Zeitschrift: Bulletin / Vereinigung der Schweizerischen Hochschuldozierenden = Association Suisse des Enseignant-e-s d'Université

Band: 42 (2016)

Heft: 2

Artikel: "Ethics in nursing? So what?" : Do we really need ethics in nursing?

Autor: Sala Defilippis, Tiziana

DOI: https://doi.org/10.5169/seals-893876

"Ethics in nursing? So what?" Do we really need ethics in nursing?

Tiziana Sala Defilippis*

"Ethics is ethics and there is no need for a nursing perspective. Why do nurses need ethics if all the important decisions are taken by others? The important thing is that nurses are willing to carry out prescriptions and medical orders".

Such questions and statements are frequently voiced. Sometimes I get angry, and sometimes I have to smile. Nevertheless, these remarks are legitimate, and deserve a clear and satisfactory answer. Probably in all of medicine, but certainly in nursing, we support the great ideas that periodically emerge: nursing theories, nursing process, clinical assessment, etc. Ethics is one of those things that nurses have always considered in their daily work but they have not always done so consciously. Recently, we have started to teach ethics across all nursing curricula (diploma, bachelor, and Masters level). However, this does not explain if and why ethics are pivotal to the nursing profession.

Many situations in practice, in which ethics clearly failed, come to mind. Sometimes the importance of something is easier to grasp if it is absent. Ethics is one of those things. Periodically, newspapers and television report scandals in healthcare institutions. In Switzerland, one of the latest scandals involved a nursing home in the south of the country, where a healthcare assistant apparently verbally and physically abused elderly patients suffering from dementia. This case came to light because an apprentice healthcare assistant made it public. It appears that some of the co-workers were aware of the abuse. However, it remains unclear whether they also took action or not. A trial is now pending. In previous cases, misconduct has already been declared. For example, there was the scandal at the *Pflegezentrum Entlisberg* in Zurich where elderly patients with dementia had been abused. These abuses had been filmed by four healthcare professionals who have themselves been convicted. These healthcare professionals are now subject to probation measures. Such cases provoke indignation, shame, and anger among the population. In all these cases, the healthcare professionals as well as the management were expected to have ethically correct behaviour. In fact, we are to believe that if these professionals had displayed ethically correct behaviour, these horrible scandals would not have happened. I therefore believe that we all agree that there is a need for ethics, even though we could argue that common sense should be enough to prevent such gruesome episodes.

This contribution aims at highlighting the need for ethics in nursing practice, and the way nursing ethics can contribute to the ethics discourse in healthcare. A brief overview of the history of nursing ethics will be provided, a definition of nursing, and a discussion of nursing's moral practice. In addition, the challenges nurses encounter in their daily work will be described. A short description of the nursing ethics perspective will conclude this contribution.

1. A Brief History of Nursing Ethics

Lacking common sense does not constitute a sufficient reason for such incidents to take place; most of us would agree that there is a clear lack of professionalism. A profession possesses a recognized body of knowledge. The admission to practice is based on standards of competence attested by examination. Every member of the profession is expected to recognize the responsibility to advance and extend the body of knowledge. As part of a profession, its members recognise and adhere to a high standard of ethics and professional conduct [1]. The latter point here is the most interesting. The first code of ethics and conduct for nurses was written in 1950 in the USA. However, the ANA (American Nurses Association) already discussed the need for a code of ethics as early as 1896 [2]. Discussions of ethics in nursing had started even earlier, namely in 1888. The publication of the first nursing journal, *The Trained Nurse and Hospital Review*, provided a series on ethics. Although not mentioned explicitly, ethics was part of nursing education in the form of the Nightingale Pledge. This pledge was composed by Lystra Gretter, an instructor of nursing at Harper Hospital

* Scuola universitaria professionale della Svizzera italiana, Dipartimento sanità, Galleria 2, 6928 Manno.

E-mail: *tiziana.sala@supsi.ch*
www.dsan.supsi.ch

Tiziana Sala Defilippis, RN, BScN, MScN, PhD cand, born in 1976 in Sorengo, after 10 years working as an intensive care nurse in Zurich and six months in Afghanistan in a war victims NGO, she graduated with a bachelor and a master in nursing sciences at the University of Dundee UK. She is currently enrolled as a PhD student in Nursing Ethics at the University of Surrey, UK under the supervision of Professor A. Gallagher. Her dissertation focuses on moral resilience among nurses. She works as a lecturer and a researcher at the University of Applied Sciences of Southern Switzerland.

Florence Nightingale was born in Florence, Italy, on May 12, 1820 (hence her name). Her Victorian family was well-educated, affluent and aristocratic. Florence's father educated her in a more rigorous way than other young women of her time; she was tutored in mathematics, language, religion and philosophy [4]. She was a very religious woman and was persuaded that God spoke to her and called her to serve as a nurse [5]. She completed her three-months training as a nurse in 1851 in Kaiserswerth, Germany, in a Protestant religious community with a hospital facility. Back in the UK, she became superintendent of the Hospital for Invalid Gentlewomen in London in 1853. She was then asked to go to Scutary, Turkey, during the Crimean war. She arrived there in 1854 with 34 colleagues and immediately set to cleaning the place, considering this the most important element for improving the health of the soldiers [4]. After the war she returned to England and was honoured by Queen Victoria for her work. She invested the money from her honour in the teaching institutions at St. Thomas' Hospital and King's College Hospital. Soon she started to receive requests to establish new schools at hospitals worldwide, and thus modern nursing was born. Nightingale remained influential for a long time. The fact that nursing in Europe remained a vocation for a long time was partly due to her influence. Due to her religious beliefs, Nightingale opposed the vision of nursing as a profession throughout her life [3].

This perspective also delayed the development of codes of ethics in Europe. The first UK Code of Ethics was published in 1983 [3]; whereas the International Council of Nurses (ICN) published the first version of the International Code of Ethics for Nurses in 1953 [6].

in Detroit, and was taken then as it is now by nurses. By naming the Pledge after Florence Nightingale, the founder of modern nursing was acknowledged. The Pledge was an adaptation of the Hippocratic Oath, which medical students then and now take. The Florence Nightingale Pledge was first used by a graduating class in 1893. It states:

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

The Nightingale Pledge continues to be used in some English speaking countries. The Pledge has been revised in 1935. There are various criticisms of this text, especially due to the reference to God and helping physicians. It is maintained that the former should be eliminated, and the latter should be replaced by more inclusive language. Nevertheless, its ethical dimension cannot be overlooked. It is beyond doubt that the Nightingale Pledge influenced nursing ethics in the past, and continues to do so, especially in the way that it contextualizes parts of the ANA Code of Ethics [2]. The preface of the latest version of the ANA Code of Ethics [2] states: "A code of ethics stands as a central and necessary mark of a profession. It functions as a general guide for the profession's members and as a social contract with the public that it serves." (p. xi).

2. Nursing Ethics in Education

In the USA (California), ethics education was introduced into the nursing curricula in 1916. One year later, the *National League for Nursing Education* established curricular requirements for ethics in nursing education [3]. Owing to the presence of religious persons in the caring profession who understood nursing more as a vocation than as a profession, nursing in Europe remained hostage to religious thinking for longer compared to the USA [3].

Between 1970 and 1980, the schools of medicine in the USA introduced bioethics courses. These courses were opened to and subsequently attended by nurses. When Professor Jonsen opened his course in medical ethics at the University of California, San Francisco, more nurses were participating than medical students (Jameton [7]. According to Jameton [7], these courses emphasized physicians, often males, as the central or representative actor in the clinician-patient relationship. Nurses were generally excluded. This should not be a surprise as in 1981, Veatch [8] defined nursing ethics as *"a legitimate, if very limited, term referring to a field that is a sub-category of medical ethics"* (p. 17). Physicians focused more on understanding dilemmas emerging from conflicts between theoretical principles and the physician-patient relationship, or major ethical theories such as utilitarianism and deontology. In contrast, nurses were more concerned with practical care issues such as the nurse-patient relationship, the nurse-physician relationship including issues of power, inequality and assertiveness. These latter problems characterise the feminist literature, which was not prominent at the inception of bioethics [7].

As nurses attended bioethics courses, ethicists came into contact with nurses' realities. For nurses, the

main ethical preoccupations related to institutional life, such as delegation, scope of discretion, managerial responsibility, the role of management, fairness among employees, public relation, etc. [7]. In addition to these contrasting interests, nurses displayed a different way of dealing with moral problems, showing less confidence in their view and little hope of getting support from physicians and managers [7]. Such premises set the conditions for a new term: *moral distress*.

3. The Contribution of Moral Distress to Nursing Ethics

It is in this climate that the term 'moral distress' was coined. In his book *Nursing Practice: The Ethical Issues*, Jameton [9] defined moral distress as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Jameton differentiated moral distress from moral uncertainty, where someone is unsure about what moral values or principles to apply and from moral dilemmas which arise when two or more clear moral principle apply [9].

This was in 1984. Jameton could not have imagined the effect the term "moral distress" would have in the history of nursing ethics. By naming the phenomenon, nurses finally had a term to name their unease. Through this term, other healthcare professionals and ethicists realised that nurses have their own moral perspective of patient care and on healthcare organizations.

Based on revised definitions of moral distress by Corley *et al.* in 2001 [10], the *Moral Distress Scale* was developed and tested for intensive care nurses. Other scales and instruments were developed in order to measure moral distress among nurses in terms of frequency and intensity. All studies demonstrated that nurses are subject to moral distress in terms of intensity and frequency [11, 12]. Many journal special issues were dedicated to the theme of moral distress. Moral distress has been studied in relation to all the possible socio-demographic variables such as age, gender, ethnicity, education, years of professional experience, etc. Findings are heterogeneous, which makes it hard to deal with this phenomenon. Nevertheless, the phenomenon is serious as it represents one of the causes for burnout in nurses and for them to leave the profession [11]. Moral distress has physical and psychological consequences. Physically, moral distress can cause headaches, muscular, neck and stomach pain [16], sleeplessness and nightmares [16, 17], and loss of appetite [17]. Psychological consequences of moral distress include frustration [16–19], anger [16, 20, 21], anxiety [20, 21], depression [17, 21, 22], self-blame [23], loss of self-worth [17, 18, 21, 23], which in turn lead to diminished work engagement [13], lower job satisfaction [14], and high emotional exhaustion [15]. All these consequences possibly explain why nurses decide to leave their profession [21, 24–30]. Nurses employ predominantly negative coping strategies in response to moral distress, which directly affect quality of care. Avoidance of engagement [16, 26, 31, 32] turns out to be one of nurses' main coping strategies, which inevitably negatively influences quality of care.

The debate around the term "moral distress" is ongoing. At least, the term has the merit of forcing other healthcare professionals to acknowledge that nursing is an ethical practice, that nurses are concerned with different ethical issues, and that nurses have different perspectives and ethical conflicts.

4. Nursing as an Ethical Practice and its Moral Component

MacIntyre [33] stated that nursing practice is carried out in a socially established way. By entering into practice, the person needs to accept standards, subordinating attitudes, preferences and her or his own taste for them [33]. This implies two further characteristics of practice: a) it must display a certain degree of complexity, which needs collaboration and knowledge; b) by entering into a practice the individual must reject any hedonistic motivation.

In order to understand nursing practice better, the definition of practice by MacIntyre will be introduced [33]:

"By a 'practice' I am going to mean any coherent and complex from of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (p. 218).

First of all, practice must be carried out within a community that guarantees collaboration and coherence. The community must have a shared knowledge of the practice. There is no doubt that nursing is carried out within a community that has shared knowledge. Practices have internal and external goods. External goods are external rewards, which are not specific to any given practice. Internal goods are virtues, which are exercised for their own sake, and with the aim of achieving standards of excellence. Internal goods can

only be appreciated and judged by individuals who engage in the practice.

For MacIntyre [33] internal goods are virtues because they represent the means for achieving standards of excellence. The virtues nurses should possess and exercise in the right means are, according to Begley [39], practical wisdom (prudence), theoretical wisdom (knowledge), justice (as fairness), competence (skills), compassion, understanding, benevolence, imagination, integrity, deliberation, honesty, diligence, veracity, perseverance, courtesy, generosity, kindness, genuineness, patience, tolerance, courage.

Nursing practice's ultimate goals and, thus, the standard of excellence, are to alleviate pain and suffering, maintain patients' dignity, promote recovery, enhance quality of life, and offer comfort [34, 35, 38, 40, 41]. Unfortunately, these goods of excellence clash in reality with the goods of effectiveness often pursued by organisations and within healthcare systems that controls nurses' practice [42].

All the standards of excellence are part of caring, which is central to nursing. Caring represents the uniqueness of nursing's perspective. According to Holt *et al.* [43], the moral component of nursing is represented by caring. Literature on caring in nursing is abundant and research has been carried out with the aim of defining caring from a general and from a specific perspective, such as in intensive care units, end-of-life care, oncology units, education, cross-cultural care, etc. [44–55]. The fact that so many experts have researched and are still researching caring indicates little agreement on its meaning. In his sharp critique of the attempt of defining caring, Paley [56] concluded that there will never be a consensus. Paley [56] analysed in a sarcastic but very lucid way all the attempts made in order to clarify the concept of caring: "Each author notes that caring is elusive, complex, ambiguous or vague, and then offers an analysis designed to bring order to the confusion – only to be followed by yet another author, who does exactly the same thing" (p. 189). According to Paley [56], who followed the analysis of knowledge conducted by Foucault, this is due to the tools used by researchers to describe the concept of caring. The knowledge that emerges from studies is a list of 'things said', associations and resemblances that are constantly repeated and extended with each new finding. This leads to a plethora of knowledge, which cannot be tested and, therefore, can neither be accepted nor refused. Trying to find a clear definition for caring is, according to Paley [56], an endless and probably senseless effort. Nevertheless, it is worth an attempt. According to Tronto [57], care should be understood as a process that encompasses four phases: *caring about*, which encompasses the recognition that there is a need for care; *caring for*, which implies the assumption of responsibility to meet the need; *care giving*, which is the practical activity of delivering care; and *care receiving*, which understands how to evaluate if the needs were met. If the phases of the process are fulfilled and integrated holistically, then good care has probably been delivered. All these caring phases have a moral connotation, which represent the moral obligation of nursing. According to Gastmans [58], nurses show this attitude by respecting patients, being available to patients, and step beyond their personal values, taking up the patients' values in order to better understand their condition.

Therefore, the nurse patient-relationship is pivotal for nursing. Indeed, the nurse-patient relationship represents "the vehicle through which the work of nursing is accomplished" (Peter & Liaschenko p. 219) [59]. Entire nursing theories have been developed around this assumption, for example, Watson's theory of human caring [60]. Watson [60] believed that the personal caring relationship is the foundation of nursing. She emphasised the importance of "the transpersonal caring relationship" [60], which involves the nurse's moral commitment in protecting, promoting, enhancing, and potentiating the human patient's dignity.

Tschudin [61] entitled her book: *Nursing ethics. The caring relationship.* She discussed the characteristics of caring by referring to Roach's [62] work, which details caring as consisting of compassion, competence, confidence, conscience, and commitment. These characteristics are the premise for a caring relationship.

5. Moral Challenges in Nursing

Varcoe *et al.* [63] described the several sources of tension around ethical nursing practice, describing nursing as "working in-betweens" (p.321). This refers to the fact that nurses often find themselves in fields of tension, such as between patients and other healthcare providers (especially physicians), between family members and patients, between different family members, between staff members and managers. This is probably due to the fact that nursing is only one of many practices within a healthcare organisation. Each practice has its own internal goods and final goals, which are not always convergent. The idea of what is in the patients' best interests can vary between nurses and physicians, between the patients and their loved ones, or between nurses and patients. Even within nursing practice, internal goods

are not always shared. These tension fields represent the source of nurses' moral challenges.

The tension field between nurses and physicians represents a major source for moral challenges. On this issue Austin [64] asserts:

"It is true that, although as health professionals we accept responsibility for competent, compassionate, ethical care and treatment, we do not genuinely have control over what unfolds for patients and families. Often responsibility is not aligned with the necessary power, and sometimes the responsibility can be too great and beyond the lone (and lonely) efforts of the individual." (p. 29)

Austin [64] points to the fact that there can be a difference of opinion. In addition, there is also a clear difference in decision-making power between nurses and physicians. Oberle and Hughes [65] stated: "The key difference between the groups was that doctors are responsible for making decisions and nurses must live with these decisions" (p. 707). Austin [64] suggested that this difference is given by the different mandates and expectations society entrusts to healthcare professionals. She gives the example of psychiatry, where society expects physicians to deal with and, thus, solve societal problems that have to do with persons who deviate from the norm. These problems include violent people who threaten others (and should, therefore, be hospitalized), or persons who reject medical treatments (and who are, therefore, to be certified as incompetent). Another example is given of paediatric intensive care where society clearly expects from physicians not to let children die [63]. Nurses have a different position and a different mandate, which finds expression in nursing's moral practice. The main sources for tensions between physicians and nurses then become interest-related issues, in which nurses take the role of patient advocate, especially if it concerns what nurses consider as futile treatment or carrying out tests and treatments, etc. when patients are dying [11]. The final decision is the physicians'. However, nurses have to live with the consequences of such decisions for the patients, and with their own conscience for either speaking up or not.

Conflicts with patients and/or patients' family members represent another source of tension for nurses' moral life. Indeed, situations such as following a patient's or family's wishes to continue life support, even though it is not in the best interests of the patient, represent a serious challenge to nurses. On the one hand, they acknowledge the right for autonomy, on the other hand, nurses find that such situations are only prolonging the patient's suffering [10].

Nurses are also challenged by managers and institutions and healthcare organisations. A few years ago, the Swiss Academy of Medial Sciences SAMS [66] published a position statement titled *Medizin und* Ökonomie – *wie weiter?* As part of this publication, interesting quotes were offered from interviews, in order to understand the effects of economic constraints on healthcare. In doing so, the SAMS quoted a nurse (original in German). This nurse was responding to a woman, who had asked her, why she did not get the help she needed during mobilisation. The nurse stated:

"Right now, I have absolutely no time for you, I simply have no time. And then I thought to myself: what kind of person are you? You are just leaving your patient in bed. This is ethically wrong, if she now gets pneumonia because you left her in bed... But I really could not do otherwise. I then went home and I thought to myself I have never been like that." (p.20)

Economic constraints influence nurses significantly in their daily work. These constraints potentially set the conditions for nurse staffing levels that have to be considered unsafe, or working with healthcare assistants who are not as competent as patient care requires, etc. [10]. These situations prevent nurses from carrying out their daily work at a high quality level.

As discussed above, moral distress arises when one knows the right thing to do but constraints make it nearly impossible to pursue the right course of action. Though it is hard to believe that nurses always know what the right thing to do is, they suffer from moral challenges, some of which are similar or even in common with other healthcare professionals, while other challenges specifically address nursing's moral practice.

6. Nursing's Ethical Perspective

Nursing's ethical perspective should be seen as an additional value to the ethical dimension of healthcare. Although nurses are not normally allowed to take core decisions in their role and position within the healthcare team, I argue that their opinion would enrich the discussion, and should, therefore, be taken into account, while deliberating on care decisions. Indeed, nurses' concerns should be addressed.

From the 1970s onward, nurses have tried to adopt the principles of bioethics or medical ethics, and adapt them to the discipline of nursing. However,

nurses have some difficulty in internalising deontological codes of conduct and bioethical principles because these offer little guidance in everyday practice. In recent years, much emphasis has been placed on virtue ethics and care ethics among nursing ethicists. The fact that virtue ethics is closer to nursing practice is demonstrated by the instinctive way nurses seek advice in uncertain situations, is a long way from declaring and respecting principles. Indeed, the majority of nurses argue from their own ethical stance, reflecting on their own values, and this has much to do with virtue ethics [67]. The virtues that (should) guide nurses in their daily practice are practical wisdom (prudence); theoretical wisdom (knowledge); justice (as fairness); competence (skills); compassion; understanding; benevolence, etc. [39]. In addition, nurses are much concerned with all the issues addressing vulnerability, autonomy, advocacy etc., which find an answer and guidance in care ethics.

If we accept that moral behaviour and moral decisions should not only be informed by reason, and, thus, by a possibly detached analysis but by emotions as well, as suggested by Banks and Gallagher [68], then it is not difficult to see that indeed there is a nursing ethics perspective.

Conclusion

The healthcare systems and society need ethical nurses, that is to say nurses with ethical competence. The nursing profession can be defined as a moral practice carried out for the good of the community and society. According to MacIntyre's definition of practice, nursing is a practice that has a shared knowledge, is carried out within a community, and its internal goods are represented by virtues such as practical wisdom (prudence); theoretical wisdom (knowledge); justice (as fairness); competence (skills) and further virtues as listed above.

Even though the history of nursing ethics goes back to the late 1800s, and the first code of ethics was published in 1950 in the United States, nursing ethics today has still some difficulty in being accepted, and sometimes it is still considered to be part of bioethics as in the 1980s. In addition to this, nursing ethics is still regularly seen as a kind of extra, if there is time or money to squeeze it in. This is too often the managers' and financiers' point of view. For nurses, it is then a question of defending their beliefs and practice, and to ensure that they are taught and can practice nursing ethics. Trying to squeeze nursing ethics into bioethics or medical ethics and not, can be evaluated as partially responsible for nurses' malaise that took the name of "moral distress". Moral distress has the merit of having brought to light the moral difficulties nurses encounter in their daily practice.

The uniqueness of the nursing perspective of problems as well as on approaches has brought nurses closer to virtue ethics and care ethics. Including nurses into health-related ethics can represent a chance for enriching the discourse while honouring a unique profession. On the uniqueness of caring, Tschudin [61], a pioneer of nursing ethics in Europe and worldwide, wrote:

"Caring is not unique to nursing, but it is unique in nursing. Nursing is a practical hands-on job, where experience, emotion, affection and relationship make up the bulk of everyday work. Caring is about people. It is done with people, for people, to people and as people. It is this last aspect that makes caring unique: people relate to people, one person relates to another person." (p. 1) ■

References

1. Basford, L. and O. Slevin, *Theory and practice of nursing: an integrated approach to caring practice.* 2nd ed. ed. 2003, Cheltenham: Nelson Thornes.

2. Fowler, M.D.M., *Guide to the Code of Ethics for Nurses.* 2nd ed. 2015, Silver Springs: American Nurses Association.

3. Fowler, M.D.M. and V. Tschudin, Ethics in nursing: an historical perspective, (13–26) IN *Essentials of Teaching and Learning in Nursing Ethics*, A.J. Davis, V. Tschudin, and L. De Raeve, Editors. 2006, Edinburgh: Churchill Livingstone Elsevier.

4. Pfettscher, S.A., Florence Nightingale, IN *Nurisng Theorists and Their Work*, A. Marriner Tomey and M.R. Alligood, Editors. 2006, Mosby Elsevier: St. Louis.

5. Holliday, M.E. and D.L. Parker, Florence Nightingale, feminism and nursing. J *Adv Nurs*, 1997. **26**(3): p. 483–8.

6. International Council of Nurses. *Code of Ethics for Nurses. http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/* (28 April 2016)

7. Jameton, A., A Reflection on Moral Distress in Nursing Together With a Current Application of the Concept. *J Bioeth Inq*, 2013. **10**(3): p. 297–308.

8. Veatch, R.M., Nursing ethics, physician ethics, and medical ethics. *Law Med Health Care*, 1981. **9**(5): p. 17–9.

9. Jameton, A., *Nursing practice: the ethical issues.* Prentice-Hall series in the philosophy of medicine. 1984, Englewood Cliffs: Prentice-Hall.

10. Corley, M.C., *et al.*, Development and evaluation of a moral distress scale. *J Adv Nurs*, 2001. **33**(2): p. 250–256.

11. Oh, Y. and C. Gastmans, Moral distress experienced by nurses: A quantitative literature review. *Nurs Ethics*, 2013: p. 1–17.

12. McCarthy, J. and C. Gastmans, Moral distress: a review of the argument-based nursing ethics literature. *Nurs Ethics*, 2015. **22**(1): p. 131–52.

13. Lawrence, L.A., Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing Forum*, 2011. **46**(4): p. 256–68.

14. de Veer, A.J.E., *et al.*, Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *Int J of Nurs Stud*, 2013. **50**(1): p. 100–108.

15. Mobley, M.J., *et al.*, The relationship between moral distress and perception of futile care in the critical care unit. *Intensive Crit Care Nurs*, 2007. **23**(5): p. 256–263.

16. Gutierrez, K.M., Critical care nurses' perceptions of and responses to moral distress. *Dimens Crit Care Nurs*, 2005. **24**(5): p. 229–241.

17. Wilkinson, J.M., Moral distress in nursing practice: experience and effect. *Nurs Forum*, 1988. **23**(1): p. 16–29.

18. Fry, S.T., *et al.*, Development of a model of moral distress in military nursing. *Nurs Ethics*, 2002. **9**(4): p. 373–387.

19. Sundin-Huard, D. and K. Fahy, Moral distress, advocacy and burnout: theorizing the relationships. *Int J Nurs Pract*, 1999. **5**(1): p. 8–13.

20. Nathaniel, A.K., Moral reckoning in nursing. *West J Nurs Res*, 2006. **28**(4): p. 419–438.

21. Elpern, E.H., B. Covert, and R. Kleinpell, Moral distress of staff nurses in a medical intensive care unit. *Am J Crit Care*, 2005. **14**(6): p. 523–530.

22. Adams, F., *Ethical issues for the twenty-first century*. 2005, Charlottesville: Philosophy Documentation Center.

23. Kelly, B., Preserving moral integrity: a follow-up study with new graduate nurses. *J Adv Nurs*, 1998. **28**(5): p. 1134–1145.

24. Brazil, K., *et al.*, Moral distress experienced by health care professionals who provide home-based palliative care. *Soc Sci Med*, 2010. **71**(9): p. 1687–1691.

25. Corley, M.C., *et al.*, Nurse moral distress and ethical work environment. *Nurs Ethics*, 2005. **12**(4): p. 381–390.

26. Deady, R. and J. McCarthy, A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspect Psychiatr Care*, 2010. **46**(3): p. 209–220.

27. Eizenberg, M.M., H.S. Desivilya, and M.J. Hirschfeld, Moral distress questionnaire for clinical nurses: instrument development. *J Adv Nurs*, 2009. **65**(4): p. 885–92.

28. Laabs, C.A., Moral problems and distress among nurse practitioners in primary care. *J Am Acad Nurse Pract*, 2005. **17**(2): p. 76–84.

29. Rice, E.M., *et al.*, Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital. *J Nurs Manag*, 2008. **16**(3): p. 360–373.

30. Sporrong, S.K., A.T. Hoglund, and B. Arnetz, Measuring moral distress in pharmacy and clinical practice. *Nurs Ethics*, 2006. **13**(4): p. 416–427.

31. De Villers, M.J. and H.A. Devon, Moral distress and avoidance behavior in nurses working in critical care and noncritical care units. *Nurs Ethics*, 2013. **20**(5): p. 589–603.

32. Varcoe, C., *et al.*, Nurses' perceptions of and responses to morally distressing situations. *Nurs Ethics*, 2012. **19**(4): p. 488–500.

33. MacIntyre, A.C., *After Virtue*. 2011, London: Bloomsbury.

34. Sellman, D., *What makes a good nurse: why the virtues are important for nurses*. 2011, London: Jessica Kingsley Publishers.

35. Edwards, S.D., *Philosophy of Nursing*. 2001, New York: Palgrave.

36. Bishop, A.H. and J.R. Scudder, *Nursing ethics: holistic caring practice*. 2nd ed. NLN Press. 2001, Sudbury: Jones and Bartlett.

37. Armstrong, A.E., *Nursing ethics: a virtue-based approach*. 2007, Basingstoke: Palgrave Macmillan.

38. Gastmans, C., B. Dierckx de Casterle, and P. Schotsmans, Nursing considered as moral practice: a philosophical-ethical interpretation of nursing. *Kennedy Inst Ethics J*, 1998. **8**(1): p. 43–69.

39. Begley, A.M., Practising virtue: a challenge to the view that a virtue centred approach to ethics lacks practical content. *Nurs Ethics*, 2005. **12**(6): p. 622–37.

40. Benner, P., A dialogue between virtue ethics and care ethics *Theor Med Bioeth*, 1997. **18**: p. 47–61.

41. Armstrong, A.E., *Nursing ethics: a virtue-based approach*. 2007, Houndmills, Basingstoke, Hampshire ; New York: Palgrave.

42. Peter, E., V.L. Lunardi, and A. Macfarlane, Nursing resistance as ethical action: literature review. *J Adv Nurs*, 2004. **46**(4): p. 403–16.

43. Holt, J. and H. Convey, Ethical practice in nursing care. *Nurs Stand*, 2012. **27**(13): p. 51–56.

44. Finfgeld-Connett, D., Meta-synthesis of caring in nursing. *J Clin Nurs*, 2008. **17**(2): p. 196–204.

45. Gastmans, C., Care as a moral attitude in nursing. *Nurs Ethics*, 1999. **6**(3): p. 214–23.

46. Gastmans, C., Caring for a dignified end of life in a Christian health-care institution: the view of Caritas Catholica Vlaanderen. Ethical Perspect, 2002. **9**(2–3): p. 134–45.

47. Cronqvist, A., *et al.*, Caring About–Caring For: moral obligations and work responsibilities in intensive care nursing. *Nurs Ethics*, 2004. **11**(1): p. 63–76.

48. Price, A.M., Caring and technology in an intensive care unit: an ethnographic study. *Nurs Crit Care*, 2013. **18**(6): p. 278–288.

49. Widmark-Petersson, V., L. von Essen, and P.-O. Sjödén, Cancer Patient and Staff Perceptions of Caring and Clinical Care in Free versus Forced Choice Response Formats. Scand J Caring Sci 1998. **12**(4): p. 238–245.

50. Wikberg, A. and K. Eriksson, Intercultural caring – an abductive model. *Scan J Caring Sci*, 2008. **22**(3): p. 485–496.

51. Sourial, S., An analysis of caring. *J Adv Nurs*, 1997. **26**(6): p. 1189–1192.

52. Wilkin, K. and E. Slevin, The meaning of caring to nurses: an investigation into the nature of caring work in an intensive care unit. *J Clin Nurs*, 2004. **13**(1): p. 50–59.

53. Alpers, R.R., K. Jarrell, and R. Wotring, Is caring really teachable? *Teach Learn Nurs*, 2013. **8**(2): p. 68–69.

54. Ranheim, A., A. Kärner, and C. Berterö, Caring Theory and Practice–Entering a Simultaneous Concept Analysis. *Nurs Forum*, 2012. **47**(2): p. 78–90.

55. Papastavrou, E., *et al.*, A cross-cultural study of the concept of caring through behaviours: patients' and nurses' perspectives in six different EU countries. *J Adv Nurs*, 2012. **68**(5): p. 1026–1037.

56. Paley, J., An archaeology of caring knowledge. *J Adv Nurs*, 2001. **36**(2): p. 188–198.

57. Tronto, J.C., Creating Caring Institutions: Politics, Plurality, and Purpose. *Ethics Soc Welfare*, 2010. **4**(2): p. 158–171.

58. Gastmans, C., Care as A Moral Attitude in Nursing. *Nurs Ethics*, 1999. **6**(3): p. 214–223.

59. Peter, E. and J. Liaschenko, Perils of proximity: a spatiotemporal analysis of moral distress and moral ambiguity. *Nurs Inq*, 2004. **11**(4): p. 218–25.

60. Watson, J., *Human caring science: a theory of nursing.* 2nd ed. 2012, Sudbury, MA: Jones & Bartlett Learning.

61. Tschudin, V., *Ethics in nursing: the caring relationship.* 3rd ed. 2003, Edinburgh: Butterworth-Heinemann. ix, 218 p.

62. Roach, M. The human act of caring. A blueprint for the health professions, rev edn. 1992, Ottawa: Canadian Hospital Association, IN: Tschudin, V., *Ethics in nursing: the caring relationship.* 3rd ed. 2003, Edinburgh, Butterworth-Heinemann.

63. Varcoe, C., et al., Ethical practice in nursing: working the in-betweens. *J Adv Nurs*, 2004. **45**(3): p. 316–325.

64. Austin, W., Moral distress and the contemporary plight of health professionals. *HEC Forum*, 2012. **24**(1): p. 27–38.

65. Oberle, K. and D. Hughes, Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *J Adv Nurs*, 2001. **33**(6): p. 707–715.

66. Schweizerische Akademie der Medizinischen Wissenschaften, *Medizin und Ökonomie - wie weiter?*. 2014: Basel, Switzerland.

67. Goethals, S., C. Gastmans, and B.Dierckx. de Casterlé, Nurses' ethical reasoning and behaviour: A literature review. *Int J Nurs Stud*, 2010. **47**(5): p. 635–650.

68. Banks, S. and A. Gallagher, *Ethics in professional life: virtues for health and social care.* 2009, Basingstoke: Palgrave Macmillan.