Experiences of moral challenges in everyday nursing practice – in light of nurses' self-understanding

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Background

Experiences of moral challenges are described in various ways.[1,2] However, such challenges can be understood as situations where conflicting values are involved and deciding what to do seems difficult.[3] In other words, such challenges involve situations where healthcare professionals have to choose between options which are more or less good. Research has previously documented that moral challenges in everyday nursing practice are often experienced as burdensome,[4-9] they occur frequently,[8-11] and can be related to aspects within the healthcare professionals' and patient relationship.[4,12] Challenges arise, for example, in communication situations about illness and treatment,[13,14] while being close to suffering and death[1,15,16] or when patients and relatives act out,[17,18] or due to difficulties in providing help.[8,15,19] Moreover, moral challenges can be related to relationships between colleagues[1,9,20-22] and related to aspects within the healthcare sector, such as organizational changes after the introduction of New Public Management (NPM).[9] Due to factors such as unsatisfactory basic staffing, heavy workload and time pressure, nurses experience a conflict between patient-oriented work and organizational conditions,[15,23-25] implying that reality does not match healthcare professionals' intention to deliver high quality care.[16,20,26-28]

Previous research has documented that experiencing moral challenges in everyday nursing practice influences how healthcare professionals understand themselves and maintain their personal or moral integrity.[10,29,30] This means that moral challenges often involve a threat to moral integrity due to having to engage in conflicting situations where setting aside beliefs is necessary, which in turn can give rise to intense emotional frustrations[2,31] and ultimately may result in moral distress.[2,7,32] Nevertheless, healthcare

professionals are individuals[33] and are thus affected by experiences of moral challenges in different ways, depending on who they are as human beings.[32,34,35]

From a Norwegian perspective, support from the healthcare sector in handling such challenges seems to be scarce.[36] It is claimed that abilities such as developing moral competency and dealing more systematically with experiences of moral challenges in everyday nursing practice need to be supported by managers on different levels.[9,11,13] It is also worth noting that being introduced to and practising performing moral reflections in community healthcare has been documented to contribute to healthcare professionals' moral awareness with understanding and respect for both patients and colleagues.[11]

With this background, it is possible to see that considerable research has focused on experiences of moral challenges related to nursing practice but that there are few studies which can be linked explicitly to healthcare professionals' self-understanding. This study therefore has two aims:

Firstly, to describe experiences of moral challenges in everyday nursing practice, as expressed in reflection groups.

Secondly, to interpret how healthcare professionals' self-understanding can bring light to such challenges.

To this end, we refer to the Canadian philosopher, Charles Taylor,[37,38] to link experiences of moral challenges to self-understanding. Taylor has explored the concept of self-understanding within the field of philosophical anthropology and specifically connects it to morality. It can therefore be argued that his view is a useful basis for deepening healthcare professionals' experiences of moral challenges in everyday nursing practice.

Materials and methods

Settings

This qualitative study is a part of a Norwegian project initiated by the community healthcare sector in order to strengthen moral awareness among healthcare professionals. A researcher was contacted and invited to design the project.[39-41] A context of short-term rehabilitation including care for dying patients was selected as appropriate because moral challenges were embedded in this setting related to patients' everyday nursing care.

Participants and data collection

The sample was based on non-probability method. Participant selection criteria was all the nursing staff working in the short-term rehabilitation. The participants were recruited by the clinical leader and invited to a group established to reflect on moral challenges in everyday nursing practice. All the nurses and nursing assistants that showed an interest to take part in the group were included in the study.

One reflection group consisting of 6 participants was established and conversations with the group were held in 2011–2012. All the participants had extensive and wide-ranging experience as registered nurses or nursing assistants. Although the participants as a group were asked about their professional backgrounds, specific demographic information was not collected. The reflection group met for up to two hours during working hours, once a month for eight months.

The primary focus of the group conversations was to express and reflect upon moral challenges experienced in everyday nursing practice. The conversations were held in a narrative manner and led by a clinical co-researcher. Data collection was initiated with a guiding question to participants, for example, "Could you please tell us about a moral challenge in your everyday practice?"[42] Participants would then take turns to commence narration of a self-experienced moral challenge[42] to which the other participants and researchers actively listened. The second phase involved a follow-up question: "Would you like to tell us more about this?"[42] In this way, the data constitutes a kind of narrative. One reason for collecting data as narratives was to acquire "a limited description of a certain event" (p. 178)[43] with consequently relatively little interference by the researchers.

Ethical considerations

The study was reported to Norwegian Social Science Data Services. Written and verbal information about the study was given by the researcher to those who wished to participate in the reflection group conversations and they signed a written consent form. The participants were assured confidentiality and notified about their right to withdraw. All the participants participated for the duration of the study. The research protocol was searched and approved by the Regional Committee for Medical and Health Research Ethics (REK).

Analysis

The data analysis of 170 pages of verbatim transcripts from the audio-taped reflection group conversations was inspired by a three-step phenomenological hermeneutic method presented by Lindseth and Norberg.[44] In order to interpret the experiences of moral challenges, the analysis was dialectical, moving between the spontaneous understanding of the text gained through naïve reading, and the comprehensive understanding mediated by the thematic analysis.

The first step was to gain a naïve understanding[44] by repeatedly reading the text in as open-minded a manner as possible. The first tentative guess was important because it guided the subsequent analysis.

The second step was an inductive thematic analysis done by reading and re-reading the text in whole and in part, and vice versa.[44]

De-contextualizing the data gradually contributed to a more systematic reading and a more stringent structure. This was achieved by identifying and sorting meaning units. The thematic analysis included abstracting themes from meaning units through condensed meaning.[44] It was important to pose several analytical questions to the text in order to condense it further, meaning that several thematic analyses had to be performed. The thematic analysis included abstracting themes from meaning units through condensed meaning.[44]

It was also important to identify anything in the text that might go against the interpretation, before formulating the theme. The co-authors assisted in reflecting on and examining the condensed meanings and interpreting them into themes. This internal verification process was carried out on a continuous basis between naïve understanding, meaning units, condensed meaning and theme. An external reviewer was also used to validate the analysis. According to Lindseth and Norberg,[44] the naïve understanding is validated by the thematic analysis and themes.

The third step was to achieve comprehensive understanding by re-reading the naïve understanding and validated themes from the thematic analysis in order to reflect on both the study's research question and the literature and obtain an overall interpretation of the revealed meaning.[44] This involved ensuring that the comprehensive understanding was rooted in what was expressed in the reflection group conversations and also re-contextualizing the data in a larger picture.

Findings

Naïve understanding

The open-minded first reading showed that the participants' experiences of moral challenges were related to demanding situations in caring for the patient, where they nevertheless wanted to do their work. This naïve interpretation provided the direction of the thematic analysis.

Thematic analysis

The findings are presented in three themes: Having to be affected in order to help the patient, Having to accept that colleagues do not always collaborate and Having to endure organizational demands. These themes show how the participants described, identified and understood their experiences of moral challenges in everyday nursing practice.

Having to be affected in order to help the patient

This theme demonstrates how the patient's need for help sometimes gave the participants a sense of being affected. They experienced being affected personally when meeting challenging situations with patients. One such challenge centred round the patient's condition, particularly when the latter was so sick and weak that the chance of recovery was zero and they had entered a different phase: preparing for the end. A participant described how sickness and suffering changed a person:

> The patient has become so incredibly ill, and he is in pain and is marked by anxiety and in a way, I mean, the patient is most likely a very different man to the one he was before.

Being affected also involved being challenged when patients chose to live their lives in ways that were not health-promoting. One participant related how patients continue to smoke, or smoke all the more, even though they are in their final phase of life. However, talking to the patients about why they are not allowed to smoke was perceived as difficult, particularly when the participants observed that a cigarette offers the patient a kind of added quality of life. Nevertheless, in the worst cases, a patient's unhealthy habits could mean an enema would have to be administered to save their life, and thus the participants were obliged to violate the patient's autonomy because his or her condition was so serious it would be aggravated without intervention.

Moreover, the participants sometimes felt indignation on behalf of the patient. A participant described this challenge as more concretely related to patients afflicted with an illness that is stigmatized in society at large, and specifically in nursing.

> When it comes to drug addicts, I mean, there is an attitude that they're at the bottom; and we know that already, that we don't give them equal treatment. This has made me feel very frustrated and sad because everyone deserves equal treatment, no matter what his or her position is.

Further, the participants were subjected to the emotions of the patient's family. Family members may have difficulties accepting the fact that the patient has become gravely ill and have unrealistic demands on care, and do not always recognise their own boundaries. One participant described that they sometimes had to suffer verbal aggression from the family, "time and time again, sometimes a verbal earful in the hallway, for ten minutes straight". Such aggression might also involve the family commanding the participants to administer help despite the patient's refusal. At worst, participants described feeling obliged to feed the patient, even if the latter was unable to swallow. The food got stuck in their windpipe, resulting in coughing and mucus. And after inserting the feeding tube, the patient had pulled it out.

Despite feeling affected, the participants wanted to help patients feel better. This means that they had a strength to perform the help. They described the importance of conversation to create a feeling of safety for patients on admission and clarified expectations patients had about their stay. The participants described talking to patients when their condition started to deteriorate and their lives were moving towards the end. One participant also pointed out the importance of offering properly nutritious food to patients in order to improve their nutrition status and also expressed concern about the manner in which patients are offered food and drink, suggesting, for example, that drinks be served in "fine wine glasses, and with an ice cube in the glass" to create a little bit of a festive mood in the routine life of the patient.

Having to accept that colleagues do not always collaborate

This theme concerns situations in which colleagues forget to pass on information about a patient, even though they are aware of the importance of reporting information more than once. Another challenging experience was related to colleagues taking smoking breaks. One participant commented that this situation can become a repeated cause of emotional irritation for non-smoking nurses and nursing assistants, particularly considering that

smoking is prohibited during working hours. Such irritation could be aggravated if several smokers went outside to have a smoke together at the same time as their assistance was needed in the unit.

Participants also described challenges connected to new or foreign colleagues. One participant said these colleagues may struggle to understand the care culture and do not always comply with the expectations of their co-workers.

> Some may spend too long in the medicine room, or do not participate in caring for the patient and during meals. Consequently, colleagues become disgruntled and form a negative attitude towards the new employees.

At worst, the situation was exaggerated by colleagues mutually avoiding each other. One participant said that they sometimes "get angry with each other and scowl at each other; perhaps bickering arises and the situation becomes nasty".

Despite having to accept that colleagues do not always collaborate, the participants acknowledged that helping patients feel better requires teamwork, which requires them to contribute to a respectful team spirit among colleagues, coordinate patient care, stand together as colleagues and demonstrate a sense of loyalty regarding decisions they make together, particularly in complex situations that need to be resolved by meeting with patients. Speaking appropriately to one another as colleagues was also mentioned as important in this regard.

Having to endure organizational demands

Various reforms in the healthcare sector put great pressure on the participants. One challenge was related to unsatisfactory basic staffing because there was an increase in the number of patients without a corresponding increase in the number of or qualification of employees. Moreover, as patients got increasingly ill and suffered complications, they required adequate monitoring and assistance, and the participants felt it might be important for nurses to have the opportunity to monitor patients over time. Nevertheless, one participant said that organizational reasons prevented them from achieving continuity of care for the patient.

> If we find it interesting or say so, why shouldn't we be allowed to stay in that group, or be allowed to stay with this patient, instead of being told 'no, we're rotating the groups now'.

The participants also experienced that they were torn between the different parties involved in the healthcare sector. This challenge was particularly evident when patients were discharged faster for reinstatement into their homes. The participants emphasized that if patients are functioning at a low level, are unable to care for themselves and do not receive adequate assistance, the situation becomes medically unsustainable. A very demanding work situation then exists for the healthcare professionals, prompting one participant to comment, "we are run off our feet". Another challenge related to imposed haste was that the participants felt they did not have time to do everything they planned or wanted to do properly and ended up going home feeling bad because they did not do enough.

A comprehensive understanding

With the aim of achieving a comprehensive understanding, it is highlighted that, despite the participants' struggle with demanding situations while caring for patients, they strive to achieve the good. Having a comprehensive understanding of this means understanding that demanding situations in everyday nursing practice involve having a sense of being affected in order to help the patient, having to accept that colleagues do not always collaborate, and having to endure organizational demands. The participants nevertheless emphasized their efforts to do their best, thereby preventing demanding situations from leading to unacceptable nursing care. This was demonstrated in their willingness to help patients and collaborate with colleagues. Put otherwise, here it is possible to see how conflicting values are involved in everyday nursing practice when demanding situations challenged how to achieve the good and thus, deciding what to do becomes difficult.[3]

The comprehensive understanding can be interpreted further using the concept of self-understanding, and deepened with contributions from Taylor.[37,38] He describes self-understanding as

> what I must be in contact with in order to function fully as a human agent, and specifically to be able to judge and discriminate and recognize what is really of worth or importance, both in general and for me (p.258).[37]

Here Taylor[37] links self-understanding to morality by relating self-understanding to what is really important in life, meaning that a self is connected to an orientation towards the good. According to Taylor,[38] it is possible to understand the good in a highly general sense as "anything considered valuable, worthy, admirable, of whatever kind or category" (p. 92). Taylor[38] further claims that "what I am as a self, my identity" (p.34), implies

knowing “who I am” and “where I stand” (p.27). In other words, it means being able to discriminate and recognize what is really of worth or importance.

Thus, in Taylor’s view,[37,38] the participants’ experiences of moral challenges in everyday nursing practice can be understood as related to really significant aspects of their lives and may therefore constitute a fundamental challenge to their self-understanding. It can be argued that such challenges may present an attack on self-understanding because the participants’ self-understanding and the good they strive to achieve can be understood as “inextricably intertwined themes” (p.3).[37] This means more concretely that when living in touch with the good becomes too demanding (as in this context), experiences of moral challenges arise because there are consistent difficulties in assessing what really is of worth or importance related to everyday nursing practice. However, this does not mean the participants were unable to discriminate and recognize what high quality care involved but that they had to choose between more or less good options in caring for the patient.[3]

Discussion

While acknowledging the importance of the comprehensive understanding above, this concluding discussion starts by pointing out that healthcare professionals appear to experience moral challenges because they are able to answer the questions of who they are and where they stand, implying they are oriented in moral space. Consequently, healthcare professionals’ experiences of moral challenges in the context of short-term rehabilitation, which here includes care for dying patients, do not appear to revolve around uncertainty related to the good they strive to achieve. This is supported by the present study’s documentation of what the healthcare professionals articulated as their experiences of moral challenges. Research has previously documented that healthcare professionals want to do good for patients.[1,30,45] Lindh[30] has reported how they want to take care of the patient in a way that respectfully protects the patient’s dignity, meaning that they wanted to be faithful to the good. However, this does not indicate that the healthcare professionals never experienced moral uncertainty and always knew what to do in a given situation.[46,47]

The present study thus points out that experiences of moral challenges arise in relation to an attack on the ability to fully achieve the good in care for the patient. This is supported by the fact that the healthcare professionals struggled with demanding situations in the context of short-term rehabilitation, which included care for dying patients. This finding

is in line with previous research which has documented that moral challenges are complex and arise when reality, for a variety of reasons, does not measure up to healthcare professionals' intentions to deliver high quality care.[9,13-15,18,19,46,48] This again implies a challenge to healthcare professionals' moral integrity,[1,8,23,24,33] as integrity refers to a coherence between beliefs and actions.[49] Here it is also important to mention that such experiences can be understood as something touching on moral distress.[46,47,50,51] Particularly because moral distress has been described as knowing the right thing to do, but institutional constraints make this nearly impossible to pursue.[47] However, this study highlights that experiences of moral challenges do not basically arise related to institutional constraints but rather related to really significant aspects of healthcare professionals' life and constituted therefore a fundamental challenge to their self-understanding. One main argument for this is that healthcare professionals' self-understanding and the good they strive to achieve are understood as inextricably intertwined.[See 37] This also implies emphasizing that experiences of moral challenges involve more than pure role morality understood as that which nurses do to meet the goals of nursing.[50,51] It is nonetheless relevant to question: is achieving the good in everyday nursing practice too demanding an ideal? Striving to achieve the good touches on altruism – the good of the patient for his or her own sake – although research has previously pointed out altruistic ideas as one-sided on behalf of the patient and therefore something healthcare professionals should free themselves from.[19,20,26-28,50,52] Pure altruism could therefore be understood to be unrealistic as a professional mandate, particularly related to the healthcare sector. Even though the present study states that experiences of moral challenges arise in relation to an attack on the ability to fully achieve the good in care for the patient, it does not imply that it may be helpful to free the healthcare professionals from their endeavour.[53]

On the contrary, particularly in situations when living in touch with the good becomes too demanding in everyday nursing practice and the healthcare professionals have to choose between more or less good options, they need to articulate and reflect on their experiences of moral challenges as care for the patient is based upon their willingness to contribute to high quality care, which more basically springs from their self-understanding. This is line with previous research.[8,10,54] Hartrick Doane[33] more precisely emphasizes the importance of "bringing together" what is called "the multi-voiced self" to reach consensus "about what values and actions will be lived in the everyday practice

of nursing" (p.634). This again can contribute to deepen their horizon of self-understanding.[38]

Strength and limitations

The trustworthiness of this study is considered a strength inasmuch as the healthcare professionals experienced moral challenges in everyday nursing practice, implying that they had knowledge of the research topic. Additionally, the method of data collection is considered as suitable as the data constitutes a type of descriptive data which resembles the participants' daily language about experiences of moral challenges. [55] The same may be said about data stemming from group conversations, which is thereby created relationally.[43] On the other hand, the data may be considered limited due to the participants being less open in the group conversations, particularly because a researcher was present and represented a kind of expertise. The researcher was nevertheless aware of her own role in regard to following up questions.[42]

It is also seen as a strength that the theme and comprehensive understanding validated the naïve understanding, meaning that the tentative guess was validated. This indicates that the analysis was conducted appropriately and in such a way that the study's themes were found to be credible.[56] The analysis was conducted by more than one researcher and has been sufficiently described, which again adds to the study's trustworthiness. There is, however, a risk that an interpretation on a comprehensive level may imply an over interpretation of descriptive data.[57,] Consequently, to delimit that risk, alternative interpretations have been discussed. Although the data was generated in a limited setting and with a small sample, one can assume that the findings are relevant to similar contexts.

Conclusion

Supporting healthcare professionals when they experience moral challenges is important particularly because such challenges seem to involve a challenge to healthcare professionals' self-understanding, which may ultimately lead to their questioning why they are struggling with demanding situations in caring for the patient. This is not to say that healthcare professionals' self-understanding cannot change through experiences of moral challenges. Nevertheless, the study leads to a further question of how the experiences of moral challenges in everyday nursing practice are connected more

explicitly to self-understanding used as a theoretical frame, and this question needs to be elaborated upon in the future.

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