UMEÅ UNIVERSITY MEDICAL DISSERTATIONS

NEW SERIES NO 1841

Experiences of being in ethically difficult care situations and an intervention with clinical ethics support

Catarina Fischer Grönlund

Department of Nursing
Umeå 2016

Responsible publisher under Swedish law: the Dean of the Medical Faculty
This work is protected by the Swedish Copyright Legislation (Act 1960:729)
ISBN: 978-91-7601-556-8
ISSN: 0346-6612
New Series 1841
Elektronic version available at http://umu.diva-portal.org/
Printed by: Print & Media, Umeå University
Umeå, Sweden 2016

Två sanningar närmar sig varann.
En kommer inifrån,
en kommer utifrån
och där de möts
har man en chans att få se sig själv

Tomas Tranströmer (ur mörkerseende 1970)

Table of Contents

Table of Contents i
Abstract ii
Abbreviations v
Enkel sammanfattning på svenska vi
Original papers 1
Introduction 2
Background 3
Ethically difficult situations and ethical dilemmas in healthcare 3
Consequences of experiencing ethical difficulties 5
Experiences of ethically difficult situations and a troubled conscience 6
Communication as a way to deal with ethically difficult situations 7
Habermas' theory of communicative action 8
Interventions for clinical ethics support (CES) 10
The CES intervention studied in this project 11
Rationale for the thesis 11
Aims 13
Overall aim 13
Specific aims 13
Methods 14
Context 14
The CES intervention *15*
Participants 15
Data collection 16
Interviews *16*
Data analysis 17
Ethical considerations 18
Results 19
Study I 19
Study II 21
Study III 23
Study IV 25
Discussion 29
Methodological considerations 34
Conclusions 36
Clinical implications and further research 37
Acknowledgements 39
References 41

Abstract

Background: Studies show that healthcare professionals often experience ethical difficulties in their relations with patients, relatives, and other professionals and in relation to organisational issues, and these can sometimes be difficult to handle. Failing to act or to relate in accordance with one's values for what is good and right might cause a troubled conscience that is connected to feelings of guilt and ill-being. Ethical issues related to the care of patients with end-stage renal disease have been described, but no studies in this context have been found that explore registered nurses' (RNs') and physicians' experiences of being in ethically difficult situations that give rise to a troubled conscience. The importance of communicating ethical issues in order to understand and handle ethically difficult care situations has been emphasized. Various forms of clinical ethics support (CES) have been described and evaluated, but studies on the communication processes and the organisation of CES interventions are sparse and no study describing a CES intervention based on Habermas' theory of communicative action has been found.

Aim: The overall aim was to increase our understanding about being in ethically difficult care situations and about how communication concerning ethical issues in healthcare can be promoted. More specifically, the aim of studies I and II was to illuminate experiences of being in ethically difficult situations giving rise to a troubled conscience among RNs and physicians, while studies III and IV aimed to describe the communication of value conflicts (III) and the organisation and performance of a CES intervention (IV).

Methods: In studies I and II narrative interviews with ten RNs (I) and five physicians (II), were performed in a dialysis care context. The interviews were analysed using a phenomenological hermeneutic approach. In studies III and IV, eight audio- and video-recorded and two audio-recorded sessions of the CES intervention, were conducted and sorted by the data tool Transana and analysed in accordance with a qualitative content analysis (III) and a qualitative concept- and data-driven content analysis (IV).

Results: The RNs' narratives (I) resulted in the theme 'Calling for a deliberative dialogue'. Their narratives expressed feelings of uncertainty, solitude, abandonment, and guilt in complex and ambiguous ethically difficult situations. The narratives concerned the value conflict between preserving life by all means and preserving life with dignity. The physicians' narratives (II) resulted in the themes 'Feeling trapped in irresolution' and 'Being torn by conflicting demands'. Their narratives expressed feelings of uncertainty, solitude, abandonment and guilt related to the obligation to make crucial decisions and in situations when their ideals and the reality

clashed. The analysis of the communication of value conflicts during the CES intervention inspired by Habermas' theory of communicative action (study III) revealed a process of five phases: a value conflict expressed as feelings of frustration, sharing disempowerment and helplessness, revelation of the value conflict, enhancing realistic expectations of the patients and relatives, and seeing opportunities to change the situation instead of obstacles. The CES intervention (study IV) was organised as a framework with a given structure and an openness for variations to facilitate communicative action. Three courses of actions to reach a communicative agreement were identified and concerned the approach to achieve a permissive communication, opening up for extended views, and enhancing mutual understanding (IV).

Conclusion: The results show that both RNs and physicians expressed feelings of uncertainty abandonment and loneliness in similar ethically difficult situations but from different points of view. They struggled with the same value conflicts and feelings, but they did not share their struggles with each other. The lack of communication and confirmation led to distrust and increased feelings of uncertainty. The CES intervention, inspired by Habermas' theory of communicative action, offered the possibility of dealing with experiences of ethically difficult care situations. In the permissive atmosphere, the professionals helped each other to balance their ambiguity, frustrations, and powerlessness and came to an agreement about how to handle the value conflicts and how to act. The findings from this CES intervention constitute a step towards a CES method that is clearly described so that leaders can be educated and extended intervention studies with different kinds of data can be conducted in order to further develop knowledge about how to promote an inter-professional dialogue about ethical difficulties.

Keywords: Care ethics, healthcare professionals, ethically difficulties, clinical ethics support, narratives and inter-professional communication

Abbreviations

CES Clinical ethics support

ESRD End stage renal disease

RN Registered nurse

MCD Moral case deliberation

Enkel sammanfattning på svenska

Bakgrund: Studier visar att hälso- och sjukvårdspersonal i sitt dagliga arbete upplever etiska svårigheter i relation till patienter, anhöriga, arbetskamrater eller organisation, vilket ibland kan vara svårt att hantera. Att inte kunna handla utifrån sina värderingar om vad som är rätt och gott kan leda till ett dåligt samvete som följs av skuldkänslor och stressrelaterad ohälsa. I vården av patienter med njursjukdom i livets slutskede uppstår etiskt svåra situationer vilket är beskrivet i litteraturen. Däremot har olika yrkesgruppers (sjuksköterskor och läkare) upplevelser av etiska svåra situationer i dialysvård som leder till ett dåligt samvete sparsamt studerats. Att kommunicera etiskt svåra situationer för att gemensamt försöka förstå värdekonflikten och komma fram till handlingsalternativ har visat sig vara viktigt. Olika former av etiskt stöd i klinisk verksamhet (Clinical ethics support, CES) har beskrivits. Däremot har ingen studie av en CES intervention som baseras på Habermas teori om kommunikativ handling återfunnits i litteraturen.

Syfte: Det övergripande syftet var att få en ökad förståelse för vad det innebär att vara i etiskt svåra situationer och hur en kommunikation om etiska svårigheter inom hälso- och sjukvården kan främjas. Specifika syften i studie I och II var att belysa erfarenheter av att vara i etiskt svåra situationer som leder till dåligt samvete bland sjuksköterskor och läkare. Syftet i delstudie III och IV var att beskriva kommunikationen av värdekonflikter (III), samt organisation och genomförande av en CES intervention (IV).

Metod: Narrativa intervjuer genomfördes med tio sjuksköterskor och fem läkare inom dialyssjukvård. Intervjuerna analyserades med fenomenologisk hermeneutisk metod (I,II). I studie III och IV genomfördes åtta audio- och video- och två audioinspelade sessioner av en CES intervention inspirerad av Habermas teori om kommunikativ handling. Data sorterades först med hjälp av audio- och video- analys verktyget Transana. Sedan analyserades data med hjälp av kvalitativ data driven innehålls analys (III) och kvalitativ begrepps och data driven innehållsanalys (IV).

Resultat: Sjuksköterskornas berättelser (I) resulterade i temat ’efterlyser en reflekterande dialog’. Berättelserna uttryckte känslor av osäkerhet, ensamhet, övergivenhet och skuld i komplexa, tvetydiga situationer och en längtan efter en fördjupad dialog. Berättelserna handlade om värdekonflikter mellan att upprätthålla liv till varje pris eller värna patientens värdighet. Läkarnas berättelser (II), resulterade i två teman ’känslan av att vara fångad i obeslutsamhet’ och ’att slitas mellan motstridiga krav’. Berättelserna uttryckte känslor av osäkerhet, ensamhet och övergivenhet i etiskt svåra situationer när de skulle fatta livsavgörande beslut eller när det uppstod en konflikt mellan egna ideal och verklighet. I analysen av kommunikationen

om värdekonflikter i CES interventionen inspirerad av Habermas teori om kommunikativ handling (III) framkom en process av följande fem faser: Värdekonflikten uttrycks som känslor av frustration, delar känslor av maktlöshet och hjälplöshet, värdekonflikten framträder, realistiska förväntningar utvecklas, ser möjligheter att förändra situationen i stället för hinder. Under processen förändrades förhållningssättet till den etiskt svåra situationen, från frustration och individuell tolkning av värdekonflikten mot en gemensam förståelse och en mer tolerant attityd till situationen. CES interventionen (IV) var organiserad som ett ramverk med både en fast struktur och en öppenhet för variationer. Analysen visade på tre förhållningsätt som främjade en kommunikativ överenskommelse, att öppna upp för en tillåtande kommunikation, att främja vidgade perspektiv och att bidra till utveckling av en ömsesidig förståelse.

Konklusion: Resultatet visar att både sjuksköterskor och läkare kände sig osäkra och ensamma i samma etiskt svåra situationer men utifrån olika perspektiv. De kämpade med samma känslor men de delade inte sina erfarenheter med varandra vilket ökade känslor av osäkerhet och misstro (I,II). Genom CES interventionen gavs deltagarna möjlighet att hantera erfarenheter av etiskt svåra situationer. I en tillåtande atmosfär, kunde personalen hjälpa varandra att balansera sin tvetydighet, frustration, maktlöshet och komma överens om hur de skulle hantera situationen och slutligen utvecklade de sin professionalism (III,IV). Resultatet från den här interventionen utgör ett steg mot en CES metod utvecklad för kommunikativ överenskommelse och bidrar med kunskap om hur en interprofessionell dialog om etiska svårigheter kan främjas.

Original papers

This thesis is based on the following papers, which will be referred in the text by their Roman numerals. The papers are reprinted with permission from the respective journals.

I: Grönlund Fischer CE, Söderberg AI, Zingmark KM, Sandlund SM, Dahlqvist V. Ethically difficult situations in hemodialysis care: nurses narratives. *Nursing Ethics*. 2015; 22(6): 711-22. doi:10.1177/0969733014542677.

II: Grönlund CE, Dahlqvist V, Söderberg AI. Feeling trapped and being torn: Physicians' narratives about ethical dilemmas in hemodialysis care that evoke a troubled conscience. *BMC Med Ethics*. 2011; 11,12:8. doi: 10.1186/1472-6939-12-8

III: Grönlund CF, Dahlqvist V, Zingmark K, Sandlund M, Söderberg A. Managing ethical difficulties in healthcare: communicating in interprofessional clinical ethics support sessions. *HEC Forum*. 2016; 1-18. doi:10.1007/s10730-016-9303-2

IV: Grönlund Fischer CE, Söderberg AI, Dahlqvist V, Sandlund SM, Zingmark KM. Towards a method for clinical ethics support to promote inter-professional communication about ethically difficult care situations: observations of an intervention. Manuscript in preparation.

Introduction

This thesis concerns experiences of being in ethically difficult situations that give rise to a troubled conscience, and it seeks to promote dialogue about ethical issues among healthcare professionals. It is well known that healthcare professionals experience ethical difficulties in their daily work and that they have to make judgements and difficult decisions. As a registered nurse (RN) in anaesthetics, I have encountered ethically difficult situations in my clinical work. I have experienced how difficult it can be to interpret and understand all of the various aspects of a situation, and I have experienced how difficult it can be to ensure open communication between the different professionals involved in such situations. These experiences gave rise to my desire to better understand how healthcare professionals perceive ethical issues and how communication about ethically difficulties can be supported. The point of departure for this project was the head of a ward specializing in renal medicine and dialysis asking the clinical ethics committee at the hospital for support. The professionals in the ward experienced ethical difficulties in their everyday clinical practice, and these difficulties were considered problematic in providing appropriate care for the patients in the ward. Interviews with RNs and physicians were performed, and inter-professional ethics dialogues were arranged and evaluated. Based on the evaluations the leaders of the dialogues decided to further develop the support. A clinical ethics support (CES) intervention inspired by Habermas' theory of communicative action was initiated, and this intervention was the subject of study in this thesis. At the time of the intervention, the dialysis ward was not prepared to participate so the intervention was carried out at a rehabilitation ward that asked for ethical support.

This thesis is based on the ontological assumptions that humans are subjective and reflective beings in a need to be connected in relations with others in free and meaningful communications. Ethical issues are a part of everyday life, and an ethical dialogue requires not only language and action but also narratives to get an understanding of our own and others' intentions. Narratives are never neutral and they can reveal both the past, the present and influence the future (cf. Kristensson Uggla, 1994 p 449-455). Narratives make meanings to our experiences, memories, and life stories (Singer, 2004), and by sharing narratives we can see life through another person's eyes. The stories are not only shared through verbal language or written text, but also by the person's body language (Hydén and Antelius, 2011).

According to Lindseth and Norberg (2004), people live and act out their morals without necessarily being aware of them. By asking a person to narrate an experience of an ethically difficult situation, the unspoken may be revealed and it is possible to gain access to their ethical thinking. This means that I as a researcher have to encourage the person to narrate and then must receive the narrative with an awareness of my own pre-understanding both during the interview and during the analysis of the interview data. The researchers involved in this project were all healthcare professionals with various professional training and work experiences. All had a pre-understanding of the healthcare context and experiences of what it means to be in ethically difficult care situations.

Background

Ethically difficult situations and ethical dilemmas in healthcare

Ethically difficult situations can be defined as situations in which human values, interests, and principles are in conflict with each other and there are obstacles to determining the best solution for how to act (Sarvimäki and Stenbock-Hult, 2008 p 173). Ethically difficult situations can concern decisions about treatment and care in relation to patients, relatives (Hermsen and van der Donk, 2009, Van der Dam et al., 2012), professionals (Jiménez-Herrera and Axelsson, 2015), organisational issues (Cohen and Erickson, 2006, Jameton, 1993), or legal regulations (Kälvemark et al., 2004) and can lead to uncertainty about how to act or about what kind of knowledge to use. The solution to an ethical problem might depend on relations between humans and their values (Kalkas and Sarvimäki, 1987 p 39-40, Sarvimäki and Stenbock-Hult, 2008 p 173). In an ethical dilemma there is no truly good choice; instead, one must decide on the least worse of two or more bad options (Ricoeur, 1992 p 243-248). According to Silfverberg (2005 p 31, 64), ethically difficult situations or dilemmas might be confusing because we do not know the right and good thing to do but are still bound to act. The challenge is to realize the complexity in the specific ethically difficult situation, and this requires both sense and sensibility. Lanz (1997) considers ethically difficult situations to be a part of everyday healthcare practice and argues that these situations are related to a variety of issues such as relational and existential questions and medical issues involving crucial decisions and advanced medical techniques (Lantz, 1997 p 17, 26-31). In the context of haemodialysis care (hereinafter called dialysis care), ethically difficult situations and dilemmas are related to care and advanced life-sustaining treatment for vulnerable patients, especially those suffering from

end stage renal disease (ESRD) (Bennett, 2011, Halvorsen et al., 2008). ESRD is a progressive condition that often leads to physical and functional declines due to severe complications such as heart disease, vascular disease, stroke, dementia (Tamura et al., 2009), and severe chronic pain (e.g. Cohen et al., 2003, Davison, 2012). Dialysis itself is a demanding treatment, and the patients need to comply with several restrictions (Hagren et al., 2001). RNs have described how caring for patients with ESRD means handling advanced technical equipment, dealing with existential questions (Bennett, 2011), and supporting patients in complying with their restrictions (Hermsen and van der Donk, 2009). Physicians in dialysis care have described ethical dilemmas in dialysis care, especially those concerning withholding or withdrawing life-sustaining dialysis from severely ill patients who are at the end stage of their lives (Svantesson et al., 2003, Davison et al., 2006).

Studies in other contexts show that RNs experience ethical difficulties when they are unable to fulfil patients' and relatives' expectations and needs (Rees et al., 2009, Langeland and Sørlie, 2011, Lillemoen and Pedersen, 2013, Rasoal et al., 2015) due to the work environment (Goethals et al., 2010, Casterlé et al., 2008), stringent roles and routines (Rees et al., 2009, Langeland and Sørlie, 2011, Goethals et al., 2010), and insufficient resources (Rees et al., 2009, Langeland and Sørlie, 2011, Lillemoen and Pedersen, 2013). Others have described ethically difficult situations concerning giving bad news to adults (Rasoal et al., 2015) or children (Bartholdson et al., 2015) as well as those involving a lack of collaboration with physicians in the decision making process and about patient care and treatment (Sørlie et al., 2003b, Rees et al., 2009, Silén et al., 2008). RNs have also described ethical difficulties when co-workers have shown contradicting values or negative attitudes towards the patients (Goethals et al., 2010, Nordam et al., 2005, Jiménez-Herrera and Axelsson, 2015) or violated the patients' dignity or integrity (Söderberg et al., 1997). Due to their role in the organizational hierarchy, RNs often have to follow others' opinions, even those that are contrary to their own values (Goethals et al., 2010).

Studies show that physicians experience ethical difficulties by having to make crucial end of life decisions in various clinical specialities such as paediatric care, critical care, and surgical care (Sørlie et al., 2000, Hurst et al., 2007, Torjuul et al., 2005). Ethical dilemmas described by physicians concern decisions about the right treatment (Torjuul et al., 2005, Sorta-Bilajac et al., 2008), disagreement with other professionals about treatment and care (Hurst et al., 2007, Oerlemans et al., 2015, Pavlish et al., 2014), situations in which the patient is coerced into doing something they might not agree with (Lillemoen and Pedersen, 2013, Molewijk et al., 2015, Pelto-

Piri et al., 2014), and situations where both research and treatment are performed at the same time (de Vries et al., 2011).

RNs and physicians have been found to experience ethical difficulties in some of the same situations (Lindseth et al., 1994, Oberle and Hughes, 2001, Oerlemans et al., 2015). Examples include the need to make crucial prioritisations due to scarce resources (Höglund, 2005, Langeland and Sorlie, 2011, Pavlish et al., 2014), whether or not to resuscitate critically ill patients (Cohen and Erickson, 2006, Jiménez-Herrera and Axelsson, 2015, Oerlemans et al., 2015), and decisions for removing life support from children (Bartholdson et al., 2015). Other ethically difficult situations include times when patients and relatives have differing opinions (Oerlemans et al., 2015, Pavlish et al., 2014, Goethals et al., 2010) or when patients have been coerced into psychiatric care (Pelto-Piri et al., 2013). Studies show that being forced to act in contradiction to one's values is connected to a troubled conscience (Sørlie et al., 2005) and emotional pain (Sørlie et al., 2003a). In ethically difficult situations, our intentions to do good can be disturbed, and this can lead to the experience of being inadequate and confused (Silfverberg, 2005 p 44-45).

Consequences of experiencing ethical difficulties

Being prevented from acting in accordance with one's values in ethically difficult situations might cause healthcare professionals to experience uneasy feelings and lead to conditions described as moral distress, moral stress, or stress of conscience (Lützén and Kvist, 2012). Jameton (1993) described moral distress as a condition characterized by negative feelings of frustration, anger, and guilt when being unable to act according to one's moral convictions for good care. Having to act against one's values might be a threat to one's professional integrity and affect and diminish one's moral sensitivity (Lützén et al., 2003), which can be seen as the capacity to be aware of another person's vulnerability (Nortvedt, 2003). Moral sensitivity encompasses a moral responsibility through an awareness of the consequences that our actions might have for other people (Bem, 2001). Moral distress has been shown to influence all healthcare professions (Corley, 2002, Jameton, 2013, Kälvemark et al., 2004, Førde and Aasland, 2008, Carpenter, 2010), particularly professionals with close relations to their patients (Peter and Liaschenko, 2004) or those with limited possibilities to provide good and safe care (Silén et al., 2011). If moral distress remains, the conflict between behaviour and inner beliefs might compromise one's core values and threaten one's moral integrity (Thomas and McCullough, 2015) and lead to an increased risk for burnout (Rushton et al., 2013). Moral distress might lead to powerlessness and indecisions, as

described in several care situations such as oncology care, palliative care, and critical care (Cohen and Erickson, 2006, Rushton et al., 2013, Hamric and Blackhall, 2007).

Moral stress has been described as a condition that arises in ethically difficult situations with high demands and a low level of control over the situation (Severinsson, 2003). Being aware of what is at stake in the situation but being unable to determine how to act (Lützén et al., 2003) or being faced with contradictory opinions among professionals about the best treatment and care (Cronqvist and Nyström, 2007) can cause moral stress. According to (Lützén and Kvist, 2012), moral stress does not necessarily cause negative consequences, and sometimes it can act to remind one of the moral obligations.

Stress of conscience was introduced by Glasberg et al. (2006) as a condition that might affect healthcare professionals when they act contrary to their convictions for good care, despite warnings or remarks from their conscience. Studies show that stress of conscience is related to being unable to provide good care (Juthberg et al., 2007, Tuvesson et al., 2012) and being burdened by a troubled conscience (Åhlin et al., 2013) due, for instance, to incompatible demands (Åhlin et al., 2014). It has been suggested that if a troubled conscience is silenced one runs the risk for depersonalisation (Glasberg et al., 2007) and emotional exhaustion (Juthberg et al., 2007). Consequently, being unable to act in accordance to one's values for good care might arouse uneasy and guilty feelings from a troubled conscience.

Experiences of ethically difficult situations and a troubled conscience

Childress (1979 p 326-329) described the conscience as an inner guide. Being able to act in accordance with one's values promotes feelings of integrity and a peace of mind. The very notion of conscience means sharing of knowledge, awareness, and apprehension, and several theories have been put forth for different aspects of the conscience (Langston, 2001 p 12-15). Medieval thinkers considered the conscience to be a dynamic performance of actions connected to the will and the emotions. A good conscience was seen as being related to the cultivation of virtues followed by prudence and a drive toward good actions (Langston, 2001 p 12-51). Fromm (1990) describes the conscience as divided into two interdependent parts called the authority conscience and the human conscience. The authority conscience relates to external norms, obedience, and social adjustments, and acting against the authority conscience might cause fear for reprisals and guilty feelings. However, if we are guided by the human conscience we can make our own

value judgements and maintain our integrity. Neglecting the human conscience might cause unspecific guilty feelings for failing one's innermost self (Fromm, 1990 p 13, 143-166). A troubled conscience can be described as a reminder of bad actions by causing unpleasant feelings of guilt, shame, and disunity (Beauchamp and Childress, 1983 p 268-271).

Healthcare professionals have expressed experiences of a troubled conscience when acting contrary to their values of good and safe care (Söderberg et al., 1997, Ericson-Lidman et al., 2013a). Healthcare professionals have also been shown to experience a troubled conscience differently depending on their personal perception of conscience. Some perceive their conscience as very strict and burdensome and as a source to guilty feelings, but others describe their conscience as an asset (Dahlqvist et al., 2007), a warning against doing wrong (Sørlie et al., 2005, Juthberg et al., 2007), and as an aid in providing good care (Gustafsson et al., 2010, Jensen and Lidell, 2009). Experiencing the conscience as an asset is expressed in particular by professionals who are able to carry out what their conscience conveys. The conscience, however, is not infallible and might sometimes give contradicting messages (Dahlqvist et al., 2007). Therefore it seems essential to discuss and share feelings deriving from one's conscience with others (Glasberg et al., 2007). Studies show that professionals who have opportunities to share their burdensome feelings from a troubled conscience get increased insights from others (Ericson-Lidman and Strandberg, 2013b) and experience themselves as being confirmed (Dahlqvist et al., 2009). In a study by Söderberg (1999), enrolled nurses described feeling consoled and present in the situation when they could communicate their feelings related to a troubled conscience.

Communication as a way to deal with ethically difficult situations

Edwards et al. (2013) showed that healthcare professionals who have the opportunity to communicate about ethical issues in their daily work can help each other to address ethical problem and determine the best way to act. Several studies show that healthcare professionals experience a lack of communication in ethically difficult situations, both with members of various professions (Langeland and Sorlie, 2011, Goethals et al., 2010, Nordam et al., 2005) and with their colleagues (Sørlie et al., 2005, Sørlie et al., 2003a, Sørlie et al., 2001). In a study by Silén et al. (2008), the RNs expressed the need to communicate ethically difficult situations with the physicians. They wished to understand the physicians' intentions and to convey their own aspects of the situation because they were the ones who

were obliged to carry out the physicians' decisions. Pedersen et al. (2009 b) argue that continuously increasing efficiency requirements in healthcare organizations decrease the opportunities for healthcare personnel to engage in informal reflections about ethical issues. Therefore, healthcare professionals need opportunities for systematic ethics discussions in organized formats (Pedersen et al., 2009 b, Lillemoen and Pedersen, 2013). Höglund (2005 p 148-150) claims that healthcare professionals need a forum for conscious reflections to be able to meet the increasing ethical demands of their practice, and a democratic dialogue and ethics education in everyday practice can support healthcare professionals in making well-grounded decisions when they encounter ethical issues.

Habermas' theory of communicative action

The discourse ethics philosopher Jürgen Habermas has developed a theory of communicative action based on the idea that humans are autonomous, rational beings. Integral to this theory is the idea that respect for other persons' autonomy and integrity is associated with freedom (Croona, 2003 p 55). Habermas emphasizes that certain moral principles are universal norms and that these are generally accepted through a common will. The universalization's principle means judgements of the norms and agreement in accordance with the interests of all those concerned. These universal norms work within all cultures and societies, and the validity claims of universal norms are the claims of truth. However, far from all norms are universal, and contextual norms originate from the complexity of human traditions, cultures, and interests. The assumption is that a communicative action might work as a bridge between the universal and contextual norms and that the validity of norms can be examined according to contradictions (Habermas, 1990 p 68-72). The validity claims of norms imply that all potential side effects as well as consequences of an action must be revealed, clarified, and accepted as being in the best interest of everyone concerned (Habermas et al., 1996 p 302, Habermas, 1990 p 67-71). The prerequisite for the validity claims of norms is an argumentation process that should take place in an atmosphere where everyone feels free and has equal opportunities to speak (Habermas et al., 1996 p 303). This enables not only reflection and re-evaluation of one's own point of view and views from others, but also self-regulation of controversial ideas or ideals (Carleheden, 1996 p 27).

Habermas' communicative theory includes success-oriented actions and communicative actions. The success-oriented actions are strategic and are related to social interactions as agents to achieve desired goals (Habermas et al., 1996 p 100). The communicative action refers to an interaction where the

participants talk and listen to each other's statements and arguments without any claims of power. Such an approach opens up for an understanding-oriented dialogue leading the participants to achieve a common knowledge built on a common and consensual understanding of the situation (Habermas et al., 1996 p 100-113). An understanding-oriented dialogue means that the participants define the situation and plan actions that will move them towards common values. The prerequisites for this movement are that the speaker's expressions and statements are valid, truthful, sincere, and comprehensible (Habermas et al., 1996 p 101, 119-126). The other participants can then accept or reject the speaker's expressions by providing motives and arguments, and to continue the dialogue the speaker must not only convince the other participants with counter-arguments but must also evaluate the criticized validity claims that are directed at him or her (Habermas, 1990 p 64, Habermas et al., 1996 p 85-86).

According to the theory of communicative action, it is the common judgements and the strengths of well-grounded arguments that lead to the creation of common knowledge rather than the prestige or power of those in authority (Alvesson and Sköldberg, 1994 p 187-188). The requirements to achieving common knowledge are that the listener shall be able to understand and trust what the speaker says. If those requirements cannot be met, the participants must consider changing their conversation strategies. One way is to re-start the conversation and re-evaluate the validity claims. Another way is to continue by using a strategic action (Habermas et al., 1996 p 145), which means engaging in conversations with the intention to reach desired goals (Habermas et al., 1996 p 100). The theory of communicative action has been criticized by Alvesson and Sköldberg (1994 p 188-189) who argue that we cannot expect humans to be flexible enough to understand others' perspectives let alone change their own points of view even if others' arguments are well grounded. Alvesson and Sköldberg also emphasize that it is not possible to reach consensus by a communicative action in every case and that it is ineffective to continue an everlasting dialogue without coming to some conclusion. Thus Habermas' theory is supplemented with the assumption that it is sometimes more realistic to reach a communicative compromise rather than consensus (Alvesson and Sköldberg, 1994 p 188-189). Benhabib further elaborated on aspects of communicative action theory and emphasized that the communication process should seek to reach mutuality and respect rather than seek to reach consensus (Benhabib, 1994 p 57). Instead of consensus, Benhabib (1994 p 170-171) preferred to use the concept of communicative agreement because this seeks to capture the variations of different aspects that appear in the moral dialogue and which might be accepted by all those involved in the situation. Benhabib also considered the universalization principle to be too diffuse and that the

unique in every situation, the contextual, including the human variation and moral contours in personal relations, is lost with such a view (Benhabib, 1994 p 48, 73).

Interventions for clinical ethics support (CES)

CES has been developed as a way for healthcare professionals to meet inter-professionally and to communicate ethical difficulties (Steinkamp et al., 2007, Molewijk et al., 2008b, Fox et al., 2007). There are several types of CES, but they all have the common goal of creating an open atmosphere and fostering engagement (van der Dam et al., 2011, Ulrich et al., 2007), broadening the participants' points of view by sharing knowledge from others (Gracia, 2003), and increasing the recognition and awareness regarding ethical issues so as to better understand the moral conflicts that these issues entail (Dauwerse et al., 2013).

Clinical ethics committees are organized forms of ethics support that have various organizational features, functions, procedures, and practices (Steinkamp et al., 2007, Pedersen et al., 2009 a, Førde and Aasland, 2008). The purpose of such committees is to promote decision-making processes (Førde and Pedersen, 2011), to give advice and recommendations (Pedersen et al., 2009 b, Guerrier, 2006), and to facilitate inter-professional ethical dialogues (Steinkamp et al., 2007) through a variety of methods (Pedersen et al., 2009 a, Førde and Pedersen, 2011, Slowther et al., 2012).

Clinical ethics consultations are described as organized ethics consultation services (Fox et al., 2007) with the general goal of helping healthcare professionals analyse and resolve ethical problems in practical cases (Tapper, 2013). The consultations might be provided by one individual consultant, a small team, or a full ethics committee (Fox, 2014, Tapper, 2013). The consultants provide ethical support and education, and they give guidance and advice to healthcare professionals, patients, and relatives (Fox, 2014, Weise and Daly, 2014, Tapper et al., 2010, Aulisio et al., 2000) in situations when crucial decisions have to be made (Tapper, 2013, Strech et al., 2010).

Moral case deliberation (MCD) is inspired by the pragmatic hermeneutics tradition (Molewijk et al., 2011, Widdershoven et al., 2009). MCD aims to help healthcare professionals to define good care in practical situations (Abma et al., 2009) and to foster an ethical dialogue by developing the skills needed to reflect on ethical issues (Molewijk et al., 2008a, Dauwerse et al., 2011). MCD is described as a learning process between the participants

(Widdershoven et al., 2009) with a primary focus on the moral dimension of the situation (van der Dam et al., 2013).

In ethics rounds, healthcare professionals meet to discuss issues of ethical concern facilitated by a meeting leader. The aim is to stimulate ethical reflections and to promote a better understanding of other professionals' way of thinking (Sporrong et al., 2007, Svantesson et al., 2008b). The leader's role is promote the ethical discussion in a permissive communication climate (Silén et al., 2015) and to help the participants to identify the ethical problem rather than to give advice or offer solutions (Hansson, 2002, Svantesson et al., 2008a).

The CES intervention studied in this project

The CES intervention studied in this project was inspired by Habermas' theory of communicative action. The intention was to promote communicative actions with claims for truth, correctness, and comprehensibility as a way to interpret and understand the value conflict, and to reach a common understanding for how to act in the best interest of the patients. In order to encourage an understanding-oriented dialogue, the ambition was to create an atmosphere where the participants would feel free and comfortable enough to reflect and express themselves. The intervention provided opportunities for healthcare professionals to actively communicate about the ethical difficulties that they experienced in their everyday clinical practice.

Rationale for the thesis

Ethically difficult situations or dilemmas have been described as situations when values, interests, or principles are in conflict, and when we do not know what might be the right option, or the least worse of bad options, but we are still bound to act. Having to perform caring actions that go against one´s moral conviction can give rise to a troubled conscience, which can lead to feelings of guilt, shame, and alienation. Having to stifle one's conscience because of the inability to deal with moral problems has been found to be associated with various emotional and physical ailments, including burnout. Ethically difficult situations are a well-studied concept in various care contexts, and there is a body of knowledge related to the troubled conscience. Because a troubled conscience can be seen as a sign of deep concern over the care that one is providing for one's patients, there is still a need to know more about ethically difficult situations that give rise to a troubled conscience.

Dialysis care is a life-prolonging treatment involving difficult decisions. Ethical issues related to the care of patients with ESRD have been described in the literature, but no studies in this context have been found that explore RNs' and physicians' experiences of being in ethically difficult situations that have the potential to give rise to a troubled conscience. Such narratives are important both in the specific context of haemodialysis care and in a broader perspective because they can increase our understanding of what it means to encounter ethically difficult situations. Studies carried out in the same care context but with two different groups of professionals can explore two perspectives of the same ethical issue and can increase our understanding of the complexity of ethical conflicts.

Various forms of CES have been developed for healthcare professionals to meet inter-professionally and to communicate ethical difficulties. The intention with the CES intervention inspired by Habermas' theory of communicative action that was studied in this thesis was to provide opportunities for healthcare professionals to share their perspectives of the value conflict and to motivate dialogue in order to reach a common understanding of these issues. Sparsely studies have described the communication process and the organisation of CES, and no studies have described a CES intervention based on Habermas' theory of communicative action. Thus this study has sought increase our knowledge of how healthcare professionals communicate value conflicts and how a common understanding for how to act and relate to such conflicts can be reached.

Aims

Overall aim

The overall aim of this thesis was to increase our understanding about being in ethically difficult care situations and about how communication concerning ethical issues in healthcare can be promoted.

Specific aims

Study I. To illuminate RNs' experiences of being in ethically difficult situations in dialysis care giving rise to a troubled conscience.

Study II. To illuminate the meanings of being in ethically difficult situations that lead to the burden of a troubled conscience as narrated by physicians working in dialysis care.

Study III. To describe the communication of value conflicts during a series of CES sessions.

Study IV. To explore the organisational and communicative conditions of a CES intervention with the intention to promote interprofessional communication about ethically difficult care situations.

Methods

The work in this thesis took a qualitative approach including narrative interviews and observations of an intervention. The studies were performed at a university hospital in northern Sweden, and an overview of the studies is given in Table 1.

Table 1: Participants and methods for data collection and data analysis.

Studies and status	Participants	N	Data collection method	Analysis method
I Published	Registered nurses in dialysis care	10	Audio-recorded narrative interviews	Phenomenological hermeneutic approach
II Published	Physicians in dialysis care	5	Audio-recorded narrative interviews	Phenomenological hermeneutic approach
III Published	Professionals in clinics for neuro-rehabilitation	41	Five audio and video-recorded and two audio-recorded sessions of CES	Data-driven qualitative content analysis
IV Manuscript	Professionals in clinics for neuro-rehabilitation	41	Eight audio- and video-recorded sessions of CES	Concept-driven and data-driven qualitative content analysis

Context

Studies I and II were performed at a ward specializing in dialysis care, and the professionals consisted of RNs and physicians. The patients at the ward suffered from renal insufficiency and were in need of dialysis. Dialysis is a lifesaving treatment and continues for the rest of the patient's life unless they receive a kidney transplant. The patients received dialysis 3 or 4 times a week, and each session lasted 3–4 hours. Some patients had to travel several hours to the dialysis ward.

Studies III and IV were performed at a ward specializing in rehabilitation. The patients in the ward suffered from various kinds of impairments and were in great need for rehabilitation. Because the healthcare professionals in

the ward occasionally encountered ethical difficulties in everyday patient care, they set aside time for reflections every afternoon for those who wished to attend, but they also expressed a need for organized CES.

The CES intervention

Eight CES sessions in studies III and IV were performed at the ward approximately once a month, and they were audio- and video-recorded. Because the ethical problems encountered in the ward proved to be very difficult and the participants needed more time, the leader of the project and the head of the ward decided to add another two sessions, which were audio-recorded only. All professionals at the ward were welcome to participate. Before the CES intervention, written information was distributed to all professionals at the ward describing the purposes and methods, such as the requirement of a democratic approach, and an introductory lecture covering the basic concepts of medical ethics was held. All CES sessions were advertised in advance and held in the same room and at the same time of day, and each CES session lasted for one hour. One main leader facilitated the sessions supported by two assistants. The leaders were healthcare professionals not affiliated with the ward and who had education in medical and care ethics. The CES sessions are more thoroughly described in the Results section.

Participants

In studies I and II, the participants were given information about the study verbally at a meeting at the ward and in writing. In study I, the head nurse suggested a list of RNs so as to achieve a variation in age, gender, length of work experience, and the experience of being in ethically difficult situations. In study II, the chief physician suggested the participating physicians according to the same criteria as in study I. The suggested RNs and physicians were thereafter contacted by the researchers, provided repeated information about the study, and asked for participation.

In study I, ten RNs agreed to participate. The RNs were employed in a dialysis setting at a Swedish hospital and had 3 to 16 years of working experience. Five physicians employed at the same hospital as in study I agreed to participate in study II. They were specialists in nephrology or were in training to be specialists and had 5 to 20 years of working experience in the care of renal diseases. Because the participating unit was small and highly specialized, no detailed demographic data on participants are given to ensure that the participants cannot be identified.

In studies III and IV, written and oral information about the planned intervention study was sent to all heads of the wards at a Swedish university hospital along with an offer to apply for participation. Criteria for inclusion were a need for CES and a willingness to participate in audio- and video-recorded CES sessions over a period of eight months. Five wards applied to participate. The participating ward was selected based on their description of how the professionals were dealing with intractable ethically difficult care situations in their everyday practice. The participants consisted of RNs, enrolled nurses, physicians, occupational therapists, welfare officers, physiotherapists, and psychologists. There were a total of 41 participants with 34 women and 7 men. The number of participants in each CES session varied between 11 and 17 depending on the situation at the ward and on the participants' work schedules.

Data collection

Interviews

In studies I and II, audio-recorded interviews were performed individually in a private room at the renal disease ward. With an open-ended question, the participants were asked to narrate about an ethically difficult situation that they had experienced in the ward and that had led to a troubled conscience. The narrating was supported by follow-up questions such as "How did you feel then?", "What happened then?", or "What did you do?" and further encouraged by probing and small-talk questions.

In study I, ten narrative interviews were performed. Seven RNs were interviewed in 2003, and another three interviews were carried out at the same ward in 2011. The narrative interviews lasted for 25–65 minutes. In study II, the five narrative interviews were performed in 2003. The interviews lasted for 25–40 minutes. The audiotapes were transcribed verbatim in Swedish and included laughs, sighs, and pauses.

In studies III and IV, ten CES sessions were performed. The eight planned CES sessions were all audio- and video-recorded, and the two extra sessions were only audio-recorded. Two video recorders were used during the sessions, and this gave increased opportunities to collect both verbal and non-verbal observation data in the room. The video recorders were fixed on tripods, and their placement in the room shifted from time to time in order to capture observation data of as many participants as possible. However, the participants also changed their placement in the room between the sessions as well as during the sessions in order to make space for late arrivals. It was therefore not possible to capture all participants in all

sessions. The intention with the fixed video equipment was to reduce the risk of disturbing the discussion (cf. Heath, 2011 p 38-41) and to provide opportunities for the researcher to function as a participant observer (cf. Mays and Pope, 1995, Dahlgren et al., 2007). In two of the CES sessions, only one video recorder was used due to technical difficulties.

Data analysis

The phenomenological and hermeneutic analysis in studies I and II comprised three phases – naïve reading, structural analysis, and comprehensive understanding. The first step involved repeated naïve readings of the text with an open attitude in order to get a first impression of the meaning of the text as a whole (cf. Ricoeur, 1976 p 71-72). The second step consisted of a structural analysis in order to reveal what the de-contextualized text said (cf. Kristensson Uggla, 1994 p 303-304). In the structural analysis, the text was divided into meaning units. The meaning units were reflected on, condensed, coded, and sorted according to similarities and differences, and then abstracted into subthemes and themes. The subthemes and themes were reflected on to validate or invalidate the naïve understanding. In the structural analysis of study I, one theme and six subthemes emerged. In study II, two themes and five subthemes emerged. In the third step, a comprehensive understanding of the meaning of the text as a whole was formulated based on the researchers' pre-understanding, the naïve understanding, and the themes and subthemes in relation to the literature.

The audio-recorded data in studies III and IV were transcribed into text and were read through several times in order to get a sense of what was being communicated. The audio- and video-recorded data were viewed, identified, and sorted by using Transana, which is a computer-based qualitative audio and video analysis tool (cf. Mavrou, 2007, Dempster, 2011, Antonsson et al., 2013). Transana allows simultaneous readings of transcriptions related to verbal and visual data in the video sequences. The data processing in both studies III and IV involved fusing the video-recorded data from two viewpoints into one spot and further importing the linked movies into Transana. In the first step of the analysis, the data were viewed chronologically in order to get a sense of each CES session. Thereafter all verbal communication was transcribed into text in Transana.

In study III, a data-driven, qualitative content analysis was used. The results emerged from the data according to what was communicated during the sessions (cf. Schreier, 2012 p 80-91). Audio- and video-recorded sequences of verbal and nonverbal expressions in the communications related to the

research question were identified and coded in Transana. Then the coded audio and video sequences were transcribed into plain text and recoded (cf. Schreier, 2012 p 80-91) according to the verbal expressions in the communications. In the final step, the data were sorted according to the content of the communication process. The codes were grouped into five phases according to the variations and commonalities in patterns, first separately within each CES session and then within all the sessions.

In study IV, the audio and video sequences were analysed by using a combination of concept-driven and data-driven qualitative content analysis (cf. Schreier, 2012 p 80-91). Notes about reflections were made, and verbal data were transcribed into text. A coding frame was constructed with two concepts related to the aim, namely, organisational conditions and communicative conditions. Based on the findings in study III, the process of communicative climate and action was included in the concept of communicative conditions. The concepts were re-formulated in the following two questions: How is the CES-intervention organized and structured? and How is the communicative climate and the communicative action on ethical issues promoted?

First, all the audio- and video-recorded data and transcripts were sorted under the coding frame and divided into video sequences according to how the communication between the participants was accomplished (cf. Heath, 2011 p 68-69). Second, the video sequences were analysed and coded according to how they fit within the respective concepts. Parts of the same sequence could fit into more than one content area because the sequences constituted various parts of the observed communication. Third, the video sequences about the organisation were analysed and sorted according to similarities and variations (cf. Schreier, 2012 p 84-90) and formulated as subcategories and categories. The same procedure was performed for the video sequences about the communicative climate and the communicative action. Finally, the video-recorded observations were re-viewed and validated in relation to the resulting subcategories and categories.

Ethical considerations

The research was approved by the Ethics Committee at the Faculty of Medicine of Umeå University Dnr 2003-03-499 (I, II) and Dnr 2012-338-31M (III, IV). The participants were informed that the audio-recorded interviews, transcripts (studies I and II), and audio- and video-recorded data (III, IV) were saved on an external hard drive and would be kept confidential. After information that participation was voluntary and that they had the right to withdraw at any time without explanation, the

participants signed an informed consent form. Narrating ethically difficult situations that give rise to a troubled conscience (I, II) might cause discomfort, and therefore support was offered if needed. There was a risk that recording the CES sessions (III, IV) could be experienced as a threat to the participants' personal integrity. Therefore, the participants were informed that the data would be analysed only according to the communication and not the person. In order to preserve the patients' and relatives' confidentiality, the personal characteristics concerning age and gender of the patients discussed in the CES sessions were changed.

Results

Study I

The analysis of the RNs' narratives about being in ethically difficult situations giving rise to a troubled conscience in dialysis care resulted in one theme and six subthemes, and these are presented in Table 2 and further described below.

Table 2. Overview of the theme and subthemes in study I.

Subthemes	Theme
Dealing with the patient´s ambivalence	
Responding to the patient's reluctance	
Acting against the patient's will	Calling for a deliberative dialogue
Acting against one's moral conviction	
Lacking patient's and relatives' involvement	
Being trapped in guilty feelings	

Calling for a deliberative dialogue

The narratives told about ethical difficulties related to the complexity of dialysis care that posed a challenge to the balance between preserving life by all means and preserving life with dignity. The RNs expressed uncertainty, solitude, abandonment, and guilt in various situations and called for in-depth and deliberative dialogues with those involved in such situations.

Dealing with patient's ambivalence referred to situations when the patients expressed a desire to withdraw from dialysis. The narratives expressed uncertainty, and it was difficult for the RNs to interpret the patients' intentions and to understand their wishes regarding the life-prolonging treatment. When the patients were ambivalent, the RNs became unsure about how to act and relate and about how to understand what was best for the patient.

Responding to the patient's reluctance concerned situations when patients directed aggression and accusations towards the RNs, and the RNs had difficulties in dealing with the patient's emotions in a good way. The narratives revealed that the patient's reluctance was problematic and was related to feelings of avoidance, inadequacy, sadness, and guilt in the RNs.

Acting against the patient's will concerned situations when patients in the end stage of life and with severe complications expressed reluctance to receive dialysis. According to the narratives, the RNs felt guilty when following the physicians' prescriptions and providing dialysis against the patient's will or when prolonging the patients suffering. The RNs felt responsible for conveying the patient's desires to the physicians, but they sometimes received no response from the physicians. Being unable to convince the physicians about what they considered best for the patients made the RNs feel ignored and powerless.

Acting against one's moral convictions concerned situations when organizational issues made it difficult to protect the patient's dignity. The narratives told, for example, about a sense of powerlessness, for example, when they were unable to relieve the patients' pain due to restrictions from the physicians. They tried, but failed, to convince the physicians of the patients' suffering and needs, and this gave rise to a troubled conscience.

Lacking patients' and relatives' involvement concerned situations when the RNs found it difficult to communicate with patients and relatives. The narratives told about a desire for an in-depth dialogue about the dialysis care with patients and their relatives so as to prepare them for any complications that might arise. Failing to initiate or to carry out the dialogue caused guilty feelings in the RNs who were afraid that the patients would be subjected to unnecessary suffering.

Being trapped in guilty feelings concerned difficult and complex situations in which the RNs wanted to participate in the decision-making process, to convey their knowledge and experiences and to get a chance to understand the motives behind the physician's decisions. Having to act contrary to their

values of good care, and the experiences of being rejected imposed feelings of being belittled, abandoned, and lonely, and caused the RNs to have guilty feelings. In the narratives, it was told that gathering in groups with likeminded people was a way to soothe a troubled conscience brought on by disagreements with colleagues and physicians.

Study II

The analysis of the physicians' narratives about being in ethically difficult situations that led to a troubled conscience in dialysis care resulted in two themes and five subthemes, which are presented in Table 3 and further described below.

Table 3. Overview of the themes and subthemes in study II.

Subthemes	Theme
Avoiding arousing conflicts *Being afraid of using one's authority* *Feeling the burden of sole responsibility*	**Feeling trapped in irresolution**
Feeling squeezed between time restraints and professional and personal demands *Feeling doubted and unconfirmed by RNs*	**Being torn by conflicting demands**

Feeling trapped in irresolution

The narratives told about ethical difficulties or dilemmas in which the physicians felt trapped in irresolution. They expressed uncertainty, solitude, and abandonment in situations that were related to the obligation to decide about withdrawing or withholding dialysis. Sometimes the physicians felt trapped by demands from the patients, the patients' relatives, and the RNs.

Avoiding arousing conflicts concerned situations when the physicians had to make crucial decisions about life-support treatment and the patient and relatives had different opinions concerning whether to start, continue, or withdraw dialysis. The physicians sometimes had to make crucial decisions about life-support treatment when the patient and relatives were in disagreement. The narratives told about situations when the physicians avoided intervening in conflicts and hesitated to make decisions about withdrawing dialysis. Their intention was to do good by avoiding conflicts, but in retrospect, they felt unsure and questioned whether the decision was in the best interest of the patient.

Being afraid of using one's authority concerned situations when the physicians found that it was not medically defensible to start or continue dialysis, yet they felt uncertain about their authority and the power of their words. These situations concerned, for instance, patients in end of life care with severe suffering and when patients, relatives, and physicians had different perspectives on the situation. The narratives told about the physicians' uncertainty in how to handle their medical responsibility and power. By avoiding a clear decision, the troublesome treatment continued, and the narratives expressed guilty feelings for causing the patient unnecessary suffering.

Feeling the burden of sole responsibility concerned situations when the physicians had to make crucial decisions but experienced a lack of support from their colleagues. The physicians were expected to be responsible for their own decisions, and the lack of support from colleagues made them feel lonely. They wanted to have in-depth dialogues with their colleagues and wanted to reach consensus in decision-making.

Being torn by conflicting demands

The narratives told about ethically difficult situations when ideals and reality clashed. They also told about ethical dilemmas in which the physicians tried to do good by avoiding doing wrong and about experiences of being doubted and unconfirmed.

Feeling squeezed between time restraints and professional and personal demands concerned the experience of not being able to live up to one's personal expectations or those of others. The physicians expressed feeling inadequate due to a lack of time and to conflicts between their ideals and reality. A stressful work situation was described, with high demands, increasing administrative workloads, and reduced time with their patients. The physicians often lacked enough time for careful discussions with patients and relatives in situations where crucial decisions had to be made. The narratives entailed situations when the physicians felt squeezed, alone, and inadequate when having to prioritize between necessary tasks.

Feeling doubted and unconfirmed by RNs concerned situations when the physicians and RNs had differing opinions on whether to start, withdraw, or withhold treatment. The conflicting opinions seemed related to various perspectives and to the fact that the physicians and RNs met the same patients but in different situations and at different times. Thus they encountered the same ethically difficult situations, but they tended to have different views about how to act. According to the narratives, the physicians

wanted the RNs to take into account that the patients were often in a healthier condition when seeing the physicians than during the dialysis when seeing the RNs, and they wished to have their decisions respected. They considered both the curative and the palliative aspects of the treatment, and they perceived a distance and a lack of understanding between themselves and the RNs.

Study III

The analysis of the communication of value conflicts during a series of inter-professional CES sessions revealed a communication process that consisted of five phases as presented in Table 4 and further described below.

Table 4. The five phases of the communicative action.

The process of the CES intervention
A value conflict is expressed as feelings of frustration
Sharing disempowerment and helplessness
The revelation of the value conflict
Enhancing realistic expectations
Seeing opportunities to change the situation instead of obstacles

The process of the CES intervention

The participants as a group communicated through a process where they successively moved from expressing their individual experiences and interpretations of the situation towards a common, realistic understanding and a changed attitude. The participants as individuals, however, moved back and forth between the various phases both between and during the sessions.

Phase 1: A value conflict is expressed as feelings of frustration. The participants communicated the value conflict by giving voice to their frustration from the ethically difficult situation. A tension between preserving the patients' and relatives' autonomy or having to act in a paternalistic manner was expressed, and the participants also expressed how they wanted to do good for the patients but they experienced discouragement and frustration in not being able to do so. They helped each other to put their experiences into words and thereby the value conflict became communicable.

Phase 2: Sharing disempowerment and helplessness. By sharing experiences of frustration and helplessness, the participants came to further reveal their vulnerability. The participants became closer and they confirmed

each other in a seemingly honest approach and shared experiences of shortcomings, uncertainty, and lack of knowledge. Some of the participants began to view other perspectives of the situation and were ready to touch upon the specific ethical situation, while others were not yet ready to communicate the value conflict.

Phase 3: The revelation of the value conflict. The previous discussions and added knowledge from leaders and experts seemed to open up for reflections and further interpretations of the situation. Referring their own interpretations to others in the group, the participants were able to see that the situation could be understood in various ways. With these new insights, the situation seemed to be more comprehensible and the participants expressed a broader understanding of the situation. The value conflict was communicated from a relational ethics perspective, and the real conditions of the conflict appeared to be revealed.

Phase 4: Enhancing realistic expectations. The observations showed that the participants communicated the value conflict with new knowledge and insights. The participants reflected over their own values and their changed perspectives and realized that they might have to adjust their own expectations to fit the situation. Expressions of frustration were transformed into feelings of compassion, and the participants communicated about the ethically difficult situation with increased tolerance. By changing their attitudes and having realistic expectations, a trustful relationship with the patients and relative was achieved that seemed to allow the value conflict to eventually disappear.

Phase 5: Seeing opportunities to change the situation instead of obstacles. As the focus in the communication turned from the participants themselves, and their frustrations and doubts, compassion, tolerance, and trust, a sense of creativity could be seen in the group. The participants seemed to be searching for constructive solutions in a sense of togetherness and to come up with a communicative agreement for how to act and relate and thus resolve the value conflict.

Study IV

The analysis of the organisational and communicative conditions of the CES intervention resulted in two categories and five subcategories as presented in Table 5 and further described below.

Table 5. Overview of the categories and subcategories in study IV.

Subcategory	**Category**
Constancy promoting safety and stability	**A CES framework with both a given structure and an openness for variation so as to facilitate a communicative action**
Flexibility promoting creativity and responsiveness	
A permissive communication approach	**Courses of actions to reach a communicative agreement**
An extended view approach	
A mutual understanding approach	

A CES framework with both a given structure and an openness for variation so as to facilitate communicative action.

The analysis of the CES sessions showed a framework with both a given structure and an openness for variation. This approach was observed in all sessions as an important factor in facilitating communicative agreement. The constancy and flexibility together built a stable and dynamic framework that promoted the communicative action and opened up for responsiveness and creativity. The analysis showed that the leader's role was important for establishing and maintaining this CES framework.

Constancy promoting safety and stability. The constant and given structure of the CES sessions was found to be an important condition for the communicative action. Parts of the organizational structure were decided and agreed upon among the participants before the CES intervention started. These pre-determined constant parts of the framework were, for obvious reasons, also noted in the observations. Other observed constant conditions were not pre-determined or explicitly described. The constancy of the framework provided a familiar and safe environment that promoted the expression and sharing of frustration that allowed the value conflict to be revealed.

Flexibility promoting creativity and responsiveness. The flexibility and openness for variation was also an important factor for the inter-professional communication within the CES sessions. This part of the framework was dependent upon the situation and varied between the sessions. The variations concerned, for instance, the number of participants, their placement in the room, the leaders' individual response, the level of participation of different participants, and the methodology and content being discussed. The leaders were attentive to the conversation, both on an individual and group level. The leader's methodology varied between asking reflecting questions, sharing professional and factual knowledge, and bringing literature for those who were interested. This openness for variation brought energy to the dialogue about ethical difficulties and promoted responsiveness, tolerance, realistic expectations, and creativity for finding proposals for actions.

Courses of actions to reach a communicative agreement

The observed CES sessions showed three approaches to reach communicative agreement, including permissive communication, extended views, and mutual understanding. The approaches were related to the situation and were responsive to the atmosphere, and they were both challenging and confirming.

A permissive communication approach. The leaders supported communicative action by being engaged in the dialogue and by actively listening. By maintaining inviting body language, asking follow-up questions, and allowing for thought pauses, the leaders demonstrated that they took the participants seriously. By asking questions such as "Please could you tell me?" or "What do you find difficult?", a sense of trust was indicated, which further paved the way for a communicative action. The participants seemed to be comfortable in speaking about their experiences and feelings. In many of the sessions, the leaders and some participants shared their professional and personal experiences, sometimes by using humour, and this encouraged others to follow the course of actions and to share their own experiences, feelings, and shortcomings. This approach seemed to make the participants comfortable, and this allowed them to reach a sense of equality with the other participants.

An extended view approach. This approach stimulated the participants to discuss, reflect, challenge, and validate each other's expressions. The participants were free to communicate, and the leaders intervened only to guide the communicative action forwards or to ensure that all participants had equal opportunity to speak. By being responsive to the discussion and

paying attention to various emotions and expressions among the participants, the leaders further supported the participants in reviewing their own stories. Different points of view were revealed during the discussions, and the participants could reflect on their own stories in light of others' stories and experiences. The participants communicated the value conflict by sharing experiences from their clinical reality, and the leaders maintained the ethical dimension by asking reflecting questions such as "How can you understand this?" and continuously summarizing and repeating the ethical issues of concern. By further relating the participant's stories to theoretical knowledge, the participants gained new ways of understanding the value conflict.

A mutual understanding approach. The analysis showed that the leaders made use of the participants' stories to stimulate further reflections. They repeatedly asked follow-up questions such as "How can you respond?", "How can you relate?", or "How can you act?" The observations showed individual variations in the transition toward a changed attitude about the value conflict. Some participants expressed the situation from extended views and gave creative proposals for actions, while others remained frustrated. The leaders were open for these individual variations and allowed time for thorough reflections by letting the same case be the focus of discussion until the participants expressed a common understanding of the situation. Proposals for actions were repeated by the leaders, and finally the participants came to a communicative agreement and approved the proposals for how to handle the situation.

The findings point to a need for healthcare professionals to communicate about ethically difficult situations when values are at stake and there is no true solution for how to act or relate. The theory based CES intervention with a framework involving a given structure and openness for variation showed to promote a dialogue where the participants – with support from the leaders – could change expressions of frustration and helplessness towards professionalism and could develop proposals of actions that would be in the best interest of the patients and relatives.

Towards the development of a CES method based on Habermas' theory of communicative action

The findings from the observations of the organizational and communicative conditions (IV) are here integrated with the communication process revealed in study III. The illustration below constitutes a first step towards a CES method based on Habermas' theory of communicative action, including the communication process of the value conflict, the framework with both a given structure and openness for variation, and approaches to facilitate communicative action on ethical issues in healthcare. See figure 1.

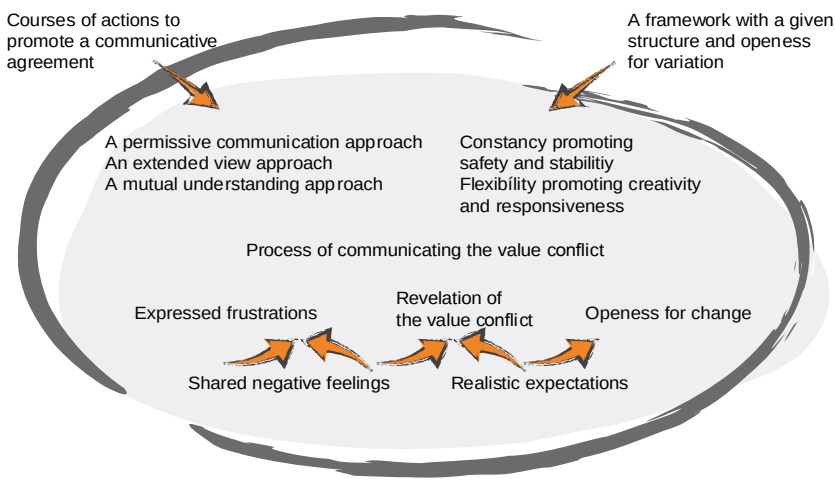

Figure 1. Descriptions of the process of communicating the value conflict, and the identified organizational and communicative conditions for communicative agreement.

Discussion

The aim of studies I and II was to illuminate experiences of being in ethically difficult situations that give rise to a troubled conscience among RNs and physicians. The narratives concerned difficult and ambiguous situations in the care and treatment of fragile and often ambivalent patients who were dependent on dialysis. The RNs and physicians conveyed a desire to do the right and good thing, but they encountered situations and dilemmas when values were at stake, and these aroused feelings of uncertainty. According to Silfverberg (2005), ethically difficult situations make us uncertain and confused because we do not know what the right and good thing to do is, but we are still bound to act.

The RNs' narratives (I) expressed how they were uncertain about the proper way to proceed when encountering patients' ambiguous and contradictory expressions concerning dialysis. Previous studies have shown that RNs also experience ethical difficulties when having to administer dialysis to terminally ill patients if the treatment will increase or prolong the patient's suffering (Redman and Fry, 2000, Halvorsen et al., 2008, Hermsen and van der Donk, 2009). The physicians in study II told about feelings of uncertainty in making crucial decisions about withholding or withdrawing dialysis. This result is similar to other studies that have shown that physicians often have difficulties in making decisions about whether to withhold or withdraw dialysis because of the consequences such actions will have for the patient's life (Halvorsen et al., 2008, Davison et al., 2006). In other contexts, being unable to act in the patient's best interest has been found to be related to feelings of personal failure (Pavlish et al., 2015), frustration, and indignation (Kristoffersen et al., 2016), and RNs have described feelings of powerlessness, insufficiency (Rasoal et al., 2015), frustration (Sørlie et al., 2005, Pelto-Piri et al., 2012), emotional pain (Sørlie et al., 2003a), guilt (Nordam et al., 2005), and failure (Rees et al., 2009) when they are unable to meet the patients' needs and to provide the best care possible. Physicians have described feelings of uncertainty, a heavy burden (Sørlie et al., 2001), and grief (Sørlie et al., 2000) by having to decide whether to withhold or withdraw life support treatment (Sørlie et al., 2000). Being unable to give good care due to uncertainty about what the patient really wishes has been found to be related to unpleasant feelings of distress and of not being good enough (Dahlqvist et al., 2009).

The RNs and physicians in this thesis were trying to handle the ethically difficult situations according to what they assumed was right and good, but

they failed to prevent or relieve suffering, and this led to a troubled conscience with feelings of guilt and failure. Both RNs and physicians (I, II) working at the same ward and encountering the similar ethically difficult situations expressed feelings of uncertainty, doubts about failing the patients, disempowerment, and loneliness, but from different points of view. They struggled with the same feelings, but they did not share their struggles with each other. The lack of communication and the feelings of not being confirmed promoted experiences of mistrust and isolation. They seemingly became trapped in their frustration, confusion, and self-doubt, and in this position they started to search for scapegoats to justify their actions and to relieve guilty feelings arising from a troubled conscience.

Being unable to deal with guilty feelings from a troubled conscience has been found to be related to stress of conscience (Glasberg et al., 2008) and to stifling one's conscience, which in turn strongly correlates to stress-related conditions such as burnout (Juthberg et al., 2008, Gustafsson et al., 2010). According to Fromm (1990 p 158-166), the human conscience is a reaction from our inner personality and is a guardian of our integrity. Neglecting the human conscience one risks feeling guilty for failing one's innermost self. Being trapped in guilty feelings due to value conflicts that give rise to a troubled conscience is a serious condition that threatens both the well-being of healthcare professionals and the quality of care they provide. It is therefore important to overcome the lack of inter-professional communication about value conflicts and related experiences that was found in this study.

The RNs (I) were calling for a deliberative dialogue with physicians but felt rejected, ignored, and belittled, and the physicians (II) wanted to be confirmed by their colleagues and RNs when making ethically difficult decisions. They perceived a lack of understanding from the RNs. Being excluded and not understood in difficult situations can provoke defense reactions such as moral accusations (cf Løgstrup, 1994 p 42-43). The individual becomes caught up in the situation and surrounds themselves with destructive expressions and thus remains a victim to the circumstances and unable to make a change (Løgstrup, 1968 p 94-95). Such tendencies were found in studies I and II as the RNs' and physicians' narratives expressed how they were ending up in resignation, isolation, and powerlessness. In order to bring people out of such unhealthy positions that threaten both patient care and the professionals' health, CES is needed.

Studies III and IV aimed to describe the communication of value conflicts and the organisational and communicative conditions of a CES intervention that sought to promote interprofessional communication about ethically difficult care situations. The CES intervention, inspired by Habermas' theory of communicative action, seemed to offer the possibility to deal with experiences of ethically difficult care situations in an atmosphere where everyone could feel free and equal and had opportunities to speak (cf. Habermas et al., 1996 p 303). In such a permissive atmosphere, the professionals not only helped each other to balance their ambiguity, frustrations, powerlessness, and helplessness, but they also came to an agreement about how to act in realistic ways. This in turn increased their creativity in finding constructive ways to handle the ethical issues. Silfverberg (2005) claims that reflecting not only on the situation of concern, but also on our emotions, intentions, will, and motives, might cultivate our character and our virtues. Virtues are closely connected to our emotions, and they derive from our character, promote actions for living a good life. Hence, virtues are important parts of professionalism in health care (Silfverberg, 2005 p 67-75, 129-132). The participants in the CES sessions (study III) further developed their professionalism during the communication process and were able to reflect on their own and others' experiences and motives. They moved from an individual interpretation of the situation towards extended views and a shared understanding.

Nussbaum asserted that emotions are closely related to our values and beliefs, and in crucial situations our emotions indicate something that is important for us. However, emotions can be either rational or irrational and they sometimes give unclear messages that are difficult to understand. By deliberating and reflecting over our emotions, we can reveal, identify, and understand our values and beliefs (Nussbaum, 1995 p 365-378, Nussbaum, 2001 p 187-195). Sharing guilty feelings from a troubled conscience can open up ways to deal with emotions (Dahlqvist, 2008 p 40), and instead of being a victim of circumstance there might be hope and a direction into the future. This was shown in study III where creativity replaced feelings of not being good enough. Sharing difficulties in a dialogue with others and seeking out improved collaboration for the patient's benefit have been shown to relieve a troubled conscience among healthcare professionals (Ericson-Lidman and Strandberg, 2015a, Ericson-Lidman and Strandberg, 2015b), and through a dialogue we can learn to share our emotions and to accept our uncertainty as a natural part of life (Sørlie, 2001 p 44-45).

Essential prerequisites for the communication process in this intervention were the CES framework and the courses of action that led to communicative agreement. The framework included a given and constant structure based on

Habermas' theory of communicative action along with flexibility and openness for variation (IV). The constancy that was built into the framework provided safety and stability, while the flexibility was related to responsiveness and creativity. The flexibility can be understood in light of Benhabib's (1990) assertion of the importance of taking into account all the variations of expressions that come up in a moral dialogue. Humans are involved in a network of relations, and morality involves a dependency among the people with openness for the richness of all variations. According to Benhabib, communicative action requires equality, respect for others, an exchange of perspectives, and receptivity to the moral aspects of others' narratives (Benhabib, 1990 p 362-363).

The courses of action (IV) consisted of the three approaches of permissive communication, extended views, and mutual understanding and these approaches were all directed towards coming to communicative agreement. The participants seemed free to express themselves from their own point of view and to reflect on the validity of each other's statements and arguments in an atmosphere of equality (cf. Habermas, 1990 p 67-71, 302) and egalitarian reciprocity (cf. Benhabib, 1994 p 48-49). The leader's engagement, responsiveness, and active listening appeared important for the development of a permissive communication climate. By being actively listened to, the participants became confident in telling their stories and expressing their experiences of the situation. Koskinen and Lindström (2015) have stressed the close connection between narrating and listening. By narrating, we not only share ourselves with others, but we also are able to listen to and receive glimpses of our innermost self (Eriksson, 2003 p 24-25). True listening with compassion means providing space for another person to listen to their innermost self and to further search for new directions in life (Koskinen and Lindström, 2015). The listening means receiving what is different and unknown and responding to the other person in their genuine otherness (Koskinen and Lindström, 2013).

The CES session leaders' presence and active responsiveness supported the participants in revealing their stories and contributed to a gradual transformation among the participants from being locked in by frustration to enhancing realistic expectations and becoming open for a change with the best interests of the patient in mind. This interpretation of our results can be understood in light of a study by Norberg et al. (2001) showing that shared feelings and suffering in a community with openness, presence, and trust allowed for a change in perspective. In this thesis, the leaders promoted both self-reflection and an openness to consider the experiences of others who are involved in the CES session. By listening to others, we can receive the

different and unfamiliar and thus come to a new and otherwise understanding of the situation (Lipari, 2009).

Of the various types of CES described in the literature, MCD seems to have the most similarities with the CES format that was used for this thesis. Like our intervention, MCD also has a clearly described theory-based structure based on pragmatic hermeneutics and dialogical ethics. The emphasis is on interpretation of the practical situation based on previous experiences, and it seeks to share this knowledge in order to develop new values and to reach a common understanding of the situation (Molewijk et al., 2008b, Widdershoven et al., 2009, Stolper et al., 2015). This implies a learning process by listening to others and being prepared to give up viewpoints, accept differences, and receive new and alternative perspectives (Widdershoven, 2001, Abma et al., 2009). Because CES is a relatively new and unexplored field, it is important to increase its body of knowledge and to try to improve its methods. This thesis contributes with a theory of communicative action, a description of a communication process, and the identification of organizational and communicative conditions that promote interprofessional communication about ethically difficult care situations.

Habermas (1990 p 62-64) emphasized, that in order to obtain moral insights, we need to test the validity of different viewpoints by intersubjective recognition and motivation of our own point of view. Through communicative action, we can test our viewpoints according to the viewpoints of others, and we can re-evaluate our own viewpoints in terms of their inconsistence. Benhabib (1994 p 76) asserts that one of the prerequisites for a dialogue on moral issues is responsiveness, which is the ability to listen and receive messages from others in order to understand how the world appears to them. Conversely, we have to convey our own representation of the world. In the permissive atmosphere of our CES sessions, the participants in this thesis were able to express themselves and their experiences. During the CES sessions, the participants came to realize that there were various ways to interpret and understand the situation, and this can be related to Habermas' et al. (1996 p 128-130) argument that communicative action allow parts of our life world to be revealed to others and that these revelations can be used to come to a common interpretation of the situation. By testing the validity claims of the interpretations, a renewed and common knowledge can be reached. Benhabib (1994 p 78) claims that if we can identify the various points of view and judge the situation together with others, we can change our perspectives and further develop a broadened mentality.

In evaluations of other types of CES, the participants have described increased insights into moral questions, increased cooperation with others (Weidema et al., 2013, Svantesson et al., 2008b), shared responsibility, moral support (Førde et al., 2008), and increased awareness of the patient's desires (Lillemoen and Pedersen, 2015, Janssens et al., 2015). The results in this thesis also showed that the participants gained new insights and increased knowledge. The participants were also urged to validate and re-evaluate their own interpretation of the situation, which in turn opened up for new understandings. Guided by their new understandings, the participants transformed expressions of frustration and helplessness into compassion and tolerance. The consequences of uncommunicated value conflicts can be a threat to both the professionals' innermost self and to the quality of care that they provide. It is therefore of utmost importance to provide opportunities to strengthen the communication channels between the various healthcare professions.

Through communicative action in a trusting and honest atmosphere, the participants in this thesis supported each other towards genuine engagement and creativity in finding ways to act in the patients' and relatives' best interests. They developed a trustful, inter-professional dialogue about ethically difficult situations and dilemmas, and they learned how to handle feelings of powerlessness, guilt, and inadequacy. Providing healthcare professionals with opportunities for CES sessions as a way for them to share experiences, feelings, and values in everyday clinical practice is one way to create an ethical climate with shared perceptions, values, and intentions to act in the patients' best interests. The question, therefore, is how to further develop the CES intervention to enable communicative action as a natural and continuously ongoing part of the everyday clinical practice in various healthcare contexts.

Methodological considerations

This thesis followed a qualitative research design for data collection and analysis in order to answer the research questions. In studies I and II, narrative interviews were performed. The sample size in study II was relatively small, with only five physicians interviewed, but the narratives were rich and revealed important knowledge of what it means to encounter ethical dilemmas in dialysis care. In qualitative research, the emphasis is on understanding things as they appear regardless of sample size (Sandelowski, 1996). The researchers were all healthcare professionals and there was a risk that their pre-understanding influenced the process from data collection to analysis. According to Ricœur and Thompson (1981 p 139) the researchers' pre-understanding inevitably influences the analysis process and thus

influences the results. As the speech act becomes transformed into text and freed from the speaker's intentions, it becomes universal and open for the reader's world. This means that it is up to the reader to understand the message and to interpret the meaning of the text. According to Lindseth and Norberg (2004), we cannot free ourselves from pre-understanding, we can only become aware of it. Therefore, the research team met regularly during the analysis process to thoroughly discuss the emerging results and the different interpretations with an awareness of the role that pre-understanding might have on the analysis.

In study I, there was an eight-year interval between the first seven interviews and the final three. The interviews with seven RNs and five physicians were carried out 2003, but the analysis had to be delayed. The analysis of the five physicians' narratives was performed first and resulted in a publication in 2011. When the analysis of the interviews with the RNs could finally start in 2011, the research group decided to conduct another three interviews. This approach must be taken into consideration in determining the trustworthiness of the results. If data collection extends over a significant period of time, there is a risk for inconsistency because of changes in the research environment and changes in the researcher's interview methodology (cf. Graneheim and Lundman, 2004). Such risks were addressed and communicated within the research team. The ethical difficulties at the ward were still present in 2011, and thus the study was determined to still be of value.

In studies III and IV, the head of the participating ward expressed great interest in participating because the professionals at the ward had expressed a need for CES. This engagement from the head of the ward might have influenced the atmosphere during the CES intervention and in turn stimulated the professionals to be more open for communication. The engagement of healthcare professionals in the CES intervention might thus be different at other wards.

No observational studies of a CES intervention were found in the literature, so the audio- and video-recorded observations in this thesis can be considered a strength by providing new knowledge about the communication process and its conditions. Recording of the CES intervention made it possible to view and review data during the analysis process, which is a further advantage because the perception of the various courses of action might change during the analysis (Heath, 2011 p 62). During the CES sessions, the audio- and video-recording initially appeared to disturb the dialogue and prevent some participants from speaking. Studies have shown that the presence of recording equipment and the presence of researchers

might cause what is known as the Hawthorn effect and thus influence the participants' behaviour. However, study participants usually become accustomed to the cameras and forget their presence (Latvala et al., 2000, Haidet et al., 2009, Caldwell and Atwal, 2005) and this seemed to be the case in our study as well and all participants in studies III and IV eventually joined in the conversations.

My primary function as a researcher during the CES intervention was to manage the recording equipment. I also took the role as a participating observer by keeping a low profile and a listening position in order to make the participants comfortable despite my presence. Two of the leaders in the CES sessions were also part of this research project, which must be taken into consideration when determining their impact on the results. The leaders' active involvement in the CES intervention and simultaneous data collection was, however, an advantage in the analysis. They had inside information about the process in the CES sessions (cf. Dahlgren et al., 2007 p 68). In study IV, the first author performed the analysis supported by the last author, who not had been involved in the intervention. This was considered to be a proper method because this study also concerned the leaders' roles and approaches in the CES sessions. The audio- and video-recorded data were rich enough to be double-used and analysed according to the different research questions and analysis methods in studies III and IV. Sandelowski (2011) claims that reusing data rests on the assumption that the data are already there and are open for being analysed in relation to another purpose. It is the attitude towards the data that matters rather than the recycling itself. No CES intervention based on the theory of communicative action has been found in the literature, so it is important to study interventions that present new perspectives and to catch both the communication process and the conditions that allow for open communication, and thus two studies were considered to be needed. The credibility of the analysis and the interpretation of the data were ensured by repeated discussions among all researchers within the research group and in seminars (cf.Graneheim and Lundman, 2004). The findings in this thesis seem possible to re-contextualize to other healthcare contexts where ethically difficult situations and dilemmas are part of the clinical practice.

Conclusions

Both RNs' and physicians' narratives about being in ethically difficult situations described feelings of uncertainty about the proper course of actions in similar situations, but from different point of views. They struggled with the same feelings, but they did not share their struggles with each other. The lack of communication and confirmation led to distrust and

increased feelings of uncertainty and of being belittled and unconfirmed, and this resulted in blaming others in order to relieve guilty feelings from a troubled conscience. The results point to the need for an inter-professional dialogue about ethically difficult situations in a respectful and trustful atmosphere in order to identify expressions from the conscience and to further reveal concealed aspects of the value conflict. The CES intervention, inspired by Habermas' theory of communicative action, offered the possibility for healthcare professionals to deal with ethically difficult situations. The CES framework had both a given structure and an openness for variation that together promoted safety, stability, creativity, and responsiveness. The courses of action consisted of the three approaches of permissive communication, extended views, and mutual understanding, and these approaches were all directed towards coming to communicative agreement. In the communication process, the participants gradually moved from an individual interpretation of the ethically difficult situations towards a new and common understanding with extended views, genuine engagement, and creativity to find ways to act in the patients' best interests. Providing CES sessions as a natural and ongoing part in the everyday clinical practice might open up for an ethical climate with shared values, perceptions, and professionalism with the intentions to act in the patients' best interests. This thesis contributes to increased understanding about the meanings of being in ethically difficult situations that give rise to a troubled conscience, the process of communicative action, and the conditions that promote communicative agreement.

Clinical implications and further research

The openness for variations in the CES intervention provided opportunities for all healthcare professionals at the ward to participate. The leaders in the CES were all healthcare professionals educated in medical ethics and were well experienced in the role of leaders. They showed an ability to manage the variations in the sessions, courses of actions, changing numbers of participants, and latecomers. However, in another context with other participants, different ethical difficulties, and other leaders, the variations might be a challenge for inexperienced leaders to manage. Therefore, the method behind the CES intervention described here needs to be further developed and more clearly described in order to be transferred and used by other leaders in other contexts. The patients and relatives were not involved in the CES intervention even though they were often the focus of the ethical difficult situations that were being discussed. The involvement of patients and relatives could on the one hand have led to a richer understanding of the situation (Nelson, 2012, Reiter-Theil, 2003), but on the other hand it might have been uncomfortable for the patient (Gjerberg et al., 2015) or inhibited

the inter-professional dialogue (Pedersen et al., 2009 a). Therefore, further investigations are needed concerning the patients' and relatives' involvement in the CES in terms of what is best for the patient.

The theory-based CES intervention observed in this thesis needs to be further investigated in larger intervention studies including quantitative and qualitative data in order to better understand the leaders' role and the usefulness of the CES intervention in reaching communicative agreement. The question is also how it is possible to develop the CES as a natural part of everyday clinical healthcare practice. Future research, therefore, should seek to determine the prerequisites to promoting a continuous dialogue in which healthcare professionals are stimulated to reflect on ethical issues in relation to their own values and to further develop their professionalism.

Acknowledgements

The County Council of Norrbotten and the Department of Nursing of Umeå University funded this thesis. Additional financial support was received from the J.C Kempe Memorial fund for scholarships, Anna Cederberg's Foundation, the Swedish Society of Nursing, and FoU (research and development) at the County Council of Västerbotten.

I would like to thank all of the participating RNs and physicians at the dialysis and renal medicine wards for sharing their experiences. I would also like to thank the professional group at the rehabilitation ward for participating in the CES intervention.

I want to extend my warmest gratitude to my supervisors, teachers, and co-authors. It has been a pleasure to be your PhD student and to take part in your knowledge and wisdom. Our supervision meetings have been inspiring, and creative with a refreshing mixture of seriousness and humour. Our meeting in Ygne on Gotland is certainly a great memory.

Karin Zingmark, my supervisor and co-author. First, I want to thank you for making this PhD project possible. It has been a pleasure working with you. You have really shown genuine engagement and care. Thank you for sharing your vast knowledge and for inspiring me to move forward by showing trust and using outstanding pedagogy with tricky questions, creative discussions, and constructive critiques.

Anna Söderberg, you have been my co-supervisor and co-author for several years and have been a very important person during this journey. Thank you for sharing your wisdom and in-depth knowledge and for your genuine engagement. You have always been available when I have been in need, and you have listened to my requests with care. Our travels together have been wonderful with their interesting discussions, laughs, and crazy happenings.

Vera Dahlqvist, my co-supervisor and co-author, your creativity and deep wisdom has been very important and a source of inspiration for my work with this thesis. Thank you for your critical readings and advice. I will never forget the stimulating night-time discussions while working in your small kitchen at "Söder".

Mikael Sandlund, my co-supervisor and co-author, thank you for sharing your knowledge and for your critical readings of my texts. Your contribution

has been very important, and it is amazing how you can give sharp critique, advice, and proposals for solutions with such a humour-filled approach.

Ulf Isaksson, as an examiner you have been invaluable. You have been a great support and have never denied my sudden requests. Thank you for giving your time and for your engagement.

Fredricka Gilje, thank you for your valuable readings and suggestions in study II.

Thanks to all my PhD scholars, fellows, and friends both former and present in the large and the small room. You have all made important contributions by interesting discussions, joy and support. In the small room, we have spent the days not only working hard but also spontaneously sharing experiences, knowledge, ideas', thoughts and everyday chats, seasoned with happiness, frustrations, and laughs. Thank you, Helena Claesson Lingehall, Anna Clara Rullander, Jenny Molin, Sabine Björk, Mara Härgestam, Sofia Andersson, and Anna Unneby.

Thank you to my present roommate and friend Eva Boström for encouragement, engagement in my framework writing, wise advice, and joy.

Thank you, Helena Antonsson and Karin Hellström Ängerud for readings and comments, Mats Lundström for sharing your deep knowledge in ethics, Liv Meidell for encouragement and support in critical situations, Inga Greta Nilsson and Peter Forsgren for invaluable help with administrative struggles. Karin Sjögren, thank you for inviting me to framework writing in Ottsjö and for your company in the Fjells and good teamwork in making the fish soup.

Susanne Enetjärn, thank you for your help in drawing the picture of the CES organisational structure and the process of communicative action. I also had a wonderful workday as pet sitter for Parva (the dog) at your veranda.

Gabriela Egerup, thank you for offering time to listen and for bringing energy on our tours in the forest and lake on water, snow, and ice.

Most of all I wish to thank my beloved family. Emil, Jakob, and Ylva, my wonderful and lovely children, you are always closest to my heart. Janne, thank you for your patience, warm heart, and for making me happy. Every day with you is a great adventure.

References

Abma, T. A., Molewijk, B. and Widdershoven, G. A. (2009) 'Good care in ongoing dialogue. Improving the quality of care through moral deliberation and responsive evaluation', *Health Care Analysis*, 17(3), 217-235.

Alvesson, M. and Sköldberg, K. (1994), *Tolkning och reflektion: vetenskapsfilosofi och kvalitativ metod [SWE] [Interpretation and reflection: philosophy of science and qualitative methos]*, Lund: Studentlitteratur.

Antonsson, H., Åström, S., Lundström, M. and Graneheim, U. (2013) 'Skilled interaction among professional carers in special accommodations for adult people with learning disabilities', *Journal of Psychiatric and Mental Health Nursing*, 20(7), 576-583.

Aulisio, M. P., Arnold, R. M. and Youngner, S. J. (2000) 'Health care ethics consultation: nature, goals, and competencies, *Annals of Internal Medicine*, 133(1), 59-69.

Bartholdson, C., Lützén, K., Blomgren, K. and Pergert, P. (2015) 'Experiences of ethical issues when caring for children with cancer', *Cancer Nursing*, 38(2), 125-132.

Beauchamp, T. L. and Childress, J. F. (1983) *Principles of Biomedical Ethics*, New York: Oxford University Press.

Bem, C. (2001) 'Moral sensibility and ethics', *Bulletin of Medical Ethics*, (173), 20-4.

Benhabib, S. (1990) 'The Communicative ethics and current controversies in practical philosophy' in Benhabib, S. and Dallmayr, F. R., eds., *The communicative ethics controversery*, Cambridge: MIT Press.

Benhabib, S. (1994) *Autonomi och gemenskap: kommunikativ etik, feminism och postmodernism [SWE], [Situating the self]*, Göteborg: Daidalos.

Bennett, P. N. (2011) 'Technological intimacy in haemodialysis nursing', *Nursing Inquiry*, 18(3), 247-52.

Caldwell, K. and Atwal, A. (2005) 'Non-participant observation: using video tapes to collect data in nursing research: ' *Nurse Researcher*, 13(2), 42-54.

Carleheden, M. (1996) *Det andra moderna: Om Jürgen Habermas och den samhällsteoretiska diskursen om det moderna [SWE] [The other modern, Jürgen Habermas and social theoretical discourse on the modern]*, Göteborg: Daidalos

Carpenter, C. (2010) 'Moral distress in physical therapy practice', *Physiotherapy Theory and Practice*, 26(2), 69-78.

Casterlé, D., Dierckx, B., Izumi, S., Godfrey, N. S. and Denhaerynck, K. (2008) 'Nurses' responses to ethical dilemmas in nursing practice: meta-analysis', *Journal of Advanced Nursing*, 63(6), 540-549.

Childress, J. F. (1979) 'Appeals to Conscience', *Ethics*, 89(4), 315-335.

Cohen, J., S. and Erickson, J., M. (2006) 'Ethical dilemmas and moral distress in oncology nursing practice', *Clinical Journal of Oncology Nursing*, 10(6), 775-783.

Cohen, L. M., Germain, M. J. and Poppel, D. M. (2003) 'Practical considerations in dialysis withdrawal "To have that option is a blessing"', *Jama-Journal of the American Medical Association*, 289(16), 2113-2119.

Corley, M. C. (2002) 'Nurse moral distress: A proposed theory and research agenda', *Nursing Ethics*, 9(6), 636-650.

Cronqvist, A. and Nyström, M. (2007) 'A theoretical argumentation on the consequences of moral stress', *Journal of Nursing Management*, 15(4), 458-465.

Croona, G. (2003) *' Etik och utmaning: Om lärande av bemötande i professionsutbildning [SWE] [Ethics and challenge: learning of treatment in professional education]'*, Diss,Växjö University.

Dahlgren, L., Emmelin, M., Winkvist, A. and Lindhgren, M. (2007) *Qualitative methodology for international public health*, Diss, Department of Public health and Clinical Medicine, Umeå University.

Dahlqvist, V. (2008) *Samvete i vården: att möta det moraliska ansvarets röster [SWE] [Conscience in healthcare: to meet the voice of moral responsibility]*, Diss, Department of Nursing, Umeå University.

Dahlqvist, V., Eriksson, S., Glasberg, A. L., Lindahl, E., Lützen, K., Strandberg, G., Soderberg, A., Sorlie, V. and Norberg, A. (2007) 'Development of the perceptions of conscience questionnaire', *Nursing Ethics*, 14(2), 181-193.

Dahlqvist, V., Söderberg, A. and Norberg, A. (2009) 'Facing inadequacy and being good enough: psychiatric care providers' narratives about experiencing and coping with troubled conscience', *Journal of Psychiatric and Mental Health Nursing*, 16(3), 242-247.

van der Dam, S., Abma, T., Kardol, M. and Widdershoven, G. (2012) '"Here's my dilemma". Moral case celiberation as a platform for discussing

everyday ethics in elderly Care', *Health Care Analysis,* 20(3), 250-267.

van der Dam, S., Abma, T. A., Molewijk, A. C., Kardol, M. J. M. and Schols, J. M. G. A. (2011) 'Organizing moral case deliberation. Experiences in two Dutch nursing homes', *Nursing Ethics,* 18(3), 327-340.

van der Dam, S., Schols, J. M. G. A., Kardol, T. J. M., Molewijk, B. C., Widdershoven, G. A. M. and Abma, T. A. (2013) 'The discovery of deliberation. From ambiguity to appreciation through the learning process of doing moral case deliberation in Dutch elderly care', *Social Science and Medicine,* 83, 125-132.

Dauwerse, L., Abma, T., Molewijk, B. and Widdershoven, G. (2011) 'Need for ethics support in healthcare institutions: views of Dutch board members and ethics support staff', *Journal of Medical Ethics*, 37(8), 450-460.

Dauwerse, L., Abma, T. A., Molewijk, B. and Widdershoven, G. (2013) 'Goals of clinical ethics support: Perceptions of Dutch healthcare institutions', *Health Care Analysis,* 21(4), 323-337.

Davison, S. N. (2012) 'The ethics of end-of-life care for patients with ESRD', *Clinical Journal of the American Society of Nephrology,* 7(12), 2049-2057.

Davison, S. N., Jhangri, G. S., Holley, J. L. and Moss, A. H. (2006) 'Nephrologists' reported preparedness for end-of-life decision-making', *Clinical Journal of the American Society of Nephrology*, 1(6), 1256-1262.

Dempster, P. W., D (2011) 'The economic crisis Through the Eyes of Transana', *Forum: Qualitative Social Research,* 12, 16.

Edwards, M. P., McClement, S. E. and Read, L. R. (2013) 'Nurses' responses to initial moral distress in long-term care', *Journal of Bioethical Inquiry*, 10(3), 325-336.

Ericson-Lidman, E., Norberg, A., Persson, B. and Strandberg, G. (2013a) 'Healthcare personnel's experiences of situations in municipal elderly care that generate troubled conscience', *Scandinavian Journal of Caring Sciences,* 27(2), 215-223.

Ericson-Lidman, E. and Strandberg, G. (2013b) 'Dealing with troubled conscience in municipal care of older people', *Nursing Ethics*, 20 (3), 300-311.

Ericson-Lidman, E. and Strandberg, G. (2015a) 'Learning to deal constructively with troubled conscience related to care providers'

perceptions of not providing sufficient activities for residents', *Clinical Nursing Research*, 24(2), 211-227.

Ericson-Lidman, E. and Strandberg, G. (2015 b) 'Learning to deal constructively with troubled conscience related to care providers' perceptions of deficient teamwork in residential care of older people–a participatory action research study', *Scandinavian Journal of Caring Sciences*, 29(2), 215-224.

Eriksson, K. (2003) 'Ethos' in Eriksson, K. Lindström., U. Å., eds. *Gryning II Klinisk vårdvetenskap [SWE] [Dawn II Clinical caring science]*, Vasa: Department of Caring science.

Fox, E. (2014) 'Developing a certifying examination for health care ethics consultants: bioethicists need help', *The American Journal of Bioethics*, 14(1), 1-4.

Fox, E., Myers, S. and Pearlman, R. A. (2007) 'Ethics consultation in United States hospitals: a national survey',*The American Journal of Bioethics*, 7(2), 13-25.

Fromm, E. (1990) *Man for himself. An inquiry into the psychology of ethics*, New York: Henry Holt and Company.

Førde, R. and Aasland, O. G. (2008) 'Moral distress among Norwegian doctors', *Journal of Medical Ethics*, 34(7), 521-525.

Førde, R. and Pedersen, R. (2011) 'Clinical ethics committees in Norway: what do they do, and does it make a difference?', *Cambridge Quarterly of Healthcare Ethics*, 20(03), 389-395.

Førde, R., Pedersen, R. and Akre, V. (2008) 'Clinicians' evaluation of clinical ethics consultations in Norway: a qualitative study', *Medicine, Health Care and Philosophy*, 11(1), 17-25.

Gjerberg, E., Lillemoen, L., Førde, R. and Pedersen, R. (2015) 'End-of-life care communications and shared decision-making in Norwegian nursing homes-experiences and perspectives of patients and relatives', *BMC Geriatrics*, 15(1), 103.

Glasberg, A. L., Eriksson, S., Dahlqvist, V., Lindahl, E., Strandberg, G., Soderberg, A., Sorlie, V. and Norberg, A. (2006) 'Development and initial validation of the stress of conscience questionnaire', *Nursing Ethics*, 13(6), 633-648.

Glasberg, A. L., Eriksson, S. and Norberg, A. (2007) 'Burnout and 'stress of conscience' among healthcare personnel', *Journal of Advanced Nursing*, 57(4), 392-403.

Glasberg, A. L., Eriksson, S. and Norberg, A. (2008) 'Factors associated with 'stress of conscience' in healthcare', *Scandinavian Journal of Caring Sciences*, 22(2), 249-258.

Goethals, S., Gastmans, C. and de Casterlé, B., D. (2010) 'Nurses' ethical reasoning and behaviour: a literature review', *International Journal of Nursing Studies*, 47(5), 635-650.

Gracia, D. (2003) 'Ethical case deliberation and decision making', *Medicine, Health Care, and Philosophy*, 6(3), 227-233.

Graneheim, U. H. and Lundman, B. (2004) 'Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness', *Nurse Education Today*, 24(2), 105-112.

Guerrier, M. (2006) 'Hospital based ethics, current situation in France: between "Espaces" and committees', *Journal of Medical Ethics*, 32(9), 503-506.

Gustafsson, G., Eriksson, S., Strandberg, G. and Norberg, A. (2010) 'Burnout and perceptions of conscience among health care personnel: a pilot study', *Nursing Ethics*, 17(1), 23-38.

Habermas, J. (1990) 'Discourse ethics: notes on a program of philosophical justification' in Benhabib, S. and Dallmayr, F. R., eds., *The Communicative ethics controversy*, Cambridge, MIT Press.

Habermas, J., Molander, A. and Carleheden, M. (1996) *Kommunikativt handlande : texter om språk, rationalitet och samhälle [SWE][Communicative action: texts about language, rationality and society]*, Göteborg: Daidalos.

Hagren, B., Pettersen, I. M., Severinsson, E., Lützen, K. and Clyne, N. (2001) 'The haemodialysis machine as a lifeline: experiences of suffering from end-stage renal disease', *Journal of Advanced Nursing*, 34(2), 196-202.

Haidet, H., Tate, J., Divirgilio-Thomas, D., Kolanowski, A. and Happ, M. B. (2009) 'Methods to improve reliability of video-recorded behavioral data', *Research in Nursing and Health*, 32(4), 465-474.

Halvorsen, K., Slettebø, A., Nortvedt, P., Pedersen, R., Kirkevold, M., Nordhaug, M. and Brinchmann, B. S. (2008) 'Priority dilemmas in dialysis: the impact of old age', *Journal of Medical Ethics*, 34(8), 585-589.

Hamric, A. B. and Blackhall, L. J. (2007) 'Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate', *Critical Care Medicine*, 35(2), 422-429.

Hansson, M. G. (2002) 'Imaginative ethics: Bringing ethical praxis into sharper relief', *Medicine, Health Care, and Philosophy*, 5(1), 33-42.

Heath, C., Hindmarsh, P. and Luff, P (2011) *Video In qualitative research analysing social interaction in everyday life*, London: SAGE Publications.

Hermsen, M. and van der Donk, M. (2009) 'Nurses' moral problems in dialysis', *Nursing Ethics*, 16(2), 184-191.

Hurst, S., Perrier, A., Pegoraro, R., Reiter-Theil, S., Forde, R., Slowther, A., Garrett-Mayer, E. and Danis, M. (2007) 'Ethical difficulties in clinical practice: experiences of European doctors', *Journal of Medical Ethics*, 33(1), 51-57.

Hydén, L.C. and Antelius, E. (2011) 'Communicative disability and stories: Towards an embodied conception of narratives', *Health:*, 15(6), 588-603.

Höglund, A. (2005) *Inga lätta val: om riktlinjer och etisk kompetens vid prioriteringar i vården : en studie i empirisk etik [SWE] [No easy choices: a study concerning empirical ethics in health care]*, Diss, Department of Studies in Faith and Ideologies, Uppsala University.

Jameton, A. (1993) 'Dilemmas of moral distress: moral responsibility and nursing practice', *Clinical Issues in Perinatal and Women's Health Nursing*, 4(4), 542-551.

Jameton, A. (2013) 'A reflection on moral distress in nursing together with a current application of the concept', *Journal of Bioethical Inquiry*, 10(3), 297-308.

Janssens, R. M., van Zadelhoff, E., van Loo, G., Widdershoven, G. A. and Molewijk, B. A. (2015) 'Evaluation and perceived results of moral case deliberation: a mixed methods study', *Nursing Ethics*, 22(8), 870-880.

Jensen, A. and Lidell, E. (2009) 'The influence of conscience in nursing', *Nursing Ethics*, 16(1), 31-42.

Jiménez-Herrera, M. F. and Axelsson, C. (2015) 'Some ethical conflicts in emergency care', *Nursing Ethics, 22(5), 548-560*.

Juthberg, C., Eriksson, S., Norberg, A. and Sundin, K. (2007) 'Perceptions of conscience in relation to stress of conscience', *Nursing Ethics*, 14(3), 329-343.

Juthberg, C., Eriksson, S., Norberg, A. and Sundin, K. (2008) 'Stress of conscience and perceptions of conscience in relation to burnout

among care-providers in older people', *Journal of Clinical Nursing*, 17(14), 1897-1906.

Kalkas, H. and Sarvimäki, A. (1987) *Omvårdnadens etiska grunder [SWE] [The ground for nursing ethics]* Stockholm: Almqvist & Wiksell.

Koskinen, C. and Lindström, U. Å. (2013) 'Listening to the Otherness of the Other: Envisioning Listening Based on a Hermeneutical Reading of Lévinas', *International Journal of Listening*, 27(3), 146-156.

Koskinen, C. and Lindström, U. Å. (2015) 'An envisioning about the caring in listening', *Scandinavian Journal of Caring Sciences*, 29(3), 548–554.

Kristensson Uggla, B. (1994) *Kommunikation på bristningsgränsen [SWE][Communication to the breaking point]*, Stockholm. Brutus Östlings bokförl.

Kristoffersen, M., Friberg, F. and Brinchmann, B. S. (2016) 'Experiences of moral challenges in everyday nursing practice: In light of healthcare professionals' self-understanding', *Nordic Journal of Nursing Research*, DOI: 10.1177 2057158516633633.

Kälvemark, S., Höglund, A. T., Hansson, M. G., Westerholm, P. and Arnetz, B. (2004) 'Living with conflicts-ethical dilemmas and moral distress in the health care system', *Social Science and Medicine*, 58(6), 1075-1084.

Langeland, K. and Sorlie, V. (2011) 'Ethical challenges in nursing emergency practice', *Journal of Clinical Nursing*, 20(13-14), 2064-2070.

Langston, D. C. (2001) *Conscience and other virtues*, Pennsylvania: The Pennsylvania State University Press.

Lantz, G. (1997) *Vårdetik : berättelsen om Arthur [SWE] [Nursing etics: the story about Arthur]* , Solna: Almqvist & Wiksell.

Latvala, E., Vuokila-Oikkonen, P. and Janhonen, S. (2000) 'Videotaped recording as a method of participant observation in psychiatric nursing research', *Journal of Advanced Nursing*, 31(5), 1252-1257.

Lillemoen, L. and Pedersen, R. (2013) 'Ethical challenges and how to develop ethics support in primary health care', *Nursing Ethics*, 20(1), 96-108.

Lillemoen, L. and Pedersen, R. (2015) 'Ethics reflection groups in community health services: an evaluation study', *BMC Medical Ethics*, 16: 25.

Lindseth, A., Marhaug, V., Norberg, A. and Uden, G. (1994) 'Registered nurses and physicians reflections on their narratives about ethically difficult care episodes', *Journal of Advanced Nursing,* 20(2), 245-250.

Lindseth, A. and Norberg, A. (2004) 'A phenomenological hermeneutical method for researching lived experience', *Scandinavian Journal of Caring Sciences*, 18(2), 145-53.

Lipari, L. (2009) 'Listening otherwise: The voice of ethics', *The International Journal of Listening,* 23(1), 44-59.

Lützén, K., Cronqvist, A., Magnusson, A. and Andersson, L. (2003) 'Moral stress: Synthesis of a concept', *Nursing Ethics*, 10(3), 312-322.

Lützén, K. and Kvist, B. E. (2012) 'Moral distress: a comparative analysis of theoretical understandings and inter-related concepts', *Health Care Ethics Commitee Forum,* 24(1), 13-25.

Løgstrup, K. E. (1968*) Opgør med Kierkegaard [DEN] [Encounter with Kierkegaard],* Copenhagen.

Løgstrup, K. E. (1994) *Det etiska kravet [SWE][The Ethical demand],* Göteborg: Daidalos.

Mavrou, K., Graeme D & Lewis A (2007) 'The use of Transana as a videoanalysis tool in researching computer-based collaborative learning in inclusive classrooms in Cyprus', *International Journal of Research & Method in Education,* 30, 163-178.

Mays, N. and Pope, C. (1995) 'Qualitative research: observational methods in health care settings', *British Medical Journal*, 311, 182-184.

Molewijk, B., Hem, M. H. and Pedersen, R. (2015) 'Dealing with ethical challenges: a focus group study with professionals in mental health care', *BMC Medical Ethics,* 16:4.

Molewijk, B., Kleinlugtenbelt, D. and Widdershoven, G. (2011) 'The role of emotions in moral case deliberation: theory, practice, and methodology', *Bioethics,* 25(7), 383-393.

Molewijk, B., Verkerk, M., Milius, H. and Widdershoven, G. (2008a) 'Implementing moral case deliberation in a psychiatric hospital: process and outcome', *Medicine, Health Care, and Philosophy*, 11(1), 43-56.

Molewijk.B, Abma, T., Stolper, M. and Widdershoven, G. (2008b) 'Teaching ethics in the clinic. The theory and practice of moral case deliberation', *Journal of Medical Ethics,* 34(2), 120-124.

Nelson, C. (2012) 'The familiar foundation and the fuller sense: ethics consultation and narrative', *Permanente Journal,* 16(2), 60-63.

Norberg, A., Bergsten, M. and Lundman, B. (2001) 'A model of consolation', *Nursing Ethics,* 8(6), 544-553.

Nordam, A., Torjuul, K. and Sorlie, V. (2005) 'Ethical challenges in the care of older people and risk of being burned out among male nurses', *Journal of Clinical Nursing,* 14(10), 1248-1256.

Nortvedt, P. (2003) 'Subjectivity and vulnerability: reflections on the foundation of ethical sensibility', *Nursing Philosophy,* 4(3), 222-230.

Nussbaum, M. C. (1995) 'Emotions and women's capabilities' in Glover, J. and Nussbaum, M. C., eds., *Women, culture, and development [Elektronic resourse]*, Oxford Oxford University Press Scholarship online.

Nussbaum, M. C. (2001) *Upheavals of thought: the intelligence of emotions,* Cambridge: Cambridge University Press.

Oberle, K. and Hughes, D. (2001) 'Doctors' and nurses' perceptions of ethical problems in end-of-life decisions', *Journal of Advanced Nursing,* 33(6), 707-715.

Oerlemans, A., JM, van Sluisveld, N., e, van Leeuwen, E., S,J, Wollersheim, H., Dekkers, W. J. and Zegers, M. (2015) 'Ethical problems in intensive care unit admission and discharge decisions: a qualitative study among physicians and nurses in the Netherlands', *BMC Medical Ethics*, 16:9.

Pavlish, C., Brown-Saltzman, K., Fine, A. and Jakel, P. (2015) 'A culture of avoidance: voices from inside ethically difficult clinical situations', *Clinical Journal of Oncology Nursing,* 19(2),159-165.

Pavlish, C., Brown-Saltzman, K., Jakel, P. and Fine, A. (2014) 'The nature of ethical conflicts and the meaning of moral community in oncology practice', *Oncology Nursing Forum*, 41(2), 130-140.

Pedersen, R., Akre, V. and Førde, R. (2009 a) 'What is happening during case deliberations in clinical ethics committees? A pilot study', *Journal of Medical Ethics,* 35(3), 147-152.

Pedersen, R., Akre, V. and Førde, R. (2009 b) 'Barriers and challenges in clinical ethics consultations: the experiences of nine clinical ethics committees', *Bioethics,* 23(8), 460-469.

Pelto-Piri, V., Engström, K. and Engström, I. (2012) 'The ethical landscape of professional care in everyday practice as perceived by staff: A qualitative content analysis of ethical diaries written by staff in child and adolescent psychiatric in-patient care', *BMC Child and Adolescent Psychiatry and Mental Health*, 6:18.

Pelto-Piri, V., Engström, K. and Engström, I. (2013) 'Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care', *BMC Medical Ethics*, 14:49.

Pelto-Piri, V., Engström, K. and Engström, I. (2014) 'Staffs' perceptions of the ethical landscape in psychiatric inpatient care: A qualitative content analysis of ethical diaries', *Clinical Ethics*, 9(1), 45-52.

Peter, E. and Liaschenko, J. (2004) 'Perils of proximity: a spatiotemporal analysis of moral distress and moral ambiguity', *Nursing Inquiry*, 11(4), 218-225.

Rasoal, D., Kihlgren, A., James, I. and Svantesson, M. (2015) 'What healthcare teams find ethically difficult: Captured in 70 moral case deliberations', *Nursing Ethics* [E pub ahead of print DOI:101177/09673301583928.

Redman, B. K. and Fry, S. T. (2000) 'Nurses' ethical conflicts: What is really known about them?', *Nursing Ethics*, 7(4), 360-366.

Rees, J., King, L. and Schmitz, K. (2009) 'Nurses' perceptions of ethical issues in the care of older people', *Nursing Ethics*, 16(4), 436-452.

Reiter-Theil, S. (2003) 'Balancing the perspectives. The patient's role in clinical ethics consultation', *Medicine, Health Care and Philosophy*, 6(3), 247-254.

Ricoeur, P. (1992) *Oneself as Another*, Chicago: The University of Chicago Press.

Ricœur, P. and Thompson, J. B. (1981) *Hermeneutics and the human sciences : essays on language, action and interpretation*, Cambridge: Cambridge University Press.

Ricoeur,P. (1976) *Interpretation Theory: Discourse and surplus of meaning*, Fort Worth: Texas Christian University Press.

Rushton, C. H., Kaszniak, A. W. and Halifax, J. S. (2013) 'A framework for understanding moral distress among palliative care clinicians', *Journal of Palliative Medicine*, 16(9), 1074-1079.

Sandelowski, M. (1996) 'One is the liveliest number: The case orientation of qualitative research', *Research in Nursing and Health*, 19(6), 525-529.

Sandelowski, M. (2011) 'When a cigar is not just a cigar: Alternative takes on data and data analysis', *Research in Nursing and Health*, 34(4), 342-352.

Sarvimäki, A. and Stenbock-Hult, B. (2008) *Omvårdnadens etik : sjuksköterskan och det moraliska rummet [SWE] [Nursing ethics: the nurse and the moral space]*, Stockholm: Liber.

Schreier, M. (2012) *Qualitative content analysis in practice*, London: SAGE Publicaions.

Severinsson, E. (2003) 'Moral stress and burnout: qualitative content analysis', *Nursing & Health Sciences*, 5(1), 59-66.

Silén, M., Haglund, K., Hansson, M. G. and Ramklint, M. (2015) 'Ethics rounds do not improve the handling of ethical issues by psychiatric staff', *Nordic Journal of Psychiatry*, 69(6), 1700-1707.

Silén, M., Svantesson, M. and Ahlström, G. (2008) 'Nurses' conceptions of decision making concerning life-sustaining treatment', *Nursing Ethics*, 15(2), 160-173.

Silén, M., Svantesson, M., Kjellström, S., Sidenvall, B. and Christensson, L. (2011) 'Moral distress and ethical climate in a Swedish nursing context: perceptions and instrument usability', *Journal of Clinical Nursing*, 20(23-24), 3483-3493.

Silfverberg, G. (2005) *Ovisshetens etik [SWE] [The ethics of uncertainty]*, Nora: Nya Doxa.

Singer, J. A. (2004) 'Narrative identity and meaning making across the adult lifespan: An introduction', *Journal of Personality*, 72(3), 437-460.

Slowther, A., M, McClimans, L. and Price, C. (2012) 'Development of clinical ethics services in the UK: a national survey', *Journal of Medical Ethics*, 38(4), 210-214.

Sorta-Bilajac, I., Baždarić, K., Brozović, B. and Agich, G. J. (2008) 'Croatian physicians' and nurses' experience with ethical issues in clinical practice', *Journal of Medical Ethics*, 34(6), 450-455.

Sporrong, S. K., Arnetz, B., Hansson, M. G., Westerholm, P. and Höglund, A. T. (2007) 'Developing ethical competence in health care organizations', *Nursing Ethics*, 14(6), 825-837.

Steinkamp, N., Gordijn, B., Borovecki, A., Gefenas, E., Glasa, J., Guerrier, M., Meulenbergs, T., Różyńska, J. and Slowther, A. (2007) 'Regulation of healthcare ethics committees in Europe', *Medicine, Health Care and Philosophy*, 10(4), 461-475.

Stolper, M., Molewijk, B. and Widdershoven, G. (2015) 'Learning by doing. Training health care professionals to become facilitator of moral case deliberation', *Health Care Ethics Commitees Forum* 27 (1), 47-59.

Strech, D., Hurst, S. and Danis, M. (2010) 'The role of ethics committees and ethics consultation in allocation decisions: a four-stage process', *Medical Care*, 48(9), 821-826.

Svantesson, M., Anderzen-Carlsson, A., Thorsen, H., Kallenberg, K. and Ahlström, G. (2008a) 'Interprofessional ethics rounds concerning dialysis patients: staff's ethical reflections before and after rounds', *Journal of Medical Ethics*, 34(5), 407-413.

Svantesson, M., Löfmark, R., Thorsen, H., Kallenberg, K. and Ahlström, G. (2008b) 'Learning a way through ethical problems: Swedish nurses' and doctors' experiences from one model of ethics rounds', *Journal of Medical Ethics*, 34(5), 399-406.

Svantesson, M., Sjökvist, P. and Thorsen, H. (2003) 'End-of-life decisions in Swedish ICUs. How do physicians from the admitting department reason?', *Intensive and Critical Care Nursing*, 19(4), 241-251.

Söderberg, A. (1999) *The practical wisdom of enrolled nurses, registered nurses and physicians in situations of ethical difficulty in intensive care.* Medical Dissertations, Department of Nursing, Umeå University.

Söderberg, A., Gilje, F. and Norberg, A. (1997) 'Dignity in situations of ethical difficulty in intensive care', *Intensive and Critical Care Nursing*, 13(3), 135-144.

Sørlie, V. (2001) *Being in ethically difficult care situations: narrative interviews with registered nurses and physicians within internal medicine, oncology and paediatrics*, Medical Dissertations, Department of Nursing, Umeå University.

Sørlie, V., Førde, R., Lindseth, A. and Norberg, A. (2001) 'Male physicians' narratives about being in ethically difficult care situations in paediatrics', *Social Science and Medicine*, 53(5), 657-667.

Sørlie, V., Jansson, L. and Norberg, A. (2003a) 'The meaning of being in ethically difficult care situations in paediatric care as narrated by female registered nurses', *Scandinavian Journal of Caring Sciences*, 17(3), 285-292.

Sørlie, V., Kihlgren, A. and Kihlgren, M. (2005) 'Meeting ethical challenges in acute nursing care as narrated by registered nurses', *Nursing Ethics*, 12(2), 133-142.

Sørlie, V., Lindseth, A., Førde, R. and Norberg, A. (2003b) 'The meaning of being in ethically difficult care situations in pediatrics as narrated by male registered nurses', *Journal of Pediatric Nursing*, 18(5), 350-357.

Sørlie, V., Lindseth, A., Uden, G. and Norberg, A. (2000) 'Women physicians' narratives about being in ethically difficult care situations in paediatrics', *Nursing Ethics*, 7(1), 47-62.

Tamura, M. K., Goldstein, M. K. and Pérez-Stable, E. J. (2009) 'Preferences for dialysis withdrawal and engagement in advance care planning within a diverse sample of dialysis patients', *Nephrology Dialysis Transplantation*, 25(1), 237-42.

Tapper, E. B. (2013) 'Consults for conflict: the history of ethics consultation', *Baylor University Medical Center Proceedings*, 26(4), 417-422.

Tapper, E. B., Vercler, C. J., Cruze, D. and Sexson, W. (2010) Ethics consultation at a large urban public teaching hospital, *Mayo Clinic Proceedings, 85(5), 433-438.*

Thomas, T. A. and McCullough, L. B. (2015) 'A philosophical taxonomy of ethically significant moral distress', *Journal of Medicine and Philosophy*, 40(1), 102-120.

Torjuul, K., Nordam, A. and Sorlie, V. (2005) 'Action ethical dilemmas in surgery: an interview study of practicing surgeons', *BMC Medical Ethics*, 6:7.

Tuvesson, H., Eklund, M. and Wann-Hansson, C. (2012) 'Stress of Conscience among psychiatric nursing staff in relation to environmental and individual factors', *Nursing Ethics*, 19(2), 208-219.

Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M. and Grady, C. (2007) 'Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States', *Social Science and Medicine*, 65(8), 1708-1719.

de Vries, M. C., Houtlosser, M., Wit, J. M., Engberts, D. P., Bresters, D., Kaspers, G. J. and van Leeuwen, E. (2011) 'Ethical issues at the interface of clinical care and research practice in pediatric oncology: a narrative review of parents' and physicians' experiences', *BMC Medical Ethics*, 12:18.

Weidema, F. C., Molewijk, B. A. C., Kamsteeg, F. and Widdershoven, G. A. M. (2013) 'Aims and harvest of moral case deliberation', *Nursing Ethics*, 20(6), 617-631.

Weise, K. L. and Daly, B. J. (2014) 'Exploring accountability of clinical ethics consultants: practice and training implications', *The American Journal of Bioethics*, 14(6), 34-41.

Widdershoven, G., Abma, T. and Molewijk, B. (2009) 'Empirical ethics as dialogical practice', *Bioethics*, 23(4), 236-248.

Widdershoven, G. A. (2001) 'Dialogue in evaluation: a hermeneutic perspective', *Evaluation*, 7(2), 253-263.

Åhlin, J., Ericson-Lidman, E., Eriksson, S., Norberg, A. and Strandberg, G. (2013) 'Longitudinal relationships between stress of conscience and concepts of importance', *Nursing Ethics*, 20(8), 927-942.

Åhlin, J., Ericson-Lidman, E., Norberg, A. and Strandberg, G. (2014) 'Care providers' experiences of guidelines in daily work at a municipal residential care facility for older people', *Scandinavian Journal of Caring Sciences*, 28(2), 355-363.