotional coldness:

> I try to do my best, but then I go home and I also have to think about myself, I also have a life … I have to understand the [patients'] situation but … sometimes I simply cannot … resolve it. So you have to put a beginning but also an end to some things. (Thea)

> Nowadays I put up a wall to protect myself and to just do what I have to do... (Leia)

Even if a lot of interviewed nurses are aware of the distressful character of their occupation and think about leaving their work place, they still want to continue working in healthcare. Yet, they aim at combining their passion for helping others with the protection of their personal health:

> I want to stay close to the patient… I think I would have way more time for my patients when I switched to ambulatory care*. There you really have time to do what you think is right… (Clara)

To summarize, the main factors that seem to alleviate moral distress for our interviewed nurses were the following:

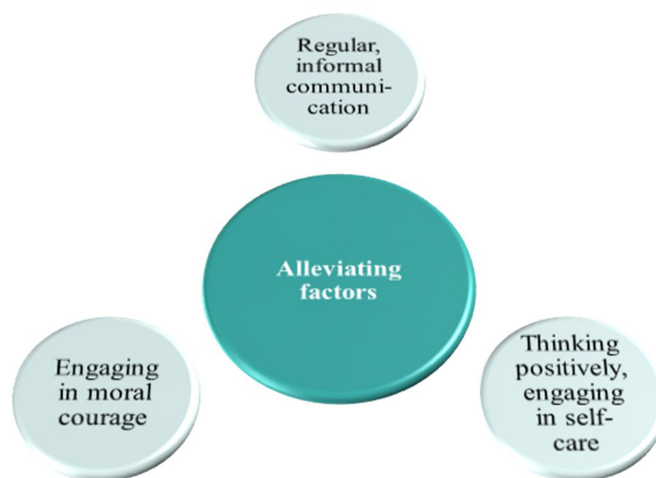

Figure 10 Conclusion of alleviating factors

4.5 INTRODUCTION TO EXEMPLARY STORIES

The following stories of our interviewees have been stuck on our mind, as we have been deeply touched by them and think that they summarize our interviews well. By interpreting these stories, we try to create a profound understanding for how moral distress is experienced and to which foundations nurses link their moral acting. The upcoming narratives focus on the topics of caring for terminally ill patients (story 1), experiencing interferences through patients' parents (story 2), assessing the decisions of doctors as immoral (story 3), suffering from time constraints (story 4) and finding oneself amidst requirements of physicians and families (story 5). By selecting stories of different nurses, we aim at illustrating multifaceted viewpoints of how moral distress can be experienced. Besides, we think that healthcare actors should be aware of the fact that moral distress often arises within seemingly uncritical, everyday work situations. We therefore also elaborate on approaches to tackle moral distress by drawing comparisons to interviews and observations in which the phenomenon was handled differently. The following questions guided us through our analyses:

- How does moral distress arise in the story?
- Why does the nurse feel distressed and how do her moral foundations become visible?
- Why does the nurse act as she does?
- What are the possible consequences for the patient?
- Which questions arose for us while listening to the nurse's narrative?
- Which experiences of other nurses could be helpful to review this story?

4.6 STORY 1: IS THIS LIFE STILL WORTH LIVING?

Leia told us a narrative about a terminally ill patient that caused her to think about the justification of a further therapy:

> We have one patient who is very sick and… I know the best for her would actually be to do nothing… I know she will hate it if we put a needle in her port catheter* but we have to do it because the parents want us to do it.

The nurse hereby clearly expressed that she assessed a continuous therapy as morally wrong, but still had to execute the parental decision. We interpret that this caused moral distress to her, as she knew that it would be difficult to perform the treatment. To understand why it feels morally wrong to Leia to put a needle into the patient's catheter, we had to investigate further into her moral foundations. Her narrative illustrates that she did not want the patient to be in pain – moreover, she had the strong sensitivity that the girl would feel better without a treatment. From our point of view, this assessment was linked to two elements. On the one hand, she expressed that the whole medical team assessed a further treatment as pointless and unpromising in the beginning of her story, on the other hand, she thought that a further medical care would cause even more harm to the terminally sick girl. Leia obviously did not feel comfortable in this situation and put herself in the shoes of the young patient:

> I know the treatment will be very tough. She will be ill and I think it would be better for her without any further treatments, needles, and so on… We cannot really do anything for her anymore… I only feel sorry for her.

While interviewing Leia, we were consequently interested in how she coped with the situation. First of all, Leia told us that she did not have a chance to change the distressful circumstances:

> I have to do it because the doctor said so and the parents want to do it as well. But I would not tell parents how I feel because the doctors are the ones who talk to the parents. I do not think that my voice counts in that way. The doctors know more than I do.

Leia hereby expressed that she feels quite subordinate to the physicians. This is interesting, as she, apart from that, assessed the cooperation with the doctors as very equivalent:

> I think I can always talk to the doctors about anything because they listen to us. It is a very good cooperation.

Thus, a good team communication, which during our interviews was often mentioned as helpful to alleviate moral distress, seems to be present at Leia's work surrounding. However, this did not seem to resolve her experience of moral distress, as she drew a clear line between decisions of different kinds:

> … When it is about the caring and not the medication, I can talk to the doctors and say what … what we should do… I can decide about tubes* and pain medication for example, but not about medical decisions such as chemotherapy.

Obviously, the physicians in this situation followed the parental wish to continue the treatment for their daughter. Yet, our interpretation of the situation is limited, as we do not know if the doctors thereby discussed the decision with the patient's parents by educating them about the possible negative consequences of a therapy. However, as Leia (also) did not raise her voice, the treatment was consequently performed. She seemed to be aware that she in fact also could have spoken up, but immediately questioned her own gut feeling of focusing on palliative care*. Instead, she silenced her own conscience by putting more trust in the doctors' hope for an unexpected healing:

> I just feel something, it feels wrong to me – but maybe the doctors have read something about it, like new articles or studies, and that is why they want to try it. They probably know more about the situation and so it could rescue her.

Thus, Leia's withdrawal from interfering in the doctors' decision to continue the treatment could bring along even more suffering for the seemingly terminally ill patient. Besides, this process can also have negative consequences for Leia, since she compromised her own integrity by nevertheless administering the therapy to the patient. When inquiring if she felt distressed after this experience, or if she even went through moral residue, she negated this:

> In this situation, I did not take it home… It is important to feel empathy, to be human, but many things can happen in 10 years when you work at this ward, so that is why I have the wall now.

With this statement, Leia described that she had to blunt her emotions over the years in order to protect herself against burning out. We see this as an evidence that she at some point suffered from moral residue and decided to distance herself from engaging too emotionally, presumably without being fully conscious of possible consequences. Might 'building a wall' be disadvantageous for Leia's patients in the long term, as she might distance herself too much from them, which hinders the creation of a transpersonal relationship? This could be critical, as it contradicts the principles of the 'ethics of care' to engage in interhuman caring.

Moreover, we question if Leia will be able to steadily live with a ‘wall’, as she still showed emotions for the sick girl she told us about. We therefore assess it as important that she further cultivates the communication with doctors, since she already felt that debriefings with her nursing colleagues are useful:

> When we have the debriefing, it is very good because you learn how to think, how to react and how to move on with your feelings…

Moreover, she clearly stated that she would actually like to participate more in medical decisions. Leia also expressed that these meetings could help her to be more self-secure in possible future interventions, as she thought that she by then did not have a foundation to intervene:

> If the children are very sick and it is more about if we should continue or stop the treatment I think I cannot say anything about it. I do not know it… If we had more ethical meetings, I would say more about how I feel about certain treatments, medications and so on.

All in all, by drawing comparisons to the statements of Leia’s colleagues, it could also be helpful if Leia trusted herself more, followed by actively raising her voice. Sara is exemplary for this:

> … It helps me that … I have more experience, and sometimes I just say ‘I do it like I want to do it, no matter what you think about [it]’.

In summary, it can be said that Leia found herself in an end-of-life-situation in which she had a gut feeling that further treatment is futile, but felt that she was not entitled to question parental and medical decisions. Hereby, it became visible that she really cares about her patient and might be able to tackle moral distress by at least trying to engage in conversations with doctors and parents about what feels morally wrong to her, since other nurses assessed this as gainful.

4.7 STORY 2: YOU CANNOT CHOOSE YOUR PARENTS

When interviewing Clara, we came across a narrative about parents who influenced the therapy of a young cancer patient:

> … It was a 16-year-old with a tumor, and he already had a lot of metastases*… The tumor was located at the shin*, and [the parents] always blamed it on a sport accident and refused every therapy… All the metastases could have been prevented if the

> mother had allowed a MRI scan* before. That was a really big conflict for me… If the leg of my son was twice as big and swollen, I would go to the doctor immediately to see what is wrong. I think you should do everything to make your child feel better...

Already in the beginning of the story, a tension between Clara and the patient's parents became obvious, as she evaluated their assessment of their son's health as inadequate. In what followed, Clara tried to empathize both with the patient in pain and with the mother who denied her son to be pain-free, in order to understand the mother's questionable attitude towards alternative medicine. Thereby, she experienced moral distress, as the mother seemed to grossly violate her moral foundation of analgesia:

> The mother was very 'eco' and tried to resolve [the illness] with globules* – she really had a whole mountain of globules, and we in the conventional medicine rather smile at them a little bit… I think that [globules] can be given additionally from time to time, but… I really thought 'this boy is 16 years old, almost half of his lung has been extirpated*, why do you not just grant him pain medication but approach this with such herbal stuff?'. I absolutely assessed this as wrong [and] did not understand the mother because I think as a mother you only want the best for your child.

Clara identified with the young boy as if he was her own son – she thereby followed a maternal approach for taking care of her patient, which is the foundation of the 'ethics of care'. Yet, she could not live up to her moral assessments, since her doing was blocked by his parents. At this point of the narrative, the question arose for us, if Clara will intrude into the parents' affairs to enable him pain medication:

> The parents can make this decision, as they are entitled to custody… We, in our team, and also the doctors found that quite unacceptable – however, you cannot enforce that on someone.

Interestingly, Clara strengthened her own evaluation of the pain management by speaking of 'we', which expressed that her assessment was also backed by the physicians who treated the patient medically – hereby, she seemed to clarify how totally wrong the parental decision was. Our interpretation of the team's acceptance of the parental decision is somehow limited as it is beyond our knowledge if longer conversations with the parents, in which the medical team tried to convince the family of an adequate pain therapy, took place. However, Clara obviously withdrew from convincing the parents to change their mind:

> Fortunately, he was not my patient so I did not have to take care of him but I know for sure that I would surely have quarreled with the mother.

It attracted our attention that Clara abstains from raising her voice for the patient merely because the sick boy was not officially assigned to her, if she was otherwise so sure that an open conversation with the mother would be meaningful. From our point of view, accepting the decision of the parents probably brought more suffering to the young boy. Besides, Clara compromised her own integrity by not engaging in a moral that feels right to her. This might in the long run lead to moral residue – indications of moral residue became already visible during the interview:

> Sometimes I might think about it while driving home or when I am on my way to work again.

However, the healthcare professionals nevertheless still tried to enable a morally right therapy for the patient:

> We also asked the patient himself then if the pain is bearable – but he was so much influenced by his mother and the globules, that he did not really have a say. Nevertheless, we ordered the pain service and sent it to the room.

Prospectively, we assess it as important that Clara engages in conversations with parents and explains the need for medical treatments like pain medication. Her colleague Vera sets an example for this:

> … You try to … talk it through with the parents once again… So it is important to explain what the problem is, why I do what, so that the parents can also understand it. And this works with most of the parents…

To summarize this story, it becomes apparent to which extent parents play a role when it comes to the care of children. Clara has a different opinion about what is 'good' for her patient, but feels blocked in doing so as the parents also have a say. The story enables an insight in Clara's moral foundation of helping others – besides, the topic of communication also plays a role as a factor that might alleviate her distress.

4.8 STORY 3: THE GODS IN WHITE COATS

Emma told us about a situation that concerns taking blood samples from children in a way that she perceived as wrong, but she still had to follow the doctor's instruction:

> Our patients usually have a central venous catheter to receive medication but as a matter of course it can also be used for blood sampling. However, only doctors are authorized to draw blood from a catheter… Unfortunately, it happens on a regularly

> basis that doctors claim to be too busy to complete the blood sampling themselves and simply direct us to carry out this task. Unlike doctors, we nurses are not entitled to operate with a catheter and therefore have to prick into a child's fingers to get the required blood sample.

During the interview, we noticed that Emma was clearly upset about this situation as she did not believe in their excuse of being busy. At this point, it is important to mention that we assess this evaluation as questionable. Are the doctors consciously refusing to draw blood from a catheter? Or do they, likewise many nurses, suffer from exhaustion, so that they have to delegate the task to nurses? As we did not conduct interviews with doctors, we can merely assume that Emma's statement might only show one side of the coin. By returning to Emma's story, she continued telling us about feeling morally distressed, caused by the doctors' order she had to execute. Her body language gave the impression that she was upset and we think that she also felt stressed and helpless as she could not change the situation:

> It is already quite stressful, and frightening for children to be hospitalized, and it definitely hurts and upsets me, if I have to increase their suffering simply because of the doctors' laziness… The prick or even several pricks hurt and scare the children, they cry, scream, try to get away, and most importantly, they lose trust in us, which complicates further treatments and our cooperation tremendously. It feels absolutely wrong that doctors pass on the task to nurses when the best and easiest solution for our patients – drawing blood from the catheter – only takes seconds and does not cause any further pain.

By suffering with the children, we interpret that Emma showed empathy and put herself in her patients' shoes. The narrative clearly states her incomprehension of the doctors' decision since they could have taken the blood sample within seconds without causing any additional pain – we interpret that this assessment grounds on a wish for analgesia. We had the impression that Emma almost felt like betraying the children by pricking in every finger and therefore worried about the impact on future treatments. This contradicts the mindset of the 'ethics of care', which assesses a close relationship between nurses and patients as important. As the children most likely lost trust and might not have cooperated easily with nurses afterwards anymore, we assess future appearances of moral distress as probable.

Pricking into the children's fingers obviously went against Emma's moral foundations, but she nevertheless subordinated herself to the doctors. This can have consequences for further patients as she might keep compromising her integrity by performing something that she

perceives as morally wrong. In the long term, if such situations of moral distress are not resolved but constantly add up, they will lead to moral residue. This in turn can cause Emma to withdraw from patient care due to the pile of the prior morally distressing situations. However, at this point we asked ourselves why she followed the doctors' instructions in the first place and did not try to interfere by raising her voice.

> ... Whether I discuss with the doctor about a patient or decision always depends on the shift and doctor I work with. If it is very busy and hectic at the ward, I do not have the time and energy to discuss. So even if I know it is wrong or it could be done differently, I just do it myself because discussions take even longer.

While talking about this, she seemed to understand that she compromises her aim of helping patients to feel better. We also believe that Emma seemed helpless against the powerful authority of physicians, and that she missed the opportunity for engaging in communication about such situations:

> … With some doctors, I already know that it does not make sense to go to them at all, they do not have time, they... are not willing to even talk about it… They are ... well, we call them 'Gods in white', they have a powerful position. Important situations are not discussed and clarified… Then I just do it... To be honest, I think too many things are simply dropped. We do not talk about it with the doctors, but I know we probably should.

We assess this quote as important, since the team atmosphere might worsen, if Emma constantly feels angry and left alone by doctors. In contrast to this, some of Emma's nursing colleagues feel heard, involved in decision-making and able to discuss with doctors on an equal basis. Moreover, we found out that nurses who feel morally distressed often stand up for change and raise their voices in order to actively reduce moral distress:

> When we do not like something, we talk to the doctors, and the doctors talk to us as well, in case they disagree with something. (Leia)

> You can always try to communicate and try to express your feelings and your opinion. You might not always be heard but at least you tried it then. (Thea)

To conclude, nurses, just like Emma, can experience moral distress due to hierarchical structures as they feel constrained to follow instructions that are against their moral foundations. Hereby, Emma brings the moral foundation of passionately engaging in

analgesia to light. Finally, to alleviate moral distress, Emma's colleagues communicate their concerns and criticisms and appreciate being enabled to work more independently.

4.9 STORY 4: IF NURSES JUST HAD THE TIME TO HEAL ALL WOUNDS

During the interview with Filippa, we encountered a narrative about time constraints. Thereby, we had the impression that this situation affected Filippa quite a lot – she seemed emotional and really wanted to share this experience:

> ... During the nightshift, I had a young patient, a boy, who suffered from vestibular disorder* and also wore a helmet. He had a palatine cleft* and therefore had to be in surgery. And in the evening, when he was on his way with his mother, he fell over and ruptured the whole lip, which led to the fact that he had to undergo another surgery. And this was all very stressful and hectic and I also had other patients to take care of and could not really take time to calm the mother down and reason with her.

Hereby, Filippa emphasized that time constraints affected her actions towards the boy and his mother. She was clearly upset about not having enough time to take care of them:

> It again all happened simultaneously and I think I could have supported her more, but it was just not possible timewise… We then had to wait until the taxi arrived and drove the child into the other clinic in order to undergo a surgery again – and I also had to leave the mother alone, and she also cried and was very worried. I think if I could have stayed with her, it would have been better for her and for the child.

We believe that this situation caused moral distress for Filippa as she felt that the enormous time pressure prevented her from doing what she perceived as right. Filippa seemed very sad and torn between supporting the mother on the one hand and not neglecting her other patients on the other hand. We found it very interesting that in this scene the patient rather stays on the sidelines while his mother is the protagonist. What does this say about Filippa? Why did the nurse act and feel as she did?

> … It is perhaps important to keep an eye on the holistic care, to recognize the child's special care problems and [to] tackle them ... you just do all this in a child-oriented way. Therefore, it is important to invest time, … you can actively engage in the well-being of the parents and the patients… The children come to us when they are sick but then we help them and we can watch them becoming better and better. This is great…

At this point, Filippa's behavior and feelings can be understood based on her moral foundations. As Filippa seemed to trust her gut feeling concerning what is best for her patient,

she consequently put herself in the patient's shoes and therefore realized that the boy needed his mother to be in a stable condition in order to feel better himself. Therefore, Filippa's principles tell her to stay with the mother and to calm her down. However, as the ward suffers from understaffing and therewith connected time constraints, Filippa experienced moral distress, since she could not invest adequate time. This contradicts the principles of the 'ethics of care', as she felt hindered in caring maternally for the patient and his mother:

> It often happens that I cannot do what I would like to do… At school, they always communicate the ideal – that you should take time and how it should be, but we did not discuss [how] I should take more time for the patients and the parents [if] I just do not have this time… And the child came back during the night, [but] I did not see the mother, so I also took that home.

As previously outlined in section 4.2, time constraints (as an explanation for feeling morally distressed) were also named by the nine other nurses. In Filippa's case, she regularly takes difficult situations and negative feelings home and thinks about them a lot. Yet, what can be done to change or at least reduce the feeling of moral distress caused by time constraints? Next to the in section 4.4 mentioned alleviating factors for moral distress (that nurses can actively contribute to), the most obvious suggestion during the interviews might also be the most difficult one to actually implement: better staffing. Filippa's colleagues stressed the demand for more personnel, viewing this as the essential factor for providing good care to their patients. Although the interviewed nurses seemed to consider the recruitment of more personnel as significant, they also emphasized that caring for themselves in order to cope with moral distress is important to hold on in the challenging surrounding of healthcare in the first place:

> ... You just run from one patient to the other… and you do not have a good feeling afterwards. But this is often the case, and I do not take this home. The next shift just has to answer these questions and you sometimes just have to leave it like that… (Clara)

> But somehow you have to see the limits… Do not take it personally all the time. (Thea)

To summarize, Filippa experienced moral distress as she believed that time constraints hindered her from doing what she perceived as morally right. This shows that she also cares for the private sphere of patients and aims at doing more than just accomplishing care tasks. Nurses we interviewed wished for more personnel and assessed it as important to take care of

oneself by drawing a clear line between work and private life in order to reduce the feeling of moral distress.

4.10 STORY 5: CAUGHT IN THE MIDDLE

In the following, a story in which Ida not just showed empathy by listening to a mother's worries but also demonstrated the wish for enabling the best therapy for her patient, is interpreted:

> I have had situations when the parent [wanted the child] to have some kind of medication … and I agree with the parent, but it is a medication I have to talk to the doctor if I give it… And the doctor is like 'No, I do not think we should give that …' and you end up in the situation again that 'Ok, I do not really agree with the doctor'… And then I will have to be the one to go and tell the parent that 'No, we are not going to give this medication, even though I think it is a good idea' and the parent thinks it is a good idea – but I still have to go and say 'No', even though I really think 'Yes'.

Despite Ida's open concern about an alternative medication, the doctor refused, leaving the nurse as the bearer of the bad news with an insufficient understanding of the reasons for the decision. We assume that Ida was in a situation of moral distress as she was blocked to implement what she perceived as morally right – thus, she compromised her beliefs, could not be genuine anymore and therefore disregarded the authenticity-principles of ethics of care. This might be disadvantageous for Ida in the long run, as moral distress could lead to frustration and the withdrawal from the nursing profession. By reflecting on the narrative so far, further questions about future patients and treatments arise: Will Ida continue to show empathy to parents and will she still try to reach the best possible outcome for her patients? Or will Ida – influenced by moral distress caused by the previous compromise – block requests for alternative treatments by simply referring to the doctor's authority? To approach these aspects, it is important to understand Ida's feelings and how she perceived the situation:

> And the mother was like '… I am going to talk to the doctor when she comes'. I did not feel any aggression towards me. She understood that this is not my decision and that I cannot do anything about it ... I do not walk home and feel bad because in those situations, I know that I cannot have done anything differently and it is not really my fault … I just happen to be the person who gets the blame at the moment.

Her narrative expresses quite clearly that she felt bad about be unable do the best for her patient through adjusting the medication. However, she quickly engaged in the maintenance

and protection of her positive self-identity and in forming an emotional protective wall to repel deep moral distress. She emphasized that she did not feel any burden and was not affected by moral residue. Ida's statements suggest that she escaped from the situation of moral distress by asserting her innocence to the patient's relative. We also interpret this reaction as passing on the accountability for patient care mostly to the doctor – Ida thereby lightens her own responsibility. Moreover, we feel that Ida saw herself as inferior to the physician – she accordingly abstained from raising her voice for her patient. Thus, this behavior, as well as building an emotional protective wall could lead to callousness against patients and might ultimately decrease the quality of care.

Although the mother that Ida talks about is very understanding, Ida also experienced situations in which she found herself amidst doctors and parents, whereby the latter were not as tolerant:

> … Of course, there are situations where I go and tell the parent the doctor's decision and the parent gets angry with me. And it can make you feel bad during that moment because I cannot really defend it! I do not know exactly why the doctors [made] the decision they [made]...

This quote highlights that Ida often feels uncomfortable about not being informed about the decision made. When asking her about this obvious lack of team communication, we learned that communication mainly takes place in more dramatic situations, but small disagreements are not taken into account:

> … When there are complicated situations and not everyone agrees, … I think it would be better if, either in that situation you have a group meeting …, or that you have it afterwards … [If] we have had a tough situation, usually involving a kid dying, … we usually have a debriefing afterwards with the doctor…, just so that we can talk about … how we feel and what we could have done differently.

Yet, which conditions must be preexisting to alleviate Ida's moral distress? Other nurses experienced similar situations: they lack an understanding about the medical decisions of doctors and therefore mentally question their choices. Thus, an improvement of team communication seems to be necessary to enable mutual learning. If nurses and physicians can communicate on the same level, nurses feel more involved and qualified to raise their voice if they do not understand a decision or disagree with the doctor's conclusion:

> I like the ward because the doctors are open, we can talk to each of them… about anything because they listen to us. (Leia)

Ida's nursing colleagues expressed that a good team communication is generally of utmost importance:

> The advanced things are no problem. It is the groundwork… I would like to discuss a lot more… There should be ethical [team] discussions every week. (Agnes)

> Every week we have a meeting, it is called 'ventilation time'. So you can say if something went wrong [and] what happened… you have to talk about it because [otherwise] it bottles up and that is not good. (Thea)

All in all, Ida's narrative clarifies how nurses aim at advocating for their patients. However, she seemed to accept her inferiority in relation to the doctor, even if the physician's decision felt wrong to her. When taking the statements of her colleagues into account, Ida might be more easily able to act as a patient advocate, if her work surrounding enabled her to approach doctors in a more equal way. Thereby, ambiguities could be more easily clarified and Ida could be enabled to express her opinion about what she assesses as 'right' for the patient.

4.11 CHAPTER CONCLUSION

To conclude chapter 4, it provided an overview of nurses' moral foundations, attributed causes for as well as consequences of moral distress, and alleviating factors to cope with the phenomenon. Moreover, five stories aimed at providing an in-depth understanding of nurses' actions and feelings in specific situations. Thereby, all stories share the similarity that the respective nurse has a passion for caring for her patients in the best possible way – for instance by enabling them to die without suffering from futile treatments (Leia), by freeing them from pain (Clara), by performing therapies as gently as possible (Emma), by taking time for things that go beyond a purely medical focus (Filippa) and by evaluating which therapy the nurse considers best for her patients (Ida). Moreover, when it comes to factors that might alleviate the nurses' distress through drawing comparisons to other interviewees, communication and moral courage play an important role.

In the following chapter, we therefore link our findings to the presented literature review by participating in the discussion about moral distress through focusing on the just mentioned main findings of our analysis: firstly, we concentrate on the connection between nurses' moral foundations and their experiences of moral distress. Secondly, we focus on the meaning of communication as a factor to alleviate the phenomenon. Thirdly, we elaborate on the opportunities and threats of trying to tackle moral distress by engaging in moral courage.

5. DISCUSSION – WHY MORAL DISTRESS SHOULD BE SEEN IN A DIFFERENT LIGHT

How can we, based on our empirical research, participate in a debate about moral distress? In the following, we aim at taking our findings back to the conclusions that are to be found in the literature. Thereby, we firstly compare the moral foundations of our interviewees with the respective aspects in the literature, followed by a closer look on the explanations, consequences, and alleviating factors found in the empirical material and stated by researchers. We then elaborate on our main insights by enabling the readers to learn about three viewpoints which diverge from the current literature.

First of all, moral distress can be seen more positively than the literature currently assesses it, as it brings the passion of nurses (which we evaluate as one of the main elements of engaged nursing) to light. Therefore, from our point of view, moral distress is to some extent also desirable, as nurses who experience it still try to live up to their foundations and have not compromised themselves yet. This highlights that the phenomenon of moral distress should not merely be seen as negative.

Furthermore, nurses experienced communication as a factor that alleviates moral distress, which is mostly in line with contemporary academic work. However, once again, only one side of communication – its function as a panacea against moral distress – is considered in the literature. However, communication measures should not be exaggerated, as this might lead to moral distress. Besides, even if raising one's voice is important to overcome helplessness, neglecting the double-edged sword character of moral courage might even cause more moral distress. These three points constitute our main argument and are therefore discussed in the upcoming chapter.

5.1 POSITIONING OUR FINDINGS WITHIN THE RESEARCH CONTEXT

MORAL FOUNDATIONS IN NURSING

Gilligan's (1993) 'ethics of care' describe a maternal approach for sick people as fundamental – but does that also become apparent in reality? Some of our interviewees set an example for engaging in the 'ethics of care' as they expressed that one of the most important aspects of care is to engage for analgesia and to abdicate from prolongating patients' suffering.

When it comes to moral foundations in nursing, our interviewees assessed ethical codes, in contrast to a vast part of the moral distress literature (e.g. Fida et al., 2016; Iacobucci et al., 2013), as rather unimportant. Similar to the 'ethics of care', which ask nurses to adjust their

care approach to each individual instead of focusing on standardized guidelines, nurses rather seem to follow their moral gut feeling concerning passionate patient care (Sander-Staudt, 2017). Therefore, several nurses perceived ethical codes as something that is somehow disconnected to reality: when comparing our findings to the 'Ethical Code of Nursing', the code for instance entails that nurses must provide patients with extensive information about their health (International Council of Nurses, 2012) – however, in reality, our interviewees told us that they regularly experience severe time constraints which make this impossible. That does not mean that the code is overall unsuitable for nursing, but that the respective constraints that are present in many healthcare organizations make its application difficult. Vryonides et al. (2015) even describe that moral distress can arise due to the clash between regularities and real work life – yet, within our study, we rather recognized a clash between the nurses' personal moral assessments and the reality, as nurses did not seem to follow certain codes. Hereby, one could also question if ethical codes are only rarely applied by our interviewees since they eventually leave too little space for adapting to different real-life situations. In fact, all our interview partners agreed that a strong gut feeling for what is morally right is more helpful for helping patients individually than any code could ever be. In any case, the question might be if nurses' gut feeling is always 'right' and what 'morally right' means in the first place. Even if nurses are in closer contact with patients, their assessments might not always turn out to be the best for the patient.

Moreover, our findings do not correspond with Lachman's (2012) statement that acting as patient advocates is part of the nursing duty, as some nurses told us that they sometimes also withdraw from engaging for patients. Besides, by looking at our empirical material, we question Thieman's assumption that nurses should undergo ethical coaching (LeAnn Thieman, 2015), as predefined ethical trainings did not seem to be useful to our interviewees. However, as we only interviewed nurses from two different hospitals, they might have undergone similar trainings, which would explain the overall negative view on ethics seminars. That seems peculiar to us, as there are surely many different training forms in healthcare. Nevertheless, the refusal of being ethically trained could also be connected to the fact that nurses do not want to be told what they should consider as morally correct. As a compromise, the approach of Janssens et al. (2015), who suggest to learn from case studies, gets close to our nurses' positive approval of 'ventilation times' about concrete occurrences and seems to be more realistic to us when it comes to morality trainings (if it is at all possible to train morality).

EXPLANATIONS FOR MORAL DISTRESS

The in section 4.2 analyzed empirical material illustrates the manifoldness of nurses' experiences with moral distress – subsequently, we relate this to the reviewed literature. First of all, understaffing and therewith associated time constraints as explanations for moral distress are both illustrated in the literature (e.g. Eizenberg, Desivilya & Hirschfeld, 2009) and were named by all the nurses we interviewed. Our interview partners could hereby experience that care gets more and more work-intensive as symptoms get increasingly complex. Thereby, their perception aligns with the findings of Winters and Neville (2012), who researched staffing in nursing through a study in New Zealand. The reasons for the emergence of moral distress due to the more complex character of care for the most part goes back to seemingly inappropriate life-prolonging measures, which is described in the literature (e.g. Whitehead et al., 2015) and supported by the narratives of our interviewees which sound accordingly.

Besides, the 'nurse in the middle problem' (which Jameton depicted in 1977) is especially relevant for our study. As we concentrated on pediatrics, almost all nurses told us that they regularly find themselves amidst doctors and parents. Hereby, some experienced what Nelson (2009) describes – small disagreements between parties in healthcare settings are not adequately taken into account. On the one hand, nurses might be constrained by patients' parents – yet, as seen in the literature review, most authors focus on adult care, which is why we assess it as gainful to set our study apart from that. The authors who already focus on pediatric care (e.g. Austin, Kelecevic & Goble, 2009; Pye, 2013) for instance name disputes about reanimation, the ineffectiveness of care, and conflicts between the medical staff and parents as explanations for moral distress – some of our interviewees experienced exactly these situations, so our findings support the insufficient literature when it comes to this point.

On the other hand, power structures and a feeling of inferiority to physicians seem to be among the major triggers for moral distress, and are described by several authors (e.g. Corley, 2002; Wall, Austin & Garros, 2016; Winters & Neville, 2012) as well as within our empirical material. Is the huge difference between the acknowledgement of doctors and nurses rather a general feeling within the nursing profession? Or is it based on repetitive experiences of nurses? If the latter is the case, the question arises why the feeling of inferiority permanently persists – could it likewise be possible that nurses rest on this perception, as it also implies that they can evade conflicts with patients and relatives by referring to the physicians' authority? Besides, it is questionable how this situation might be changed, if authorities are such a firm component of healthcare work surroundings, in which the professions of doctors and nurses are still acknowledged unequally. Anderson, Monsen and Rorty (2000) for

instance describe that there is still a "subordination of nursing to medicine [as well as] … conflicting paradigms between physicians and nurses by their ways of human knowing and in caring for and about persons" (Anderson, Monsen & Rorty, 2000, p.194).

Hereby, in light of earlier research, it is surprising and it thereby contradicts the findings of Piers et al. (2012), that our interviewed nurses only rarely assessed their colleagues as incompetent, even if they did not always understand their decisions. Interestingly, our study also differs from what Vryonides et al. (2015) describe, as we rarely heard blames about healthcare managers. Hereby, nurses seemed to assess challenges like understaffing as wider societal problems, without blaming any specific persons for that. This might be the case as our interviewees realized that doctors' decisions do not ground on their personal opinions, but on medical backgrounds that they as nurses might not be aware of.

CONSEQUENCES OF MORAL DISTRESS

Various findings conform to the consequences depicted in the literature, whereas others contradict what has been written about moral distress so far. Our interview partners first and foremost impressively narrated what Keyko (2014) describes as 'feeling powerless', when they were unable to influence parental decisions to further treat terminally-ill patients. After listening to our interviewees, we can likewise confirm the evaluations of Papastavrou, Andreou and Vryonides (2014) who contribute to the literature that nurses take their work home if they feel morally distressed. However, nurses who told us about this, did not assess it as a burden, but as part of their occupation. Our study also does not correspond with the literature (e.g. McAndrew & Leske, 2015) when it comes to nurses showing higher sickness rates or leaving their occupation because of moral distress. Of course, one wonders how openly nurses speak about illness days and termination requests – however, our interviewees did not tell us that they call in sick, and intended to stay in nursing, even though some of them regularly think of leaving the clinical work surrounding. Moreover, our empirical material stands out against other findings in the sense that it depicts that turnover in hospitals might be mainly a consequence of stress, not of moral distress. Even if we could experience signs of exhaustion, which Oh and Gastmans (2015) assess as burnout factors, our study generally illustrates little moral residue compared to the literature (e.g. Wall, Austin & Garros, 2016). This is probably the case since we interviewed a lot of nurses who have just started their career.

Our findings also suggest that not only nurses might be affected by moral distress, but that patients are sometimes those who are ultimately afflicted by less passionate caring. We often

listened to nurses who withdrew from raising their voice, which is described in the literature by Musto, Rodney and Vanderheide (2015), and sometimes also avoided caring for patients when they felt morally distressed. Our study therefore corroborates McCarthy's and Gastmans' (2015) argument that moral distress can cause nurses to neglect thorough care. Just like Halvorsen, Forde and Nortvedt (2008) report, some of our interview partners narrated that patients sometimes get their antibiotics too late and are often discharged too early after a surgery. However, our insights into long-term effects are limited, as the interviewed nurses did not seem to be keen on talking about those failures. The same applies to the neglect of hygiene tasks, which the literature depicts as dangerous, but which our interviewees did not say much about. Likewise, our empirical material stands out against the findings of Fida et al. (2016), who argue that nurses who repeatedly compromise themselves behave inappropriately towards colleagues and patients – we, however, did not hear about aggressive patient treatment. Thus, one might wonder whether the literature in general depicts the consequences of moral distress as more dramatic as they might be, or if nurses just do not speak about them.

ALLEVIATING FACTORS FOR MORAL DISTRESS

The comparison between the literature and our empirical data in terms of alleviating factors for moral distress revealed some communalities. However, in contrast to the literature which often suggests formal measures and managerial activities as important, our interviewees rather value equal and informal cooperation between nurses, doctors and patients' families.

Firstly, Watson (1997) asserts it as fundamental that nurses care for themselves in order to be able to care for others. As our study focuses on the work life of nurses, we subsequently refrain from elaborating on private activities that our interviewees mentioned as helpful to compensate moral distress. However, in general, our interviewee partners were aware of the importance of calming themselves down while working and of not being too deeply affected by patients' suffering, thus of engaging what Rushton describes as mindfulness and resilience (Rushton, 2016; The Schwartz Center for Compassionate Healthcare, 2014). The reviewed literature also displays findings about the positive effect of feedback from head nurses when it comes to how nurses evaluate their occupation (Fida et al., 2016). Our empirical data differs from this, as the nurses we interviewed evaluated feedback from the patients they treated or the respective parents as most important.

Besides, all interview partners agreed on the fact that communication is essential to get a better understanding for moral foundations of others as well as to express their feelings of moral distress – Burston and Tuckett (2013) likewise assess conversations as an important

factor for tackling the phenomenon. Yet, in contrast to Janssens et al. (2015), who evaluate it as crucial that communication measures are implemented by healthcare managers, our interviewees assigned more importance to informal, constant team communication. This is in line with the finding that our study participants assessed standardized ethics trainings as less important and seemed to count on continuous learning from practical situations, whereas the reviewed literature (e.g. LeAnn Thieman, 2015; Pauly, Varcoe & Storch, 2012) points out that moral distress coaching is of utmost importance.

When considering nurses' decision about how to proceed further in morally distressful situations, Pauly, Varcoe and Storch (2012) describe 'moral courage' as raising the voice to call attention to concerns and to morally questionable occurrences. Some of our interviewed nurses seem to engage in moral courage, as they told us emotionally about how they spoke up when they felt that something was morally wrong. The self-confidence that Dodd et al. (2004) thereto assess as essential seems to follow the assessment what is right for the patient and, when taking our nurses into account, is not age-dependent. Hereby, authors widely emphasize the positive effect of moral courage on the quality of patient care (Anderson, Monsen & Rorty, 2000; Keyko, 2014) – our interviewees doubted this assumption, as they already experienced that raising their voice could bring about interpersonal difficulties with physicians. Moreover, academics stress that nurses should not only be able to speak up openly, but hierarchies in their work surrounding should be further reduced in order to enable nurses to work more independently (Piers et al., 2012). Our empirical material only shows this to a small extent – this is eventually the case, as it might be easier to hand over the responsibility for morally difficult decisions to physicians and it might be more stressful for nurses to fulfill even more tasks, if they currently already experience time constraints. Besides, we are aware that the medical knowledge of physicians and nurses might differ and that nurses' assessments do not always have to be right in comparison to the parents' evaluations. However, we think that there a more equal and continuous exchange of thoughts between those parties might give nurses more chance to be involved, without being the actual decision-makers.

All in all, to conclude section 5.1, many of our empirical findings are in line with the existing literature. However, in the following sections, we now participate in the debate of moral distress by focusing on the three main aspects that struck us during our study.

5.2 MORAL DISTRESS REVEALS PASSIONATE MORAL FOUNDATIONS

During our research process, it attracted our attention that nurses talked extensively about their moral foundations and why they perceive situations as they do. We encountered a lot of passionate nurses who showed love for their patients and perceived them as the center of their action, thereby affirming Watson's (2015) assessment that nursing implements more than just going to work. Yet, why did most of the nurses we interviewed feel this way? One might speculate that nurses are just 'born to help others' and have a distinct feeling of empathy. But might it also be possible that they acquire their capability of moral assessment throughout their education, as Rasoul et al. (2016) consider it possible through moral case trainings? The attitudes of the interview partners anyhow often matched the 'ethics of care' of Gilligan (1993) very strongly, although they did not explicitly mention Gilligan's framework. Nevertheless, a lot of nurses deeply identified themselves with their patients and engaged in transpersonal care by thinking in the patients' and relatives' shoes, which we see as a link to the mindset of the 'ethics of care'. Several nurses also confirmed Elliott's (1999) and Nortvedt's (1998) assumption that nursing includes the responsibility of being watchful and receptive for the patients' needs and considering their situation holistically, not just the medical part of their illness. However, throughout our interviews, we realized that our interviewees might have wanted to present themselves as good nurses by telling enthusiastically about their commitment. One could also speculate that nurses may act in such a way to obtain self-affirmation. Notwithstanding the above, our interviews and observations clearly illustrated what Keyko (2014) sees as important – thus, that nurses engage in more than just pre-defined tasks and restrain themselves from taking the easy way out. This "'little extra' that alleviates suffering" (Arman & Rehnsfeldt, 2007, p.372) can seemingly improve the patient's situation and can contribute to a holistic cure (Arman & Rehnsfeldt, 2007).

If we fully believe in the narratives of our interviewees, we are able to relate to the statement of Jameton (2013) that nurses are the ones who make a healthcare setting human by getting to know the patients and trying to meet their needs. As Watson (2015) as a representative of the 'ethics of care' emphasizes, human nursing can considerably improve the wellbeing of sick people. Yet, as we did not interview physicians, believing in our nurses' assumption that doctors by contrast mainly concentrate on medical issues, might be misleading: physicians surely also have to act humanly, as well as nurses need a medical understanding. We would therefore find it interesting how doctors themselves perceive their contribution to human care in a clinic. In our opinion, the academics (e.g. Anderson, Monsen & Rorty, 2000; Piers et al.,

2012; Sabatino et al., 2016) as well as our interviewees so far often portray that in a too simplistic way by distinguishing strongly between the activities of physicians and nurses.

Nevertheless, among all healthcare professionals, we think it is essential that especially nurses develop an individual sense of what it means to do 'the right thing' for the patient, since they are the ones who are in primary patient contact. From our point of view, moral considerations are the core element of nursing: a chemotherapy, for instance, might feel medically right for the patient regarding the treatment success, but perhaps feels humanly wrong for the nurse who has to administer it to a very young child. Yet, is this train of thoughts not the only chance to ensure that nursing finds itself in a continuous struggle for human care? If nurses have stopped thinking about moral issues and have given up on caring passionately, this can have negative effects for patients. Likewise, Fida et al. (2016) point out the risk that human care gets lost if disengaging becomes commonplace and more and more healthcare professionals follow this way of acting.

In contrast to that, if nurses are not emotionally numb and still feel for others, it seems that they follow the approach of the 'ethics of care', which includes the element of transpersonal attention by thinking in somebodies' shoes (Watson, 2015). If a certain situation clashes with nurses' beliefs of what is morally right, they consequently feel blocked and morally distressed. Therefore, we generally see it as valuable if nurses are aware of their moral foundations and feel that something contradicts them. The nurses we interviewed sometimes even assessed wondering about morally distressful situations as positive, as they evaluate it as good that they still feel for the patient. During our observations at the child oncology, we also had the feeling that the healthcare professionals still recognize the patients' fates. At a ward meeting, when a nurse reported on a patient who is in a very bad condition, the routine paused for a moment. Moreover, after treating a very sick child, two nurses stopped in the middle of the aisle to talk about the young girl. Both felt sorry for the child and spoke in a hushed tone. However, we understand that it is purely speculative to interpret the observations as we just did – how sincerely passionate and committed nurses actually are probably remains their secret. Besides, we think passion in nursing should not only be seen in black and white: surely there is also something in between being cold-hearted or indifferent and engaging heartily or passionately.

Thus, moral distress is from our point of view not purely a negative phenomenon, as it only occurs if nurses still care passionately and try to live up to their moral foundations that we analyzed in section 4.1. Thereby, we do not aim at downplaying moral distress, since we

learned how distressful and exhaustive it feels to be unable to do what one perceives as morally right. Besides, we also acknowledge it as valid to question how long nurses can keep up the strength to deeply engage in their work without being exhausted or burned out. According to Rushton, to be able to care for others, one should take care of oneself, so probably a healthy balance between passion and callousness is important (The Schwartz Center for Compassionate Healthcare, 2014). Our nurses seemed to have internalized this line of thought, as they told us that they were aware of the importance to hold on in the challenging surrounding of healthcare.

The literature (e.g. Glasberg, 2007) portrays resilience as mostly positive, whereas interviewees with more work experience narrated that self-care could in the end also lead to inhuman care for patients, so it became clear that engaging in resilience can cut both ways. Nevertheless, we assess exactly these trains of thoughts as important and consent with Corley (2002) that moral distress can also be seen as a positive sign of nurses' receptiveness for the suffering of others – yet, to continue helping others in situations in which they need help, it is important to have an inner strength that allows for that. As Rushton (2016) suggests, clinics can support nurses in training resilience and mindfulness, in order to distance themselves from being too deeply affected by the patients' suffering without hardening too much either. Besides, nurses who actively concentrated on positive aspects of their occupation and told us that they do not take things home from work made a more resilient impression when it comes to experiencing moral distress and thereby seemed to be less vulnerable to drop out because of illness. Moreover, Fida et al. (2016) state that nurses feel reinvigorated when they get positive feedback – this matches the answers of our interviewees, who felt especially strengthened when the patients they cared for passionately were thankful for their help.

All in all, we think that it is important to acknowledge that the arousal of moral distress can also be positively seen as a sign for passionate moral foundations. Moreover, we assess it as desirable if nurses find a work environment that supports open communication and an exchange of feelings about distress, so that they consequently feel less blocked in doing what feels morally right. In the following, we therefore elaborate on the role of communication regarding moral distress.

5.3 INFORMAL COMMUNICATION CAN ALLEVIATE MORAL DISTRESS

The gathering of empirical material clarified that there are organizational constraints like time pressure as well as hierarchies and interferences of relatives, which all can limit nurses to do what feels morally right. We acknowledge that the occurrence of morally distressful situations

cannot be fully prevented, as understaffing in healthcare is a common phenomenon and differences between the education of physicians and nurses are still factual (Fida et al., 2016). Moreover, it is comprehensible that parents are anxious about the health situation of their sick child and therefore intervene in caring. Thus, we think that nurses should be aware of moral distress and its possible consequences in a realistic way. Yet, after conducting our interviews and observations, we are convinced that it makes a difference how moral distress is handled: if nurses accept the existence of moral distress and become aware of the fact that it can be alleviated by the engagement of every individual (Jameton, 2013), it is probable that coping with the phenomenon becomes easier.

Previous research on moral distress mainly complains about organizational constraints which make human nursing more and more impossible (e.g. Whitehead et al., 2015; Woods et al., 2015), so that nurses become exhausted and burned out (Halvorsen, Forde & Nortvedt, 2008), and ultimately often leave nursing completely (Wilkinson, 1987). Our interviewees did not intend to do so, but told us that they wish to talk more about distressful situations, in order to get a better understanding for decisions of physicians and relatives that constrain them in doing what feels morally right. We therefore truly believe that communication is the pivotal point of alleviating moral distress (which does not seem to be avoidable, as every interview we conducted revealed morally distressful situations). As previously outlined in section 4.4, enhanced communication processes within professional healthcare teams seem to already improve the situation of nursing, since communicating openly with colleagues enables nurses to better comprehend the perceptions of others and to share feelings with colleagues. Nelson (2009) agrees that a lack of communication and knowledge-sharing can cause moral distress. Besides, a more open communication between physicians and nurses might also lead to improvements in the conversations with patients and parents: as the nurses are consequently rather able to provide information about treatments, they might hence also be more acknowledged by the patients and their families.

In contrast to the overall very positive picture of communication that both the literature (e.g. Dodd et al., 2004; Pye, 2013; Whitehead et al., 2015) draws and our interviewees expressed, we would like to add for consideration that although communication might ease moral distress to a great extent, it also entails difficulties. Would nurses for instance still appreciate team communication when it takes more of their precious time than caring for their patients? We speculate that if communication measures were exaggerated and nurses merely sat in meetings, their feelings of moral distress might even increase, as they would be hindered from engaging in passionate nursing. For that reason, communication measures should be planned

and implemented with caution – this consideration is, as far as we see it, still underrepresented in the literature. In this context, short reflections and daily debriefings with 'lessons learned' might make more sense than large-scale, formal meetings.

Furthermore, one could question when communication measures become routines without providing a space for profound moral discussions. At all, to what extent should communication be controlled? Academics mostly focus on organized and standardized trainings (e.g. Burston & Tuckett, 2013; Pauly, Varcoe & Storch, 2012), whereas our interviewees prefer regular and informal communication. However, we would like to point out that we consider it of importance that communication measures should not only provide room for letting off steam – this could eventually even worsen collegial relations and communication with patients and parents. Contrary to that, we believe that it is important to design the exchange of ideas in a meaningful and respectful way. Hereby, previous research (e.g. Keyko, 2014; Musto, Rodney & Vanderheide, 2015) emphasizes the relevance of an equivalent communication with physicians – our interview partners confirmed that. During our observations, we realized that the ward we visited seemed to have found a good way of communication between nurses and doctors, since they regularly and openly talked to each other. Though, it is appropriate to speculate whether the mentioned impressions that we gained from our observations are realistic or whether they rather portray a day on which everyone tried to convey a good impression.

Our study therefore sets itself apart from the mainly danger-involving image of morally distressful situations (involving negative consequences for nurses, their colleagues and patients) which is drawn in the literature (e.g. Fida et al., 2016; Glasberg, 2007; Pauly, Varcoe & Storch, 2012; Sarkoohijabalbarezi, Ghodousi & Davaridolatabadi, 2017). We reveal that moral distress cannot only be alleviated by, for instance, hiring more personnel – on the contrary, nurses already have means to cope with the phenomenon and to reduce its arousal. Next to communicating with colleagues and patient's relatives to alleviate moral distress, our interview partners also told us about engaging in moral courage by raising their voice in order to express their thoughts and concerns. In the following section, we once again highlight both sides of the coin by calling attention to positive as well negative consequences of moral courage as a form of communication.

5.4 MORAL COURAGE IS A DOUBLE-EDGED SWORD

So far, we have talked about how communication might reduce the occurrence of moral distress in the first place – now, we focus on communication that nurses engage in while

experiencing unbearable situations of moral distress. In the following, we illustrate how communication in forms of raising one's voice by engaging in moral courage can reduce the feelings of moral distress.

As moral distress causes nurses to compromise their integrity, it contradicts the 'ethics of care' that one should be authentic in his beliefs and doings (Watson, 1997) – in situations like that, nurses have to decide whether they actively want to interfere. The founder of the 'ethics of care', Carol Gilligan, likewise states that acting morally can be seen as "an exercise of choice and the willingness to accept responsibility for that choice" (Gilligan, 1993, p.67). As previously analyzed in section 4.3, nurses often feel helpless in situations of moral distress, which leads them to withdrawing from care and to lightening their own responsibility. In the best case, the patient's situation might improve without the nurse's intervention, and she will probably feel less morally distressed, as she sees that her actions were not the crucial factor for the patient`s well-being. However, if the nurse's assessment of what is morally right for her patient is actually valid, refraining from raising her voice can also be negative for the patient, as his or her condition might stay as bad as before or might worsen. Moral distress can thereby even increase since the nurse has to witness the patient's aggravated suffering. Though, in contrast to seeing themselves as victims of moral distress, our interviewees often showed active engagement in moral courage to tackle the phenomenon and to reestablish their moral foundations by clearly expressing what they revolted against, why and how they did that. Our interview partners thereby primarily questioned physicians' conclusions and interfered in medical decisions to resist potential moral distress. The protest and active engagement of the nurses also concerned their relationships to parents – an aspect of moral courage that is still of little importance in the literature. Nurses might feel less blocked in their moral actions and therefore less morally distressed, if they actively tried to change a situation and succeeded in doing so. Thereby, it is eventually not even important if the patient's situation improves – but the nurse still has the feeling that she advocated for the sick person. We hereby do not intend to express that social and organizational changes like the improvement of staffing or the implementation of less hierarchical work forms are unimportant. Neither do we aim at leaving nurses holding the baby of tackling moral distress alone. We merely express that every single nurse can already bring about small changes which can make nursing more human in total.

So, is engaging in moral courage, thus raising the own voice, the 'solution' to moral distress? Since nurses are responsible for the well-being of their patients and the provision of human care, academics like Lachman expect them to interfere in morally wrong situations when

being interrogated about moral distress (Nancy Valentine, 2013). Researchers generally highly emphasize the positive connection between moral courage and the alleviation of moral distress (Musto, Rodney & Vanderheide, 2015; Nelson, 2009): if nurses advocate for their patients, they will automatically experience less moral distress as they stood up and fought for their moral foundations. But can it be as simple as that? We doubt this and would also like to point out the other side of the coin. While hearing and reading about moral courage, numerous questions have occurred: how does it affect a nurse, if she must repeatedly raise her voice? Is this feeling of obligation not stressful in itself? And might moral distress even increase if a nurse spoke up but still nothing changes? At this point, we would like to question whether a nurse could also feel morally distressed while doing what feels right to her.

The following example illustrates a fictitious moral distress situation, in which a patient has difficulties with eating solid food. The nurse has been watching the child for a few days and feels that its condition worsens. Therefore, she believes that a feeding tube is necessary to prevent a shortage of nutrition, while the doctor insists on continuing with the administration of solid food. If the nurse approaches the doctor to suggest a feeding tube, three different outcomes are possible: firstly, as discussed earlier, the doctor might listen and agree with her by ordering a feeding tube for the child. Consequently, the feeling of moral distress decreases as the nurse perceives that she achieved the best solution for her patient by standing up for her moral foundations that include the wish to alleviate suffering. This scenario corresponds with the existing literature (e.g. Musto, Rodney & Vanderheide, 2015; Nelson, 2009). Secondly, the nurse might speak up, but the patient's situation still does not change, since the doctor disagrees with her suggestion. So, although she took action, her patient still struggles and the nurse cannot live up to her moral foundations, which increases her feelings of moral distress. Another possibility is that she accepts her failure and does not engage in future changing attempts either – affected by this experience.

Thirdly, the situation might even worsen if the patient might not get the feeding tube and her interfering additionally strains the cooperation between her and the doctor, which again can cause the nurse to remain silent the next time. Winters and Neville (2012) state that some nurses do not speak up in the first place as they are worried about being labeled as "trouble makers" (Winters & Neville, 2012, p.25). We think that potential disputes with colleagues paired with preceding, futile attempts to change situations, could cause nurses to consider advocating for their patients rather as a distressful obligation than a as a merely positive action. Besides, through approaching the doctor about the feeding tube, the nurse might sacrifice time she does not actually have, which can cause her to neglect the remaining

patients. This clearly shows that it can also be distressful to do something that feels morally right – for example speaking up for one patient, but knowing at the same time that this will result in less time for the others.

Based on this, we believe that moral courage should be seen as a mixed blessing and not as merely positive as the literature has seen it so far. Thus, we contradict the statement of Musto, Rodney and Vanderheide (2015), who express that creating a positive work environment (which supports moral courage) is a panacea against moral distress. We problematize this assessment and think that raising the voice does not always imply change for the better – instead, nurses can even feel more distress than before, which might cause them to compromise their integrity in the future. Therefore, we argue that moral courage is not as straightforward as currently illustrated. We do not intend to question the significance of moral courage; it is definitely important to reduce moral distress as we highlighted in the beginning of this section – however, we simply call attention to the approaches' complexity.

5.5 CHAPTER CONCLUSION

To conclude the previous chapter of discussion, the first section dealt with moral foundations, explanations for feeling morally distressed, related consequences and possibilities to cope with it by putting our empirical findings in relation to the aspects stated in the literature. Thereby, we drew a more personal and positive picture of moral distress than respective academics do.

Next to this, we actively participated in the debate about moral distress by setting our thesis apart from the literature through presenting our three key findings: firstly, we illustrated why we think that moral distress is visible if nurses still act passionately – thus, we evaluate it as a multilayered phenomenon that also brings positive aspects like passion for human care to light. Next, we depicted that apparent solutions for moral distress will never fully do justice to the complexity of the phenomenon and that alleviating factors like open communication should be treated with caution. Hereby, we especially touched upon the problematic coherence between moral distress and moral courage.

6. CONCLUSION AND OUTLOOK

6.1 A BRIEF REVIEW

This thesis aimed at exploring the phenomenon of moral distress, its origins as well as consequences and possible alleviating factors. Although we assess moral distress as a cross-sectoral concept, we focused on the healthcare sector, since especially medical and end-of-life-situations can trigger more severe occurrences of moral distress. As our literature review revealed high labor turnover rates among nurses due to moral distress, we evaluated it as important to gain a deeper understanding of the topic in nursing, and determined our research emphasis accordingly. To answer our guiding question – 'why and how do nurses experience morally distressful situations and how do they handle them?' – we conducted an in-depth study through familiarizing ourselves with how nurses from two hospital settings in Germany and Sweden experience moral distress.

RESEARCH RESULTS

Our research revealed that nurses experience moral distress, as they cannot live up to their moral foundations of relying on their gut feeling, limiting suffering, and making a difference for patients' situations. Various factors influence nurses in doing what feels right: physicians make decisions that nurses have to implement, parents of children who are hospitalized have a say, and time constraints seem to hinder adequate care. Thus, our findings rely on two main aspects: on the one hand, nurses feel forced to do what feels morally wrong when they follow the decisions and wishes of others – on the other hand, they are unable to do what feels morally right because of, for instance, time reasons. Due to moral distress, nurses might be negatively affected from exhaustion, turn away from patients through providing minimum care, and lighten their own responsibility by referring to doctors' authority. In order to alleviate such consequences and to reduce moral distress in the first place, nurses appreciate regular and informal team communication and the possibility to engage in moral courage. Thinking positively about nursing in general, as well as taking care of their personal health, seemed to encourage nurses to raise their voice for patients.

OUR CONTRIBUTION

Our thesis differs from previous studies as we did not just follow an interpretative, storytelling approach for analyzing our empirical material, but also tried to illustrate moral distress in a different light. Thus, we participated in the debate of moral distress by emphasizing three main aspects that struck us during our study: first of all, moral distress should be seen more

positively than the literature currently assesses it. Even if we (based on our conversations with nurses) agree that the experience of moral distress per se is negative, we believe that its occurrence brings nurses' passionate moral foundations to light. We therefore think that moral distress cannot and should not be fully prevented. However, it became clear to us that it can already be alleviated by an open and well-conceived communication culture. We think that every nurse can already bring about change when it comes to moral distress – both for her own well-being and for her patients and relatives. At this point, we emphasize that communication as alleviating factor is not as straightforward as the literature states: it can only be useful if it is integrated well into the daily work of nurses (for instance through short reflection meetings) and if it does not take away even more time that nurses could otherwise spend with their patients. Moreover, we also challenged the apparently purely positive concept of moral courage by depicting it as a double-edged sword: we argue that raising the voice does not always change things for the better, as it can also increase moral distress, deteriorate relationships to colleagues and patients' parents as well as cause nurses to withdraw from engaging in future changing attempts. Based on this, we feel that our thesis sets itself apart and thereby enables sense-making for nurses, healthcare managers and organizations outside the healthcare sector, since it provides useful insights to approaches that are widely known for alleviating moral distress.

In summary, the key argument of this study is that moral distress is a multifaceted phenomenon, which is experienced and coped with differently. Therefore, it should be considered holistically, through acknowledging its positive as well as negative aspects. Moreover, this study also revealed that small-scale change can already make a big difference in alleviating moral distress, but should be implemented with caution.

6.2 A LOOK AHEAD

First of all, it seems to be necessary to explore the connection between moral distress and stress, since we could only rarely find this aspect in the reviewed literature. There is an extensive research about stress by itself – however, comparing it to distress might be gainful, since both concepts are often mixed. Next to this, it would also be worthwhile to explore the connection between moral distress and moral courage, which we elaborated on in the context of our discussion, in more depth and with its various risks and opportunities.

If we continued to research moral distress, we would also conduct interviews with patients, as it would surely be gainful to listen to their impressions of the received care and to find out if they could feel when nurses are morally distressed. Furthermore, we assess it as important to

conduct further research on the tensions between physicians and nurses and the opportunities and threats of reducing old-established hierarchical structures. It might be gainful to conduct studies which explore if this would lead to less moral distress for nurses, enhanced teamwork processes and finally to a better patient care. We also think that there is a potential to investigate how doctors perceive situations in which nurses feel morally distressed due to the hierarchy between those two parties and potentially hand over their responsibility to the physicians. Moreover, it might be interesting whether physicians themselves suffer from moral distress and to what extent this influences how they relate to nurses, patients and parents. Due to our empirical findings in the field of pediatrics, we think that the parents' perception of situations in which nurses feel morally blocked should also be further explored. Furthermore, knowledge about the role of relatives should be generally expanded: will their role change over time due to a potential demographic change? If hospital staffing stays alike, nurses will maybe be even more dependent on the support of relatives while taking care of (especially geriatric) patients – so the potential for moral distress due to the influences of relatives might prospectively increase.

Besides, we think that the balancing act between caring passionately and being resilient should be more prevalent in future research about moral distress. Thereby, it might also be gainful to further explore how male nurses handle moral distress and if findings possibly diverge from the studies that are so far mainly dominated by the perceptions of female nurses. Moreover, we assess it as important that research about the phenomenon does not get one-sidedly stuck in concentrating on negative aspects, but we see the necessity for more research about positive side-effects of moral distress, as we have tried to reveal – and to what extent simple activities, like the implementation of short, daily reflection meetings, can alleviate or reinforce moral distress.

Lastly, as previously outlined, moral distress is a cross-sectoral phenomenon and can occur in any organization. Therefore, we think that research on moral distress should be further expanded to other occupations.

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APPENDIX

APPENDIX 1: GLOSSARY

Ambulatory care	Care relating to or describing people being treated for an injury or illness who are able to walk, and who, when treated in a hospital, are usually not staying for the night.
Analgesia	The inability to feel pain or medication that acts to relieve pain.
Biomedicine	Medicine that uses biological science in medical developments.
Catheter	A flexible tube for insertion into a narrow opening so that fluids may be introduced or removed.
Drainage	The drawing off of fluid from a cavity in the body, usually fluid that has accumulated abnormally.
extirpated	A tissue, an organ, or a growth that has been completely surgically removed.
Futility of care	Pointlessness or uselessness of care.
Globules	A small ball of something, especially a drop of liquid. Normally used for expressing medication from alternative medicine.
ICN	International Council of Nurses
ICU	Intensive Care / Therapy Unit: A hospital unit designed to give intensive care, provided by specialist multidisciplinary staff, to a selected group of seriously ill patients or to those in need of special postoperative techniques.
Incision	The surgical cutting of soft tissues, such as skin or muscle, with a knife or scalpel.
inpatient	A patient who is admitted to a bed in a hospital ward and remains there for a period of time for treatment, examination, or observation.
Metastases	The spread of a malignant tumor from its site of origin.
MRI scan	MRI: Magnetic Resonance Imaging. A technique for producing images of bodily organs by measuring the response

	of the atomic nuclei of body tissues to high-frequency radio waves when placed in a strong magnetic field.
outpatient	A patient who receives treatment at a hospital, either at a single attendance or at a series of attendances, but is not admitted to a bed in a hospital ward.
Palatine cleft	A fissure in the midline of the palate due to failure of the two sides to fuse in embryonic development.
Palliative care	Care for the terminally ill and their families, especially that provided by an organized health service.
Pediatrics	The general medicine of childhood. Handling the sick child requires a special approach at every age from birth (or preterm birth) to adolescence and also a proper understanding of parents.
Port catheter	A device used to draw blood and give treatments, including intravenous fluids, drugs, or blood transfusions. The port is placed under the skin, usually in the chest. It is attached to a catheter (a thin, flexible tube) that is guided (threaded) into a large vein above the right side of the heart called the superior vena cava. A port-a-cath may stay in place for many weeks or months. A needle is inserted through the skin into the port to draw blood or give fluids.
Resuscitation	The action or process of reviving someone from unconsciousness or apparent death.
Shin (bone)	The inner and larger bone of the lower leg.
Tube	'Feeding tube' in our thesis: a tube passed through the nose into the stomach, used to introduce material into the stomach.
Vestibular disorder	Disorder of those parts of the body involved in balance.
Ward	One of the parts or large rooms into which a hospital is divided, usually with beds for patients.
X-ray	Electromagnetic radiation of extremely short wavelength (beyond the ultraviolet), which pass through matter to varying degrees depending on its density. An x-ray screening produces real-time imaging and is widely used in radiology to guide procedures.

APPENDIX 2: INTERVIEW GUIDELINES

Interview Guidelines – Questions and Ideas

1. If possible: meeting at an informal place, having a coffee together etc.
2. Building a trustful relationship in to get to know inner feelings and experiences, promising discretion – telling our names and study program and how we define moral distress
3. Asking for permission concerning the interview recording
4. In which department does the interviewee work?
5. Approach: Just letting the interviewee tell about experiences, situations, dreams…
6. Asking for examples of situations – what do these instances tell us? Do interviewees use metaphors? (in-depth and open, can also be critical)
7. Making breaks – letting interviewees talk
8. What is the interviewee not saying/keeping back?
9. Being skeptical about the social interaction between us and the interviewee – does the interviewee really tell us what is going on? Or is there an influence of power, organizational norms etc.?

Overall question

Why and how do nurses experience morally distressful situations and how do they handle them?

Sub-questions

How does it arise?

- Do you sometimes have the feeling that you know what is right, but you cannot do this?
- What is 'doing the right thing' for you?
- In which situations do you feel this?
- What hinders you in doing what you think is right?
- How do you feel in this situation? Which words would you use to describe your feelings?
- Do you know about ethical codes in the hospital that apply to you as a nurse?
- How do you deal with ethical standards in the hospital?
- Do ethical codes influence your actions?

How does it influence nurses?

- How do you feel when you think about your work in general?
- How do you feel before going to work?
- Do you think that distressful feelings stay on your mind (moral residue) and influence your future actions?
- Do you think that the situation in nursing got generally worse?
- For more experienced nurses: Do you think that moral distress influenced you more when you were young?
- Do you think that these feelings can be seen as positive in any way?
- We know that this is a personal question, but we would like to ask you if you sleep well?
- If you dream, do you remember the dreams and if you do, do they have to do with work?
- What do you then dream of (where are you, who is with you, what are your actions, how do you feel…)?
- How do you act in situations of moral distress – do you sometimes also work around the system/resist? Do you act differently towards patients? Do you think they are aware of that?
- How do you feel when you treat patients in a way that you think is not the right way?
- Do you feel motivated about your job?
- Do you feel important and recognized at your workplace?
- Do you think you can make a difference?
- If you were asked by a student if you can recommend your occupation, what would you answer?
- How does a stress-free day look like for you?

How does it influence their workplace?

- Do you express your difficulties with these situations to your colleagues?
- Do you feel understood when expressing your feelings?
- Are talks about this feeling part of regular team meetings?
- Is there any contact point/counseling/contact person that is responsible for helping you in these situations?
- Are nurses represented in ethics committees?
- How would you wish your workplace to be? Can you explain it in detail?

- How do you act at your workplace?
- Do the feelings that you have in these situations influence the team in any way and how?
- Do you think this kind of stress influences the whole hospital and how do you see this influence/can you give examples for that?
- What would you do about it, if you could?

Do you have final comments?

APPENDIX 3: OVERVIEW INTERVIEWEES

Ida

Ida is a pediatric nurse at a neurology ward in Sweden. She works with children who suffer from tumors, epilepsy or have to receive breathing support, a lot of those are terminally ill. Ida has 4 years of nursing experience – she has worked for three years as a pediatric nurse. Her answers seemed to be quite self-secure, however, her body language revealed some nervousness.

Agnes

Agnes is an epilepsy nurse, working with children in the neurology reception of a university hospital in Sweden. She has more than 35 years of work experience and has worked with children for 20 years. Her answers and body language seemed to be very self-secure.

Maja

Maja is a nurse working in the pediatric emergency of a Swedish university clinic which treats patients who are between 0 and 18 years old. She has 13 years of work experience and has worked as a pediatric nurse for almost two years. Maja's answers and body language seemed to be self-secure, she answered the questions deliberately and was very calm.

Sara

Sara is a pediatric nurse and family nurse working in the pediatric surgery of a university clinic in Germany. Sara has 31 years of work experience – currently, she works part-time. Her answers and body language seemed to be self-secure, she gave a very sprightly and compassionate impression and answered the questions deliberately and.

Emma

Emma is a pediatric nurse, likewise working in a pediatric surgery in Germany. After successfully completing her three-year apprenticeship program to become a nurse, she has been working there now for three years. Her answers and body language seemed to be self-secure, she answered the questions thoughtfully and gave a very communicative, motivated as well as reflective impression.

Vera

Vera is a pediatric nurse working in a pediatric surgery in Germany. She completed her nurse apprenticeship program one year ago and works at a university hospital since then. Her answers and body language seemed to be self-secure, thoughtful and calm. She gave a fresh impression of a young nurse – however, she was realistic about the challenges of her occupation.

Clara

Clara is a young nurse working in the pediatric surgery of a German hospital. After completing her nurse apprenticeship program in 2012, she started working at the university clinic in 2015. Her answers and body language were direct, lively and open-hearted. She seemed to be a joyful and positive young nurse who is confident in working with nursing and physician colleagues and tries to see things lightly.

Filippa

Filippa is a young nurse working in the pediatric surgery and urology of a German university clinic. After completing her nurse apprenticeship program in 2015, she has worked at the hospital since then. Her answers were rather short and she was quite insecure if her experiences are relevant for our study – we had the impression that tried to think of 'good stories'. Generally, she seemed to be satisfied with her work and reported many positive aspects about being a nurse.

Thea

Thea is a 23-year-old nurse working at an inpatient infection ward in Sweden after gaining experience at an oncology ward. Since completing her nurse apprenticeship two years ago, she has worked at a university clinic as an assistant nurse and nurse. Her answers were very straightforward, there were no long pauses for reflection and she smiled and gesticulated a lot. She seemed to be a very passionate nurse who really engages in work, tries to see things positively and thinks that cooperation with colleagues is essential when caring for patients.

Leia

Leia is a nurse working in a pediatric oncology ward for approximately 10 years. She also left the ward in between, but always came back to the ward she is now working at. When she answered the questions, she seemed to be self-secure and thoughtful, as she narrated about her work life very lively, but sometimes also gazed into the distance to think of how to formulate her answer. She conveys the impression of an experienced nurse who is realistic about the fact that there are distressful situations and that she has to defend herself from engaging too deeply in the suffering of patients, but still has the ambitions to care for children who suffer from cancer and to improve processes within the clinic.

Nurses from observations: Ella, Ines, Ingrid and Matilda

During the day at the inpatient ward, Sonja had the chance to accompany two nurses with up to 10 years of work experience: *Ella*, the nurse she followed first, who works part-time, and *Ines*, the other nurse, who works fulltime. Carolin also spent the day with two nurses – one has been at the outpatient ward since 1984 *(Ingrid)*, whereas the other one has been a nurse for 11 years but only joined the outpatient ward one year ago *(Matilda)*.