

# Nursing Ethics

<http://nej.sagepub.com/>

---

## **Caring About - Caring For: moral obligations and work responsibilities in intensive care nursing**

Agneta Cronqvist, Töres Theorell, Tom Burns and Kim Lützén

*Nurs Ethics* 2004 11: 63

DOI: 10.1191/0969733004ne667oa

The online version of this article can be found at:

<http://nej.sagepub.com/content/11/1/63>

---

Published by:



<http://www.sagepublications.com>

**Additional services and information for *Nursing Ethics* can be found at:**

**Email Alerts:** <http://nej.sagepub.com/cgi/alerts>

**Subscriptions:** <http://nej.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>

**Citations:** <http://nej.sagepub.com/content/11/1/63.refs.html>

>> [Version of Record](#) - Jan 1, 2004

[What is This?](#)



# CARING ABOUT – CARING FOR: MORAL OBLIGATIONS AND WORK RESPONSIBILITIES IN INTENSIVE CARE NURSING

*Agneta Cronqvist, Töres Theorell, Tom Burns and Kim Lützén*

**Key words:** descriptive interpretation; ethical concerns; experiences; intensive care nurses; qualitative content analyses

The aim of this study was to analyse experiences of moral concerns in intensive care nursing. The theoretical perspective of the study is based on relational ethics, also referred to as ethics of care. The participants were 36 intensive care nurses from 10 general, neonatal and thoracic intensive care units. The structural characteristics of the units were similar: a high working pace, advanced technology, budget restrictions, recent reorganization, and shortage of experienced nurses. The data consisted of the participants' examples of ethical situations they had experienced in their intensive care unit. A qualitative content analysis identified five themes: believing in a good death; knowing the course of events; feelings of distress; reasoning about physicians' 'doings' and tensions in expressing moral awareness. A main theme was formulated as caring *about* – caring *for*: moral obligations and work responsibilities. Moral obligations and work responsibilities are assumed to be complementary dimensions in nursing, yet they were found not to be in balance for intensive care nurses. In conclusion there is a need to support nurses in difficult intensive care situations, for example, by mentoring, as a step towards developing moral action knowledge in the context of intensive care nursing.

## Introduction

Nursing care is claimed to be an ethical enterprise by several researchers because it is based on society's (moral) obligation to care for others<sup>1-5</sup> who temporarily or over a longer period of time are unable to care for themselves. Moreover, the growing amount of literature on bioethics substantiates not only a theoretical interest in understanding the morality of care but also a heightened awareness of the complexity of ethical problems in clinical practice. One such area is the intensive care unit (ICU) characterized, for example, by advanced technology, a high

---

Address for correspondence: Agneta Cronqvist, Department of Health Care Sciences, Ersta Sköndal University College, PO Box 4619, SE-116 91 Stockholm, Sweden. E-mail: agneta.cronqvist@euc.ersta.se

working tempo, and crucial end-of-life decisions for critically ill patients. These aspects of nursing raise ethical questions, particularly which situations concern nurses and what type of moral knowledge is needed to deal with ethical questions.

Sarvimäki<sup>6</sup> suggests that moral knowledge consists of four aspects. Briefly, these can be recognized as theoretical ethical knowledge, moral action knowledge (how to), personal moral knowledge (motivation to act), and situational moral knowledge (moral awareness). A morally integrated person exhibits these four aspects. Nurses' moral knowledge may promote a reflective, ethical attitude and thereby support them in their professional growth.<sup>4,6</sup>

It is well known that caring for critically ill patients in intensive care means encountering situations with an ethical constituent. Earlier studies have focused on these situations from a problematic perspective, implying that they are always prone to be problematic and conflictual in nature.<sup>7-9</sup> A predetermined definition of the term 'ethical difficulty' was, for example, used as a focus in studies by Söderberg<sup>7</sup> and Sørliie.<sup>9</sup> In intensive care, different ways of reasoning between nurses and physicians concerning ethical problems<sup>10</sup> may reflect on the different aspects of ethics. A common theme for both nurses and physicians in ICUs can be related to 'too much treatment'. The physicians described it from a decision-making perspective, that is, they are responsible for making decisions; the nurses described it from an executive perspective, meaning that they carry out what is ordered. In the present study we were open to the possibility that nurses could have moral concerns without viewing these as conflicts or dilemmas.

## **Theoretical perspective**

In this study we chose to focus on nurses' experiences of situations in ICUs that contain a moral constituent from the perspective of relational ethics, sometimes referred to as ethics of care. Within this perspective it is understood that nursing/caring is a moral enterprise or a moral value.<sup>1,3-5,11</sup> Caring is a relational concept and involves caring about someone.<sup>3,5</sup> The way in which this relationship is described and conceptualized as a 'dispositional notion of care' involves a willingness to be open for others (patients) as individuals with special needs, beliefs, desires and wants (p. 150).<sup>5</sup> Caring can be characterized in qualities such as compassion, competence, confidence, conscience and commitment, and can also be based on sharing and mutual respect. When a person is seen as a living being (a whole person, not fragmented into objective parts of the body) then every relationship becomes unique to both the receiver and the giver of care.<sup>12</sup> This type of caring relationship is not limited to the nurse-patient dyad, but also comprises the relationship nurses have with other nurses, physicians and co-workers.

To refer to the term 'ethical' on a theoretical level with principles and theories and apply the term 'moral' to the manifestation of what is right and wrong, good and bad in practice is an oversimplification. In the literature there is no clear-cut difference between the two terms. In this study they are used interchangeably, with one exception. When we formulated the interview questions, the term ethics was preferred because we understood that this is used in everyday language in Swedish health care.

## Aim of the study

The aim of the study was to analyse experiences of moral concern in intensive care nursing from the perspective of relational ethics. The main questions raised were: what situations are ICU nurses morally concerned about and how do they reason about them?

## Method

### Study background

This study is a part of a project focusing on different aspects of intensive care nurses' experience of critical care situations and is in parts described elsewhere.<sup>13</sup> The participants were employed in general, thoracic and neonatal ICUs in Sweden. High technology, a high working pace, parsimonious budgets, and frequent reorganizations of the structure of care were common characteristics of the ICU contexts. All the participants described their working situation as unsatisfactory because they could not meet the needs of the patients. All sites were filled to over-capacity at the time of the study, which meant, according to the respondents, that at times 'impossible prioritization of patient care' was required. Nurses were expected, for example, to give priority to newly admitted patients. There was also a shortage of specially trained intensive care nurses. The consequence was that newly employed and inexperienced nurses were required to take full responsibility for making decisions and carrying out tasks without having sufficient experience and training.

### Selection of participants and procedure

Ten head nurses representing the 10 ICUs in Sweden were contacted by telephone and asked to participate in the study. Contact with staff nurses who were willing to take part was made possible with the help of these head nurses. Ethical principles for conducting research were applied by giving written and oral information about the purpose of the study, obtaining informed consent from the participants, and guaranteeing confidentiality and anonymity during analysis and publication of the results. All 36 nurses who were invited agreed to participate. Their length of experience varied from one to 32 years; two respondents were male.

The participants were asked to give an example of an ethical situation that they had experienced in the ICU in which they worked. The interviews were conducted privately according to the participants' own choice, in a room adjacent to the ICU ( $n = 32$ ), at a university office ( $n = 2$ ) or in the respondents' own home ( $n = 2$ ). The interviews were conducted either during working hours or immediately before and were all audiotaped.

### Analysis of data

A qualitative content analysis as used by Berg<sup>14</sup> and by Coffey and Atkinson<sup>15</sup> was used. The process of data analysis was also influenced by Thorne *et al.*'s<sup>16</sup>

interpretive description and consisted of the following five levels.

#### *First level of analysis*

The interviews were listened to in order to identify the responses specifically related to the interviewer's (AC) questions about ethical situations that the participants had experienced. These parts of the interviews were transcribed. A reading of all the transcripts resulted in a general overview:

- Responses that did not encompass examples of ethical situations;
- Responses that portrayed ethics as integrated in practice;
- Responses that contained specific examples of ethical experiences.

At the same time, relevant domains were identified for further analysis. The next step was to divide the text into meaning units, guided by the identified domains. An analysis was carried out using these text units, resulting in the designation of codes. These were examples, descriptions of situations, feelings, opinions, reflections (on self, physicians, patients, organization, other nurses) and beliefs.

#### *Second level of analysis*

The codes were compared and the codes 'examples' and 'description of the situation' were subsumed and described as the examples' typical features. The remaining codes were compared, which resulted in the formulation of five categories.

#### *Third level of analysis*

The categories were interpreted in order to uncover latent meanings and consequently to form five subthemes: believing in a good death, knowing the course of events, feelings of distress, reasoning about physicians' 'doings', and expressing moral awareness.

#### *Fourth level of analysis*

Within each subtheme moral tensions were identified. In order to raise the analysis from a descriptive level to a theoretical understanding of the findings,<sup>16</sup> the notion of care *about* and care *for*<sup>17</sup> was used. Care about is to acknowledge or pay attention to another person with his or her welfare in mind, and to care for (tend to) can be described as the task-orientated dimension of care. One can care for (tend to) someone and not care about the person and, vice versa, one can care about someone and not care for the person. Health care personnel tend (care for) others as a part of their working responsibility and may not necessarily care about these people, although they often do.

#### *Fifth level of analysis*

As a result of contrasting the five subthemes with the theoretical notion of care about and care for, a main theme was formulated: caring about – caring for: moral obligations and work responsibilities in intensive care nursing.

## **Methodological and ethical considerations**

The first author of this article has extensive experience in working in ICUs, which has methodological implications. On the one hand, clinical experience can contribute to an understanding of the phenomenon studied and the context, and can serve as a facilitating 'bridge' between interviewer and interviewee.<sup>16</sup> On the other hand, the experience or preunderstanding could also bias the researcher in the process of the analysis. To counteract possible research bias, regular discussions of potential interpretations of the data were held by the research team (the authors of this article) and with a group of doctorally prepared nurses.

The study was reviewed by the Ethics Committee, Faculty of Medicine, Uppsala University, Sweden, which considered that a formal application was not necessary (Dnr. 99414). Confidentiality was maintained throughout the research process.

## **Findings**

### **General overview of participants' responses**

The participants' reflections on examples of ethical situations in an ICU could be divided into three general groups: responses that did not encompass examples of ethical situations, those that portrayed 'ethics' as integrated in practice, and those that contained specific examples of experience of ethical situations. None of the participants referred explicitly to traditional principles or theories of ethics.

Those participants who did not give any examples of a specific ethical situation said that they had limited experience of such situations in the present unit and argued that ethical problems occur more frequently in ICUs other than in their own.

Another group of participants who did not give an example of a specific ethical situation instead claimed that the ethical dimension 'was present' all the time when caring for a patient. This was expressed in 'everything you do to a patient', not to expose them, not to talk about them in the third person, and also how to give adequate information to relatives. Several participants were critical of how staff members behaved and socialized in patients' rooms while carrying out nursing assignments and how they discussed patients' medical condition with physicians.

The third group of respondents gave more detailed descriptions of ethical situations from which typical features were identified, as described below.

### **Typical features of the examples**

The examples given by the participants most frequently concerned older patients who had experienced major surgery or had received advanced medical treatment, or adolescents under 12 years old who had undergone organ transplantation for the first time or had received several transplants. In some examples, parents with a younger child or a newborn baby were involved. The physicians working in the unit or the anaesthetist were also frequently mentioned in the participants' examples. Two typical situations dominated the examples: withdrawing and with-

holding treatment. These were expressed in terms of giving either too much treatment or administering meaningless treatment.

## Main theme

'Caring about – caring for: moral obligations and work responsibilities in intensive care nursing' was identified as the main theme (Figure 1).

The notion of caring about rests on moral grounds because moral obligation is inherent in that notion and assumes a personal ability to know what is morally good to do in a caring situation. Caring about also implies that there is a genuine concern about the well-being of the other. In this study, a genuine concern for patients in terms of feelings, beliefs and insight into patients' vulnerability were expressed in the participants' examples of ethical situations (see Figure 1).

Caring for is task-orientated nursing care that is assigned and controlled by 'others' (employers, superiors, physicians) and can be considered as a moral obligation to fulfil work responsibilities. Caring for rests on what organizations provide as guidelines concerning practical, technical and medical assessments (see Figure 1).

As the analysis shows, tensions occur when caring for and caring about a patient cannot be achieved at the same time. The four subthemes reflect this type of tension. In the fifth subtheme the balance between caring about and caring for is in part maintained.

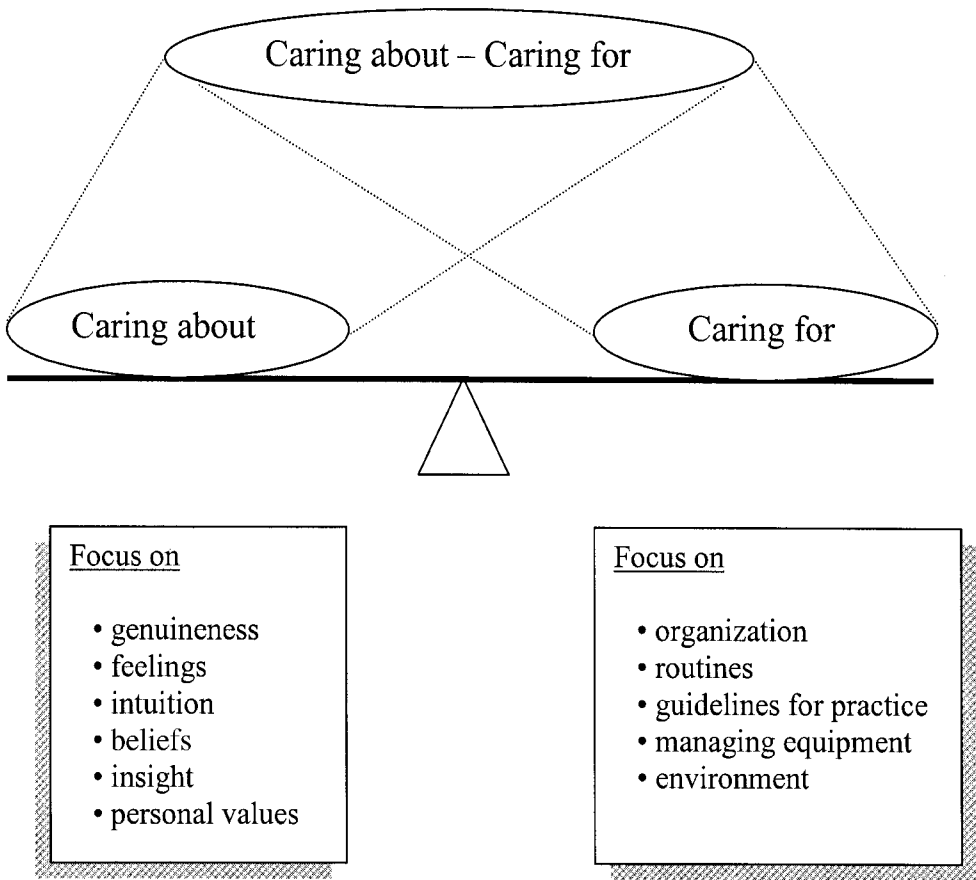
## Subthemes

The five subthemes related to caring about and caring for were identified as: (1) believing in a good death; (2) knowing the course of events; (3) feelings of distress; (4) reasoning about physicians' 'doings'; and (5) expressing moral awareness. The presentation of the subthemes given below begins with a description of how they relate to the notions of caring about – caring for, followed by a presentation of the content of each subtheme. Finally, an explanation of how moral tension occurs within each subtheme is given.

### *Believing in a good death*

Beliefs, or convictions of what is morally good, were found as constituents in the notion of caring about (see Figure 1). Beliefs were specifically expressed as values related to death and suffering. The participants believed that 'to let a suffering patient die' was more morally justified than allowing him or her to suffer, for example, from painful medical interventions that would only stall the inescapable event of death. In critical care, death is a frequent reality and the purpose of intensive care is to save lives as long as it is possible. Yet it is an inevitable fact that not all patients will survive. The participants expressed the ambiguity of these types of situation with comments such as: 'people have the right to die', but asking rhetorically, 'why can't she [patient] be allowed to die?' Another believed that 'there has to be somewhere you are allowed to die when the body has given up.'

As our results showed, the participants were concerned about not allowing



**Figure 1** Caring about – caring for: tensions between moral obligations and work responsibilities in intensive care nursing

older patients die, as one explained: 'It often happens that very old people aren't allowed to die.' They also believed that patients should 'die peacefully and with dignity', but 'to die naturally in the ICU is not allowed'. One believed that 'it is a respect for life to be allowed to die' when it is time.

Some respondents attempted to explain the resistance to allowing patients to die naturally in that it could be seen as a failure and that there were no limits in what it would 'cost' to keep a patient alive. As one said, 'Sometimes I think this is the only ward where you eat yourself to death because they [patients] have tube feeding right to the end.' What she was referring to was the routine of giving nutrition to dying patients.

The way that the participants commented on patients' death and dying, the right to die, how to die, and the possible resistance to allowing patients to die, illustrates that they had an idea about what a 'good death' was and that this was desirable. Moreover, they believed that caring about a 'good death' is a moral and



personal value. Thus, a tension seems to exist between these nurses' personal value of care, 'a good death', and the wish to achieve this versus the broad purpose of intensive care, which is to save lives using all available resources.

### *Knowing the course of events*

The subtheme 'knowing the course of events' indicates the participants' intuitive feeling leading to an awareness of what will occur in a specific situation. In knowing the course of events, their awareness attuned to the specifics in the situation seemed to be based on their earlier experience of similar situations. Feelings and intuitions also have significance in caring about because they 'tell' the individual what is at stake (see Figure 1). In this study, at a certain point in time during a patient's critical period, the participants 'knew' that the patient was not going to survive.

The respondents described situations in which they had been at the bedside of a patient for a long time, administering treatments and monitoring the possible effects. They also followed patients' and families' emotional ups and downs related to arousing families' hopes at the start of new treatment and disappointment when the treatment had no effect. The participants thought that this was 'an endless suffering' and believed that each new treatment effort only caused the patient more harm and was of no benefit. Feelings of meaninglessness dominated the examples, as one expressed: 'They [patients] are put on a ventilator and will never come off and then you know that they will never regain consciousness.'

Some respondents were convinced that all nurses in ICUs shared the same knowledge and understanding concerning the course of events. Some examples were: 'everybody knows about the poor prognosis'; 'everybody understands that this is not going to work [the patient will not survive]'; and 'everybody knows that he [the patient] will not make it'.

This assumed shared knowledge was identified as an attempt to justify their own knowledge of the course of events (i.e. the patient was going to die against all the odds to survive).

A tension occurs between knowing the course of events and the organizational goal to save lives via treatment. The participants were caught between their beliefs about 'allowing a patient to die', as a moral 'good' (caring about) and their responsibility to carry out the duties defined by the organization (caring for).

### *Feelings of distress*

Feelings of distress serve as a signal telling (us) that something is wrong in a situation or as a reaction to a difficult situation. That is, in certain situations, feelings of discomfort (and pleasure) arise and thereby serve to distinguish a right action from a wrong action. These feelings can be described as a form of intuitive 'knowledge' about what the participants believe is best for the patient, and, as such, be a dimension of the notion of caring about (see Figure 1). When the participants gave examples of moral situations they spontaneously reflected on the situation. On behalf of themselves they were bothered and distressed and talked about their own difficulties and limitations. Those with limited experience of nursing expressed a sort of self-reflection when discussing the care of patients who suffered from multiorgan failure and of transplant patients with complicated aftercare. One participant said, 'In the beginning I had a hard time

[understanding, coping] . . . I think it is very unsatisfactory, [thinks] I think it is frustrating with intensive care.' The more experienced nurses also had feelings of distress when they reflected on critical situations, for example, when taking care of children: 'If you are not used to care for [sick] children then it is even harder to keep a professional attitude while being terrified, [laughing] that is hard [to cope with].'

Another example of distress was when the participants came to realize that they did not not agree with the physicians and said, for example,

Sometimes you get a little frustrated when you don't feel like doing anything more or just withdraw [treatment], and then there are physicians who say 'not yet' and then you are in a jam . . . [thinks] that could sometimes be very frustrating.

When the respondents expressed, for example, their own frustration in these examples, they also seemed to express their own vulnerability. A tension seems to exist between the patient's vulnerability and the nurse's vulnerability, for example, when nurses are attempting to relieve a patient's suffering while at the same time having a personal need for emotional support. Another problem is that nurses may not have the opportunity to deal with their own needs because of the time limitations of intensive care nursing. In the high-speed ICU environment with critically ill patients demanding minute-by-minute decisions it is distressing for nurses not to find a moment to themselves to contemplate and to obtain support.

#### *Reasoning about physicians' 'doings'*

In the ICU, the physician is the authority governing the organization of care and has specific responsibility for the highly specialized medical treatment administered. This responsibility is upheld by an organizational structure consisting of schedules, instructions and guidelines. These features are also characteristics of the notion caring for (see Figure 1). In practice, physicians are responsible for medical treatment and the guidelines that nurses must follow and execute. Collaboration between nurses and physicians is often intense and it is necessary for them to maintain a good working relationship. Both the nurses and the physicians are expected to work together for *each* patient, although they have different responsibilities. Nurses have responsibility for fewer patients than physicians; they are at the bedside, closely monitoring the patient's condition, sometimes for many hours. Physicians have responsibility for more patients, who may be cared for on different wards. In times of heavy workload physicians are not as available as nurses may wish. In this study, the participants reflected on or questioned the actions taken and orders given by physicians concerning withdrawing or withholding treatment. Some criticized the physicians as a group, for example:

The physicians are more like, you know – we must try this [treatment] and this can have an effect – but in my eyes I already see a dead patient.

The physicians do have different opinions [thinks] about what matters.

Other participants expressed criticism of physicians by describing specific situations. An example of this was when a 'do-not-resuscitate-order' was made for a patient who was considered not to have any chance of survival, yet the physicians ordered dialysis and tube feeding. The participant believed that these

were contradictory orders: not to resuscitate (i.e. to allow the patient to die when the heart stops) while giving dialysis so that waste products in the blood would not be toxic to the patient and lead to coma and death. The nurse thought that this was an illogical way of ordering care and the question should be asked: What type of death is acceptable when death as a consequence of severe kidney failure seems to be preferred to cardiac arrest?

Another criticism of the physicians was expressed by referring to them in the third person, as demonstrated in this example:

when patients deteriorate on the regular ward and when they [patients] end up here [ICU] they are not allowed to die, they [physicians] push the whole battery of treatments, though you know they are not going to work [the patient will not survive].

However, other participants expressed that they acknowledge the difficulties the physicians have and felt empathy with them. An example of this is: 'It is a physicians' decision to be made, perhaps in the middle of the night, and he may not be used to this ward and gets a lot of criticism from us [nurses].'

In this theme, the tension is overtly due to the participants' awareness that they disagree with what the physicians decide and do. There is disquiet between what the nurse understands as good care (caring about) and the responsibility to carry out orders as a working responsibility (caring for).

### *Expressing moral awareness*

In this study, moral awareness was expressed as the ability to discuss complex caring situations from different perspectives. The feeling that 'something is wrong' is an essential part of the process of becoming 'aware', followed by a cognitive ability to grasp that the situations can be 'looked on' from different perspectives. Caring about is characterized by the individual's ability, for example, to feel, to have insight and to be genuine in a caring situation (see Figure 1). The participants expressed this dimension by the way they reflected on the situations. They also had the ability to 'see' things from different angles and often referred to issues within the organizational structure, such as prioritization of patients and medical treatment (see Figure 1). However, they were also critical of their own beliefs and standpoints.

Most respondents gave detailed examples of situations they considered to have moral significance. Often their moral reasoning about the situation occurred without probing. When they began to analyse how and why a specific situation had originated, the participants gave various explanations of why different views among the professionals involved (e.g. on withholding treatment) were morally problematic. While deliberating about the situations they had experienced, they changed perspectives, indicating that the moral awareness of any situations concerning life or death can be contradictory in nature. An example of this type of contradiction is when one of the participants asks rhetorically, 'What use is surgery on an 85-year-old person?' and then answers her own question by saying, 'On the other hand we have done surgery on very old patients who have felt quite well, being grateful [thinks] then you think maybe it's worth while at least to try.'

Another respondent claimed that nurses often have thoughts about why a treatment is not withdrawn in situations when it seems futile and there is no chance

that the patient can survive. Occasionally there is a possibility that the patient will survive against all odds, as one nurse said, 'Patients that you believe do not have any chance [to survive] and then really do it.'

The way in which the participants expressed their moral awareness indicates that they were also aware of the different perspectives involved in the situations. Their way of reasoning illuminated dimensions of the concepts of caring for and caring about. By expressing a moral awareness and their reflection on situations, they attempted to balance their moral obligations and work responsibilities.

## Discussion

The aim of this study was to explore nurses' experiences of situations that had a moral constituent in intensive care from the perspective of relational ethics. The way these intensive care nurses answered the question illuminated a most complex picture of their working situation. Shogan introduced the concept of 'care about – care for' as a pedagogical perspective on moral motivation (p. 7).<sup>17</sup> In this study, the same interrelated concepts were found to be a relevant conceptualization for explaining intensive care nurses' experiences. As the findings imply, nurses do not seem to be able to balance moral obligations and work responsibilities that call for different actions in order to reduce the tension that emerges. It may be that the lack of a shared value system, different professional expectations, and different levels of knowledge and experience lead to different caring for or caring about priorities. Is this a comparison between nurses and physicians? The question thus becomes, how can caring about and caring for be integrated into nursing interventions without leading to tension between these two dimensions?

The results of this study seem to characterize moral dimensions of everyday practice in the context of intensive care. By feeling, knowing and believing (values) these nurses demonstrated a type of moral awareness, which can also be described as a personal moral knowledge.<sup>6</sup> A morally integrated person, according to Sarvimäki, should exhibit both theoretical ethical knowledge and moral action (practical) knowledge.<sup>6</sup> However, in this study, the participants did not articulate any traditional ethical principle or theory. In that sense, on applying Sarvimäki's idea, they would not have knowledge at the theoretical ethical level. Instead, they viewed ethics as a type of value system, saying that ethics is present in everything they do. Whether these nurses actually have moral action knowledge (i.e. the application of moral knowledge in practice) is a question that needs further exploration and calls for other research methods, such as participant observation.

The nurses who said that they could not give examples of any ethical situations are interesting. Whether they did not see situations as 'morally' relevant or lacked the ability to reflect on moral issues, or whether they chose not to talk about them, cannot readily be answered. According to Heath,<sup>18</sup> nurses vary in their verbalizing skills, yet this should not be a barrier to reflection. However, if we are to believe that these nurses chose not to talk about their moral experiences, maintaining so-called moral muteness, it seems necessary to explore the reasons for this. Moreover, if reasoning abilities are indeed a central part of a caring about response<sup>17</sup> and if reflection is decisive for the development of clinical

knowledge and ethical judgement,<sup>4</sup> what does this mean for a nurse who does not have these abilities?

The theme believing in a good death indicates that the process of dying, as perceived by the participants, can be viewed as good or bad. A good death is similar to the alternative concepts of a 'healthy death'<sup>19</sup> and a 'natural death'.<sup>20</sup> Seymore<sup>20</sup> has identified four aspects of natural death in the ICU: (1) the process of dying is not prolonged or rushed (timing); (2) technical death is aligned with bodily death; (3) the family has accepted the death; and (4) careful planning of withdrawal of treatment is made to enable control of the situation so the family can witness a gradual, quiet and dignified death. Whether these four conditions were met in the situations that the participants described is not clear. Instead, they highlighted ethical aspects of the dying process that may not easily be aligned according to Seymore's four aspects.

The nurses' mode of expressing certainty is prominent in the theme 'knowing the course of events'. This mode is similar to Wurzbach's<sup>21</sup> concept of moral certainty. When Wurzbach studied the experiences of moral certainty among acute care nurses, the basic themes identified were 'speaking up', 'standing up' and 'refusing to participate'. Several questions could be raised: is this way of arguing a personal trait and, if so, are nurses who exhibit such traits prone to working in acute care settings, or does the specific setting (acute care) foster the way in which nurses argue? Moral certainty could facilitate decision making but it can also constitute a hindrance for in-depth discussion because it could lead to arbitrary decisions made by those in power.

The theme feelings of distress refers to the participants' own feelings, frustrations and concerns in ethical situations. This state of feelings could be compared with what is considered to be moral distress.<sup>22-24</sup> Both Jameton and Wilkinson, for example, suggest that moral distress, a psychological disequilibrium or negative feeling state, refers to situations in which moral decisions are not followed through. However, the nurses in this study did not seem to express negative feelings in relation to their own decisions that were not followed. Instead, they expressed feelings, similar to distress, which had emerged in complicated caring situations. It is fair to assume that this frustration had caused feelings of stress for the nurses. In intensive care nursing, dissonant imperatives are described as inducing stress.<sup>13</sup> For example, lacking the authority to act but at the same time knowing something should be done, could be seen as leading to (moral) stress.

The way in which the participants reasoned about the physicians' 'doings' show that nurses may approach ethical problems in different ways to physicians. Similar findings have been presented in a study from Canada<sup>25</sup> on end-of-life decisions, which show that physicians question themselves concerning whether or not they have made the right decision, and nurses question the physicians' decisions. Some researchers view this divergence in collaboration as a product of power positions based on nursing existing in a highly gendered environment with strong hierarchical and patriarchal structures.<sup>5,26,27</sup> The tensions between the two professions continue; the boundaries between them are still somewhat diffuse and still undermined by economic constraints. Nurses attempt to handle these situations, but they are not always successful.

For the theme expressing moral awareness the participants showed an ability

to reflect but it is unclear whether this skill was applied in the situations they described. Thus, an interesting area for further research would be to explore how nurses reflect on moral concerns in concrete problematic situations and whether this reflection is put into action.

## Conclusion

Moral concerns are inevitably inherent in intensive care. Nurses are challenged by life and death situations in which they are compelled to balance priorities. Reasoning about these situations involves believing in a good death, anticipating events, coping with feelings of distress, reasoning about physicians' 'doings' and expressing moral awareness. Basic to these themes is a tension between the professional dimensions caring about – caring for and nurses' concerns about the care given. These professional dimensions are complementary but they must be kept in balance for intensive care nurses. How can these nurses be supported in maintaining this balance? Perhaps this tension is an everyday reality for them (i.e. not all moral concerns can be solved). There is, therefore, a need to support nurses in difficult intensive care situations, for example, by mentoring focused on gaining insight into how this tension between caring about and caring for arises. This can be viewed as the first step towards developing moral action knowledge in the context of intensive care nursing.

## Acknowledgements

This study was supported financially by the Swedish Council for Work Life Research and the Board of Research for Health and Caring Sciences at the Karolinska Institutet (Reg. no. 3560/98 UFA and 3667/99 FFU).

*Agneta Cronqvist and Töres Theorell, Karolinska Institutet, Stockholm, Sweden.*

*Tom Burns, Uppsala University, Sweden.*

*Kim Lützén, Ersta Sköndal University College, Stockholm, Sweden.*

## References

- <sup>1</sup> Noddings N. *Caring – a feminine approach to ethics and moral education*. Berkeley, CA: University of California Press, 1984.
- <sup>2</sup> Bishop AH, Scudder JR. *The practical, moral, and personal sense of nursing*. Albany, NY: State University of New York Press, 1991.
- <sup>3</sup> Tschudin V. *Ethics in nursing: the caring relationship*, second edition. Oxford: Butterworth-Heinemann, 1992.
- <sup>4</sup> Benner P, Tanner CA, Chesla CA. *Expertise in nursing practice*. New York: Springer Publishing, 1996.
- <sup>5</sup> Kuhse H. *Caring: nurses, women and ethics*. Oxford: Blackwell, 1996.
- <sup>6</sup> Sarvimäki A. Aspects of moral knowledge in nursing. *Sch Inq Nurs Pract* 1995; **9**: 343–53.
- <sup>7</sup> Söderberg A. *The practical wisdom of enrolled nurses, registered nurses and physicians in situations of ethical difficulty in intensive care* [Dissertation]. (Umeå University Medical Dissertations, new series no. 603.) Umeå: Umeå University, 1999.
- <sup>8</sup> Bunch EH. Hidden and emerging drama in a Norwegian critical care unit: ethical dilemmas in the context of ambiguity. *Nurs Ethics* 2001; **8**: 57–67.

- 9 Sørli V. *Being in ethically difficult care situations. Narrative interviews with registered nurses and physicians within internal medicine, oncology and paediatrics* [Dissertation]. (Umeå University Medical Dissertations, new series no. 727.) Umeå: Umeå University, 2001.
- 10 Söderberg A, Norberg A. Intensive care: situations of ethical difficulty. *J Adv Nurs* 1993; **18**: 2008–14.
- 11 Gilligan C. *In a different voice: psychological theory and women's development*. Cambridge, MA: Harvard University Press, 1982.
- 12 Bergum V. Knowledge for ethical care. *Nurs Ethics* 1994; **1**: 71–79.
- 13 Cronqvist A, Burns T, Theorell T, Lützn K. Dissonant imperatives in nursing: a conceptualisation of stress in intensive care in Sweden. *Int Crit Care Nurs* 2001; **17**: 228–36.
- 14 Berg BL. *Qualitative research methods for the social sciences*. Boston, MA: Allyn and Bacon, 1995.
- 15 Coffey A, Atkinson P. *Making sense of qualitative data*. London: SAGE, 1996.
- 16 Thorne S, Kirkham SH, MacDonald-Emes J. Focus on qualitative methods. Interpretive description: a noncategorical qualitative alternative for developing nursing knowledge. *Res Nurs Health* 1997; **20**: 169–77.
- 17 Shogan D. *Care and moral motivation*. Toronto: OISE Press, 1988.
- 18 Heath H. Reflection and patterns of knowing in nursing. *J Adv Nurs* 1998; **27**: 1054–59.
- 19 Omery A. A healthy death. *Heart Lung* 1991; **20**: 310–11.
- 20 Seymore JE. Revisiting medicalisation and 'natural' death. *Soc Sci Med* 1999; **49**: 691–704.
- 21 Wurzbach ME. Acute care nurses' experience of moral certainty. *J Adv Nurs* 1999; **30**: 287–93.
- 22 Jameton A. *Nursing practice: the ethical issues*. Englewood Cliffs, NJ: Prentice-Hall, 1984.
- 23 Jameton A. Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONN Clin Issues* 1993; **4**: 542–51.
- 24 Wilkinson JM. Moral distress in nursing practice: experience and effect. *Nurs Forum* 1987/88; **23**(1): 16–29.
- 25 Oberle K, Hughes D. Doctors' and nurses' perception of ethical problems in end-of-life decisions. *J Adv Nurs* 2001; **33**: 707–15.
- 26 Sundin-Huard D. Subject positions theory – its application to understanding collaboration (and confrontation) in critical care. *J Adv Nurs* 2001; **34**: 376–82.
- 27 Davies K. *Disturbing gender. On the doctor–nurse relationship*. (Lund Studies of Sociology, vol. 4.) Lund: Department of Sociology, Lund University, 2001.