Ethical Competence and Moral Distress in the Health Care Sector

A Prospective Evaluation of Ethics Rounds

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Abstract

Ongoing structural and financial changes in the health care sector have resulted in increased risks for ethical dilemmas and moral distress. It is purported that increased ethical competence will help staff manage ethical dilemmas and hence decrease moral distress. To enhance ethical competence several approaches may be used – theoretical education, and methods focusing on reflection and decision-making abilities.

Ethics rounds are a widespread systematic method hypothesized to improve ethical competence, nurture a reflective climate, and help in ethical decision-making. Despite its popularity, its effects on moral distress have hitherto never been evaluated in a controlled study.

The purpose of this thesis was to evaluate the impact of an intervention, including ethics rounds; the hypothesis being that the intervention would decrease perceived moral distress. An additional aim was exploring the concept of moral distress in various health care establishments, including pharmacies.

Focus groups were conducted to explore the concept of moral distress. To evaluate the intervention a scale assessing staff-perceived moral distress was designed, validated, and implemented.

Results showed that moral distress is evident in diverse health care settings. Some factors associated with this were lack of resources, conflicts of interest, and rules that are incompatible with practice. An expanded definition of moral distress was presented.

The training program was much appreciated by participants. However, no significant effects on perceived moral distress were found. Reasons could be that the intervention was too short or otherwise ineffective, there is no association between ethical competence and moral distress, the assessment scale was not sensitive enough, or management was not sufficiently involved.

There is a need to further refine the various aspects of ethical dilemmas in clinical settings, and to evaluate the most efficient means to enhance skills for dealing with ethical dilemmas, for the benefit of staff, patients, institutions, and society.

Keywords: Moral distress, Ethics rounds, Ethical competence, Professional ethics, Clinical practice, Pharmacy practice, Work organization, Sweden

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Contents

Introduction.....................................................................................................7
  The objectives of this research ..............................................................8
  Personal reflections................................................................................9
  Outline of the thesis .............................................................................10

Background...................................................................................................11
  Occupational stress: stressors and symptoms……………………………12
  Ethical theory and health care ............................................................14
  The context of ethical practice in health care ......................................16
    Organization ......................................................................................17
    Gender, ethnicity, and sexual orientation ...........................................17
    Profession ..........................................................................................19
  Work experience ..................................................................................19
  Ethics in health care – stakeholders and demands ................................20
  Ethical competence .............................................................................22
  Ethical decision-making ......................................................................23
  Moral distress ......................................................................................25
    Moral distress and ethical decision-making .....................................28
  Learning and training ethical competence .........................................28
  Ethics rounds ......................................................................................31

Aims..............................................................................................................33

Methods ......................................................................................................34
  Design ....................................................................................................35
  Ethical aspects ......................................................................................36
  Focus groups .......................................................................................36
  Questionnaire ......................................................................................38
  Statistics ...............................................................................................39
  The intervention ...................................................................................39
  Reflections on methods ........................................................................39

Summary of findings.....................................................................................41
  Study 1 ...................................................................................................41
  Study 2 ...................................................................................................42
  Study 3 ...................................................................................................43
Introduction

...in the field of moral action truth is judged by the actual facts of life, for it is in them that the decisive element lies. So we must examine the conclusions we have reached so far by applying them to the actual facts of life: if they are in harmony with the facts we must accept them, and if they clash we must assume that they are mere words. (Aristotle cited in Fins et al. 1998 p. 39)

Situations with an ethical dimension often arise in health care. This has been a reality since ancient times. The recognition of the ethical aspects has varied over time and context, but is readily acknowledged today. Ethics courses are included in most curricula for health professionals, ethical committees are introduced at many hospitals, and ethical guidelines are being developed or revised by professions. At the same time burnout, turnover rates, and stress are terms that appear frequently when working environments of health care professionals are discussed. Health care has been said to have saved ethics; will ethics save health care? (Thomasma 1984)

This thesis deals with ethics in health care from a certain perspective, specifically the fact that ethical dilemmas can result in stress reactions among health care staff. The perspective is that of the professionals, and empirical data has been obtained from two settings, those of hospital departments and pharmacies. Pharmacies are not always included in the concept of health care, but as pharmacists do provide health care and are responsible and acting within the same or similar laws and regulations as other health care professions it is not only possible but also logical to include them. The point has been to have two very different environments to see if there are (dis)similarities in ethical dilemmas and moral distress.

An example of the difference is that in hospitals there are patients, while in pharmacies there are customers. These may just seem like different terms, as the patient and the customer can be one and the same person, but connotations differ. From a professional viewpoint the role will vary if you are dealing with a patient as compared to dealing with a customer. The word “patient” is associated with illness, and traditionally with passivity, while the word “customer” is associated with someone who is more in command, or at least more equal in relation to the service provider.

There are vast amounts of regulations and guidelines to help, or control, care personnel faced with problems having an ethical dimension. Even so,
earlier work on moral distress has highlighted the necessity for organizational support, as rules and regulations are not enough. This can be in the form of committees or bioethical consultants who will respond to problems raised by those involved. Another way to go is to strengthen the ethical competence in the actual work force. There is a need for awareness of ethical dilemmas (ethical sensitivity), abilities to sort out what values are at stake, knowing one’s own ethical values etc. In this research the method of ethics rounds, used to support ethical competence, is evaluated.

The objectives of this research

We know from our everyday experience that often ideas serve well enough to substitute for the true motives of our actions. (Habermas 1966, p. 294)

Habermas (1966), in his article Knowledge and Interest, defines three categories of knowledge: information, interpretation, and analysis. These are coupled with different underlying interests: technical, practical, and emancipatory, respectively. The ideal for a social science researcher is, according to Habermas, the emancipating research that delivers us from rigid structures.

Interest in empirical research in bioethics has increased, often using methods from social science (Borry et al. 2004). Reiter-Theil (2004) distinguishes three functions of medical ethics: theoretical medical ethics, problem-oriented medical ethics, and interest groups-related medical ethics. The first function is not necessarily relevant to practice, even though it can be. Problem-oriented medical ethics aims at problem-solving in practice, for example by ethical decision-making, and is linked to guidelines and policies (the product can be guidelines/policies). The third function resembles the second but is more directed at specific groups or areas, including patients. The two later functions require empirical data.

The research presented in this thesis is, from the ethical research viewpoint, empirical. It is not specifically directed at problem-solving, though the ethics rounds method can have help in ethical decision-making as an objective. The first part of the study is explorative and descriptive. Using qualitative methodology, the focus was on gaining a better understanding of ethical dilemmas and problems experienced in the daily practice of health care personnel. One area – pharmacy practice – was also examined from various viewpoints.

The intervention was created and evaluated in order to give professionals an evaluated tool which could lighten their moral burden somewhat. Even if this did not turn out to be the case, it is still important to show the ethical responsibilities that are evident for health care staff, and for other stakeholders, including society, to admit this responsibility and give professionals tools and power to handle it. An emancipatory interest exists there.
Personal reflections

Looking at our immediate experience inevitably opens the door to the values and beliefs that direct our lives and our research. (Drew 2006)

In many research traditions, especially those engaging in qualitative research, it is important for the researcher to account for her/his pre-understanding. This thesis is influenced by the different experiences I have had of health care and research; it is probably beneficial for the reader to know some of them.

For a total of five years in the 1980s and 1990s I worked in a geriatric care hospital, primarily as an auxiliary nurse in wards. My own experiences from this time of ethical dilemmas and stress resulting from them have, in the work of this thesis, served as illustrations, and reality checks for me.

For over ten years I have been employed by Apoteket AB, the state-owned company that operates all pharmacies in Sweden. My understanding of pharmacies has been influenced by the hundreds of pharmacy staff members and pharmacy customers I have met during this time. To me pharmacies and pharmacists are clearly important parts of health care, not only for distributing medicines, but primarily for the competence that, if used in the right way, can help bring about better treatment and hence better outcomes for medicine users.

Another experience was that of working as a secretary in a government committee on the future of health care in Sweden. This not only gave me increased knowledge and empirical experience of governmental bodies and control, but also of how politicians, labor union and patient organization representatives and others discuss and view health care. My lasting impression is of the profound seriousness and dedication that went into this work, but also of how different viewpoints and descriptions of reality could be.

I have also been a patient though only with minor ailments. My only time as inpatient in a hospital was when I gave birth to my daughters. I probably have more experience of being a relative of patients, i.e. of my daughters and mother, who at different times have needed health care assistance.

I came to social medicine from the social sciences. The truly multidisciplinary environment in which I have written this thesis also includes the different viewpoints on research that vary between different research disciplines with their differing research traditions, for example how it should be conducted and reported. Positivism, or technical interests to use Habermas’ terminology, is still predominant in the natural sciences, even if other interests are (somewhat) accepted, at least in the departments adjacent to social and humanistic sciences. On this I have reflected a great deal, while trying to adapt to both without losing the honest dedication to facts, processes, and myself that, to me, is the foundation of the art of science.
Outline of the thesis

This work is a combination of three areas – professional ethics, work stress, and work organization. In the Background section various research areas relevant to this thesis are presented, an overview of stress theories and ethical theories is given, contextual factors are examined, as are theories on ethical competence, and models of ethical decision-making. Furthermore the concept of moral distress is considered, followed by examples of how ethical competence can be learned and trained.

Aims and methods are presented in a separate section, including reflections on the methods used. Summaries of findings are then given, following the outline of the articles on which the thesis is based. At the end there is a discussion, conclusions, and proposals for further research.

The words “ethics” and “morality” are used here in the conventional sense, i.e. morality refers to current and personal opinions of good and bad, right and wrong, and ethics to the theoretical reasoning about morality. Since the concepts often overlap both terms could sometimes be used. Nevertheless, when citing or referring to other research, the original wording is often used.
Background

Health care systems in the western world have been, and are still, going through major changes. New technologies are being developed. One example is advancement in the biomedical area, which creates new ways of diagnosing, treating, and even better predicting the course of a disease. Political, administrative and organizational reforms have been and are carried out with aims of increasing productivity and efficacy (WHO Regional Office of Europe 1997). Elements of competitive inducements between health care providers are often included, and these bring about altered priorities. New roles develop within and between the old health care professions, especially to cope with new techniques and new organizational surroundings.

A more educated population, more residents with diverse cultural background, and changes in values have increased or altered demands from patients. The same is true for new possibilities for patients to choose among health care providers. This enforces changed behavior and attitudes from health care personnel. Self-care and integrated care are also growing in popularity, challenging the traditional role of health care professionals. Although beneficial per se, these developments bring about ethical dilemmas for health care staff.

As most health care is, in one way or another, financed via third party payers, an additional responsibility exists for health care staff, not only caring for patients’ medical needs but also to be as effective as possible, and being able to answer to societal needs. Health care professionals are supposed to take responsibility not only for the treatment of the present patient, but also for health in society in general, e.g. through prioritizing in scarce resources and preventing poor health.

Sweden is currently experiencing just such challenges. For example, in the 1990s several major organizational reforms were carried out, involving areas such as care for the elderly, psychiatry, medicines, and steering models emphasizing financial incentives (Forsberg 2001, Brown et al. 2003, SOU 1999:66).

The health care sector contains a lot of different settings; they include hospital clinics, outpatient settings, home-care, and pharmacies. Care can be provided using different techniques such as highly advanced technology and counseling. Relationships with patients can be short- or long-term, more or less emotional, dealing with life and death and everything in between. Caring demands knowledge in science as well as in psychology, and in addition
requires self-awareness. All this is to say that it is not easy to generalize what the implications are of working in the health care sector. But then again, to work in health care is to, directly or indirectly, care for people who need the competence and skills of professionals to live as good a life as possible. It gives carers a responsibility not only to their employer, but also to present and future patients.

The complex and demanding working environment for health care workers of today might increase their work-related stress. Numerous studies have reported that psychosocial stressors and in most cases stress-related disorders appear to be more common among health care professionals as compared to other branches and professions (Arnetz 2001). In a study of professions in Sweden (Swedish Work Environment Authority 2001), health care personnel reported high work demand, low autonomy, and high psychological pressure compared to most other groups. This was especially true for women.

Occupational stress: stressors and symptoms

Stress reactions are a natural part of being a living organism, and are not unique to humans. The stress reactions are supposed to help us in acute and dangerous situations, making us more aware and more concentrated on the danger ahead, be it an aggressive lion or another situation appraised as threatening. That an attacking lion is an immediate risk is not difficult to understand, but in modern society stress reactions are a reality in many situations assessed, consciously or unconsciously, as hazardous. In this brief overview, stress related to working life in health care will be discussed.

There are a number of theories regarding causes of occupational stress. The stressors have been traced to characteristics in the organization, in the individual or both.

The control-demand-support theory, originally developed by Karasek and Theorell (1990), has three dimensions. The first is decision latitude, which is a combination of skill discretion (task variety) and decision authority (autonomy). The second dimension is psychological demands, which consist of task pressures, personal conflicts, etc. The third dimension is support, denoting overall levels of social interaction. Combinations of high or low values in these dimensions, for example low decision latitude, high psychological demands, and low support, can be experienced as stressful and lead to stress reactions.

Another theory is the person-environment fit theory, which focuses on the interaction between the individual and the work environment. The result when there is a mismatch between the person and the environment can be stress reactions (Arnetz 2006).
Siegrist (1996) has developed the effort-reward imbalance model. In this model, stress reactions are the result of high efforts from the employee that is met by low rewards from the employer.

In all three models development of and support for the professional can lead to less stress reaction as can changes in the organization, e.g. management and role ambiguities.

When looking at stress in working life, both individual and organizational aspects need to be taken into account. Individual factors include coping strategies and self-esteem (Thomsen et al. 1998, Thomsen et al. 1999); essential organizational factors are leadership, participation, and goal clarity (Arnetz 2006).

Stress responses are diverse, but can roughly be divided into physiological, emotional, cognitive, and behavioral (Levi 2002). Physiological symptoms include cardiovascular, gastrointestinal, musculoskeletal and biochemical reactions (Nyhlin 2002, Folkow 2006, Theorell 2006). Emotional symptoms include anxiety, depression, exhaustion and fatigue, while problems with memory, perception, and ability to learn and concentrate are cognitive functions that can be disturbed by stress (Anderberg 2002, Ghatan 2002). Behavior linked to stress includes alcohol, food and drug abuse, job turnover and suicide (Levi 2002).

Perceived strain – physical as well as mental – is reported to be increasing among health care professionals. There has been a decline in the health of staff in the health care sector in Sweden. Reasons for this include economic cutbacks, increases in regulations, and organizational reforms (Thomsen 2000, Petterson 1999). When compared to other professions, health care staff experience their work as more physically and psychologically wearisome, and their workloads as greater (Gustafsson and Petterson 1999).

Ethical demands can also be the cause of stress reactions. The concept of moral distress will be described further on, after a review of some ethical perspectives on health care.
Ethical theory and health care

Pragmatists understand moral considerations, including rules and principles, as tools suited to do moral work in facing problematic situations. (Fins et al. 1998, p. 40)

The ultimate lesson, though, is that it is people who matter, not things, and it is the love of people that directs the moral life, not the love of abstract and decontextualised principles. (Johnstone 2000, p. 131 on Wittgenstein)

One part of being a “good” caregiver is to be ethical – but how do you do that? Moral philosophy deals with the way we should lead our lives and how we should relate to and behave towards others.

The work of Beauchamp and Childress (2001) has had a great impact on ethics in health care. They present four principles, derived from common morality and medical tradition, to guide practitioners in health care. These principles are: respect for autonomy, nonmaleficence, beneficence, and justice. Following is a brief view over their descriptions of these principles.

The concept of autonomy is defined as follows: “Personal autonomy is, at a minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice” (Beauchamp and Childress 2001, p. 58). To act autonomously, according to this definition, is to act with intention, understanding and without controlling influences that determine action. In consequence, to respect autonomy in health care is to enable the patient to make her/his own decisions, with enough understanding of the issues at hand, and to make it possible for the patient to act in accordance with his/her decisions.

Nonmaleficence is described as “an obligation not to inflict harm on others” (Beauchamp and Childress 2001, p. 113). It also includes avoiding risking harm. It is mostly about not doing things, like non-treatment, and is a principle present in discussions on such issues as whether to withhold life-sustaining treatment for terminally ill patients and on physician-assisted suicide.

Two principles of beneficence are presented. They are positive beneficence, which is to provide benefits, and utility which is to balance benefits and drawbacks. As opposed to nonmaleficence, beneficence requires action. Beneficence is described as the core of care, expressing the goal, rationale, and justification of medicine (Beauchamp and Childress 2001).

To be just is to treat persons equally and to distribute moral goods in a fair way (Beauchamp and Childress 2001). But what is a just distribution of care? Should it be according to need, effort, contribution, merit, free-market exchanges, or should each person have an equal share? In real life there seems to be a mix of the above. To distribute care based on sex or race seem unjust to most people – but what about age?
The four principles as such seem rather unproblematic, even though details could be discussed. But when dealing with real-life situations they are not always easily interpreted. And on many occasions they conflict, like when a caregiver wants a patient to have a certain treatment and the patient does not want it, which is a conflict between beneficence and respect for autonomy.

Well-established theories of moral philosophy concentrate on consequences of actions (utilitarianism), on conforming to ethical rules (deontological thinking), or on having virtues that are seen as ethical (Rachels 2003). When studying health care with a moral perspective different theories may be used. Beauchamp and Childress, in presenting the four principles, draw on these perspectives; nonmaleficence and beneficence are mainly drawn from ethics of consequence, while respect for autonomy and justice are associated with deontological thinking.

From the early days of philosophy, the moral thinking has been supposed to differ between men and women (Rachels 2003, Johnstone 2000). “Male moral thinking is described in terms of rational constructs and abstract moral principles […] female moral thinking is described more in terms of non-rational constructs, notably feelings” (Johnstone 2000, p. 116). Rationality is viewed as morally superior to feelings, and this also reinforces established gender norms.

In modern times feminist philosophers have again addressed the issue, criticizing modern philosophy for having a male bias. Much inspired by Gilligan’s empirical investigations in the 1980s (Gilligan 1982) on women’s and men’s moral development, a feminist ethic has been developed that can be seen as a complement to traditional ethics of principle (consequence/deontological). Feminist ethics argue that women, by socialization or biology, have a different way of interpreting what is morally right. The emphasis, compared to traditional ethics, is more on close personal relationships rather than on abstract rules (Johnstone 2000). Feminist ethics highlight how gender constructions and gender-based power relations impact moral development and ethical decision-making.

Another area in ethics is the ethics of care, which builds on Gilligan’s findings, and focuses especially on the relationship between caregiver and the person being cared for (Noddings 1984). Important aspects are involvement, empathy, a holistic and contextual viewpoint, and communication (Botes 2000). Nursing ethics, which deals with ethical questions from the nurse’s perspective, is linked with theories and practice of nursing (Johnstone 2000).

Ethical theories are useful in health care, especially when ethical problems occur. As ethical problems in health care “are predominantly anchored in institutional, professional and relational dimensions” (Gastmans 2002, p. 504), focus must also be on the contextual factors that have an impact on what ethical problems occur, how they are handled, and by whom.
The context of ethical practice in health care

Two individuals (patient and practitioner) perhaps from different cultures, with different values and levels of knowledge are meeting to address life-changing issues of disease and treatment. (Cipolle et al. 2004, p. 77)

...if you expect health care givers to fulfill certain duties [...] you still cannot hold them responsible or even guilty of failing if they are “empirically” not capable of taking the actions required for reasons beyond their control (Reiter-Theil 2004, p. 18).

There are many different types of ethical problems in practice. Some examples of those reported are listed in Table 1. An extensive review of ethical problems perceived by nurses can be found in Georges and Grypdonck (2002).

Table 1. Examples of ethical problems in practice

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Reported in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor communication with patients</td>
<td>Oberle and Hughes 2001</td>
</tr>
<tr>
<td>Appropriateness of medical treatment, e.g. over- or under-treatment, treatment against the patient’s wishes, deciding the right treatment, starting/withdrawing treatment</td>
<td>Süderberg and Norberg 1993, Redman and Fry 2000, Corley et al. 2001, Bunch 2002, Çobanoğlu and Algier 2004, Torjuul et al. 2005b</td>
</tr>
<tr>
<td>Handling aggressive or incompetent colleagues</td>
<td>van der Arend and Remmers-van den Hurk 1999, Torjuul et al. 2005b</td>
</tr>
<tr>
<td>Bending rules</td>
<td>Redman and Fry 2000</td>
</tr>
</tbody>
</table>

Studies have shown that the context, in this case clinical settings, have an impact on how patient care is understood by professionals. The results of Lützén et al. (2000), who investigated moral sensitivity among nurses and physicians in general care and psychiatric care, show that there were several significant differences between the two settings, more than between the two professions. Explanations suggested by the authors include contextual differences regarding patient autonomy. Redman and Fry (2000) reported that themes of ethical conflict varied with both settings and roles for nurses.
Are there differences in how groups perceive ethical problems? In the following evidence is presented suggesting that organization, gender, profession, and experience are among those factors that can affect how ethical problems are perceived.

### Organization
Organizational characteristics may also impact on perceived ethical conflicts. In a managed care environment a vast majority of nurses expressed that they sometimes had to bend managed care guidelines, and that the patient’s interest in reality was weighed against those of the organization (Ulrich et al. 2003). Similarly, if a patient was denied care, many physicians showed willingness to use deception towards third-party payers to ascertain payment for medically indicated care. This was especially true for physicians working in areas with high penetration of managed care (Freeman et al. 1999).

A change in venue of care, in this case from psychiatric care of inpatients to home care, led to alterations in the role of nurses. A consequence of this was that what is perceived as ethical behavior also changed (Magnusson and Lützén 1999, Magnusson et al. 2002).

Bunch (2002) found differences in ethical decision-making depending on how units were organized. Nurses and physicians made consensus agreements on, for example, decisions on discontinuing treatment, where a team-organization was established. In a more hierarchical structure, physicians made decisions themselves, sometimes against what nurses felt was the most ethical decision.

Ethical decisions have been shown to be influenced by the actions of managers. How successful managers behaved sent signals to employees on how to become successful at a workplace. Managers also served as role models, demonstrating by example what was tolerated in an organization (Deshpande et al. 2006). In a Finnish study of nurses in intensive care units one-third of respondents did not perceive their organization’s culture as ethical, and almost half stated that they did not think their supervisors would support them if ethics was violated (Leino-Kilpi et al. 2002).

Deshpande et al. (2006) found that the most important determinant of ethical behavior for health care staff was the behavior of peers.

In conclusion, organization, reimbursement system, professional hierarchies, and behavior of managers and staff evidently have an impact on ethics. But other aspects are also important, as can be seen below.

### Gender, ethnicity, and sexual orientation
There is empirical evidence that persons of different genders express or experience care situations differently from an ethical point of view, but there is
also evidence that there are no such differences (Sørlie et al. 2001, Torjuul et al. 2005a, Torjuul et al. 2005b). From interviews with female and male physicians Sørlie et al. found that both groups stressed action and justice as well as relationships. However, differences were found in how they coped with the ethical dilemmas; male physicians emphasized professional distance, whereas female physicians emphasized teamwork and communication within the team (Sørlie et al. 2000, Sørlie et al. 2001).

Diercx de Casterlé et al. (1998), based on Kohlberg, found differences in ethical reasoning between male and female nursing students, with women giving less importance to pre-conventional arguments (e.g. expectations, rules, orders) and using more post-conventional arguments (e.g. respect for patients’ feelings).

However, it is sometimes hard to determine how many of the differences are due to gender, or to profession and expectancies. As will be presented further on, the professional role and education, rather than gender can be the explanation of differences (Kuhse 1999). In addition, gender still influences the choice of profession and the experiences of individuals.

Very little research exists on differences in ethical reasoning between ethnic groups (operating in the same society). In the US, race has been shown to influence how physicians view physician-assisted suicide (Mebane et al. 1999), but not ethical behavior of hospital staff (Deshpande et al. 2006). However, physicians are more distanced and less empathic when interacting with patients of ethnic minorities (Cooper et al. 2006). In a study in the US, African American nurses scored higher on moral distress intensity than other nurses (Corley et al. 2005).

Even less research has focused on whether there are differences in moral sensitivity, moral reasoning, etc. between heterosexuals and homosexuals. Discrimination against homosexuals by physicians has been studied, as has discrimination against homosexual physicians by patients (Druzin et al. 1998).

A study of medical students in Canada revealed that medical education does not take diversity, (e.g. gender, ethnicity, social class background, religion, and sexual orientation) among the students into account (Beagan 2000). Instead of giving possibilities for reflection on their own pre-understanding the students are socialized into an artificial impartiality; “When medical students come to believe that their own membership in social groups has no impact on encounters with patients they lose the opportunity to examine how it affects the encounters” (Beagan 2000, p. 1263).

It seems that the factors mentioned above, those of gender, ethnicity, sexual orientation, social class, and religion, do affect ethical sensitivity and decision-making. These factors entail experiences and pre-understandings that differ.
Profession
Apart from the research done on nurses versus physicians, there is little done on differences in ethical perceptions between professions. Nurses are often connected with care, a focus on relationships with an emotional ethical reasoning, while physicians are associated with cure, action, and principled ethical reasoning (Lützén et al. 2000, Çobanoğlu and Algier 2004). These professions are traditionally linked to gender (see above).

Physicians have been shown to be (slightly) less concerned with relationship than nurses (Söderberg and Norberg 1993). Lindseth et al. (1994) report from interviews with nurses and physicians that the two groups had different cognitive styles; nurses tended to refer to their personal experience, while physicians referred to science. Other studies have demonstrated no differences in ethical reasoning (Kuhse et al. 1997), or rather small differences in moral sensitivity (Lützén et al. 2000), between the two groups. In the above-mentioned research by Lindseth et al. (1994) there were no great differences in the reflections of the two groups.

Lützén et al. (2000) suggest that nurses and physicians have different views of their ethical responsibilities, based on differences in their relationships with patients and their legal responsibilities. Oberle and Hughes (2001), interviewing nurses and physicians, found that there was a difference in perspectives as physicians were burdened with having to make decisions, and nurses with having to live with the decisions. For nurses this circumstance leads to moral dilemmas when they question decisions made by physicians. “In essence, doctors questioned themselves, and nurses questioned doctors” (Oberle and Hughes 2001, p. 709). Although these role-related differences existed, the core problems were the same for the two professions. In the research carried out by Söderberg and Norberg (1993) both physicians and registered nurses declared too much treatment to be the biggest ethical problem.

Work experience
Sørlie et al. found that experienced, as opposed to less experienced, female physicians recognized that they had to deal with insoluble problems. “They gain a kind of security in the midst of this uncertainty, while the less experienced physicians have to feel a painful insecurity while they are pretending to be certain” (Sørlie et al. 2000 p. 60). Physicians with less professional experience did report more ethical problems than those with more experience, in a German study (Reiter-Theil 2004).

Differences were found by Söderberg and Norberg (1993) between enrolled and registered nurses, as to types of ethical problems described by the two groups.
Older and more experienced nurses in Finland were shown to have a better ethical awareness than their younger colleagues (Leino-Kilpi et al. 2002). In conclusion, there are many factors that have an impact on how ethics is perceived and dealt with in health care. These include organizational, professional and socio-demographic perspectives. There are also many stakeholders when a dilemma arises; this is presented below.

**Ethics in health care – stakeholders and demands**

The clash between professional, corporate and societal definitions of adequacy of care are evident. (Redman and Fry 2000 p. 365)

Medical ethics guidance has a propensity to refer questions to the law, while the law has a habit of referring the problems back to medical ethics. (Miola 2006, p. 25)

Health care can be looked at from a lot of different perspectives; indeed, one person can see things from many different perspectives at once. A patient with a certain disease is probably interested in the treatment of that disease and the resources given to researchers in the field. But the same person is also a taxpayer, with concerns about how and where tax money is spent. He/she is also a shareholder in a drug company, hoping that the newly developed drug will sell, as well as a professional in health care, wanting a good work environment. The interests are many and this also applies to ethical demands made on health care. In the following some examples are presented of demands that can be derived from different stakeholders and that are applicable in almost every caregiver - patient encounter.

Ethical demands and expectations from society are shown, for example, in the form of laws, regulations and guidelines from governmental bodies. Swedish law relevant to health care includes paragraphs on (Swedish legislation 1982:763; 1998:531):

- Good health care on equal conditions for the whole population
- Respect for everyone’s equal worth and respect for the individual’s dignity
- Need as a base for prioritization
- Respect for the patient’s autonomy and integrity
- Co-operation with the patient in providing care
- Adequate provision of staff and equipment

To these can be added regulations, guidelines, and state-of-the-art recommendations from governmental bodies. The bottom line is that a person
working in the health care sector is responsible her/himself for how she/he fulfils her/his duties (Swedish legislation 1998:531, Ch. 2. § 5).

Employers make ethical demands in the form of guidelines. Organizational aspects such as formal procedures, routines and reinforcement can also be implicitly demanding.

Pellegrino and Thomasma (2000), in studying moral reasoning at the Nuremberg trials, discuss the professional individual’s relationship to the moral community. They state that “the members of the profession belong to a moral community with common commitments. […] a community whose ethical constraints are dictated by an internal morality specific to the profession itself” (Pellegrino and Thomasma 2000, p. 265). Thus physicians cannot justify, for example, participating in executions or torture – even if a state order demands that they do so.

The moral community is manifested through ethical guidelines from professional bodies. From Hippocrates and onwards, professions in medicine have had codes of ethics. Most professions in health care have codes of their own, international as well as national. Some of the larger groups with these codes are dentists, nurses (including specific codes for specialized nurses like midwives), occupational therapists, pharmacists, psychologists, psychotherapists, physicians (including specific codes for specialists like gynecologists), and physiotherapists (Codex 2007).

Patients and their advocates can and shall have a say on how care should be performed. But in some cases demands can be made that are not easily met. Patients may demand treatment that is not “best practice” or that they do not need. Or they can want greater access to care than others – making problems with justice apparent. Patient advocates can have other views of these matters than the caregiver and/or the patient.

A caregiver is part of a professional moral community, and works under certain restrictions, both legally and practically, but apart from being a professional she/he is also a person with her/his own experiences, expectancies, values, emotions etc. An individual’s personal moral convictions might not agree in every practical situation with those of the community at large, or with those of a specific group such as colleagues, employers, or patients. The individual responsibility and ethical awareness of each health professional cannot be replaced by, but may be supported by, well conceived codes of ethics. Each health professional has “to decide on each case in the light of moral obligations, expectations of stakeholders, and their own sets of professional values” (Harling et al. 2004).

The professional role is different from other roles the same person has. But as Hanna comments: “Ultimately, role morality raises the issue of whether separation of professional and personal values is humanly possible” (Hanna 2004, p. 85).
Ethical competence

Competence is something other than knowledge. This is certainly true for ethical knowledge and competence. An individual with theoretical knowledge in ethics does not necessarily have ethical competence, and vice versa: “one can simultaneously be an excellent cognitive performer [...] whilst being very poor at ethical behavior” (Rossouw 2002, p. 423). Still, ethical competence can be described in different ways.

Sandberg and Targama (1998) describe competence as not knowledge and skills per se, but what is needed to carry out the work at hand. This implies an understanding of the work and therefore competence is equivalent to how the professional understands what is to be done, and the context in which he/she is working. “We see this knowledge, these values, practical experiences, personality traits etc. as raw materials that are given meaning and sense only in those cases where they are integrated into the individual’s understanding” (Sandberg and Targama 1998, p. 164, translation mine).

Ethical competence can also be seen as a psychological skill. It is “the ability of a person, who confronts a moral problem, to think and act in a way that is not constrained by moral fixations or automatic reactions” (Kavathatzopoulos 2003, p. 44). Ethical competence thus requires, among other things, an awareness to apprehend ethical situations and, for the individual as well as for the organization, being able to realize responsibilities. It also implies an ability to treat ethical conflicts, to support and sustain ethical processes in the organization, and willingness to execute difficult decisions. (Kavathatzopoulos 2003) In order to achieve this skill both theoretical knowledge and training is needed.

Brytting argues that ethical competence in working life “is both something that you are and that you have” (Brytting 2001, p. 92, translation mine). It is an ability to integrate perception, reflection, action, and to understand oneself as being responsible for one’s own actions. It is partly formed by the context and includes a memory function to secure continuity and further learning. He continues to define high ethical competence as “taking personal responsibility for the common best through an ability to be aware of, interpret, and reflect on morally difficult situations in such a way that the individual’s other competence can be expressed in tangible action” (Brytting 2001, p. 92, translation mine). In ethical competence, knowledge, cognition and rationality are apparently not enough. Insights, intuition, and emotion are other important aspects (Gastmans 2002).

The fact that ethical theory must be complemented with opportunities to understand oneself better, to be aware of and train ethical sensitivity, means that it is in the actual context of care, in the clinical setting, that ethical competence is best enhanced (Glover et al. 1986). In this environment the individual professional is able to develop her/himself. This is facilitated by colleagues, an open working climate, and especially opportunities to reflect.
One way to understand ethical competence is to see it as tacit knowledge, i.e. hard to codify or verbalize, not explicit, gained through experience and training (Brytting 2001). This has been questioned. In a qualitative study among doctors, nurses, and nursing assistants, Höglund (2005) concludes that ethical competence is not only tacit knowledge. Nor is it mere theoretical knowledge. Höglund also argues that tacit knowledge is not enough – as it is uncontemplated. A cognitive process is necessary to articulate and be aware of both ethical dilemmas and how to act on them, or to critically review former actions.

According to the CanMEDS project, carried out by the Royal College of Physicians and Surgeons of Canada (1996), some key competencies related to ethics for specialist physicians are to know and understand ethical codes, including legislation, and to be able to recognize, analyze, and try to resolve ethically difficult situations in clinical practice, including unprofessional behavior.

Moral competence for nurses has been defined as the ability “to live in a manner consistent with a personal moral code and role responsibilities” (Jormsri et al. 2005, p. 582ff). It has been described as having three dimensions, which are moral perception, moral judgment and moral behavior, and as containing a number of attributes based on a value system (Jormsri et al. 2005). Zhang et al. (2001) identified ten core competences for nurses in China, and concluded that some of these seemed to be moral (commitment, thoroughness, and compassion).

**Ethical decision-making**

Good ethical judgment consists in appreciating how ethical principles should be interpreted in the actual situation under consideration. (Jonsen et al. 2006, p. 3)

There are several models of clinical ethical decision-making, developed to help systematically analyze ethical difficult situations and to secure “an ethically defensible judgment” (Grundstein-Amado 1991, p. 157) and an ethical decision that is “good, right, and authentic” (Agarwal and Malloy 2002, p. 245).

In his model of psychological components determining moral behavior Rest (1994) defines four; moral sensitivity, moral judgment, moral motivation, and moral character. First, a person has to be morally sensitive, i.e. be

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1 In this section ethical decision-making is described as done by professionals alone. This is because the ethics rounds method applied in this research does not include patients as decision makers. But, evidently, much ethical decision-making in health care is made by patients or their advocates in cooperation with professionals.
able to interpret the situation as containing a moral dilemma, and be aware of how actions affect others. Second, reasoning has to take place which results in a moral judgment. The third step is the establishment of moral intention, i.e. the intention to comply with the moral judgment and “willingness to place ethical values [...] ahead of nonethical values” (Gaudine and Thorne 2001, p. 182). And, finally, the ethical behavior can be performed. Jones (1991) compares Rest’s model with other models of moral decision-making, showing that most of them include these four stages or stages more or less like these.

Some examples of methods/models of clinical decision-making related to health care are the method of clinical pragmatism (Fins et al. 1997, Fins 1998, Gerdes and Richter 1999), the model developed by Sandman based on teleology (Ågren Bolmsjö et al. 2006), the four-step process – Identify, Analyze, Justify, and Decide – described by Wueste (2005), and the model proposed by Grundstein-Amado (1991). Jonsen et al. (2006) have developed a method of analyzing ethical problems where four topics are used in the process; these are medical indications, patient preferences, quality of life, and contextual features.

All these methods/models take into account different aspects such as medical indications, the patient’s preferences and capacity to decide, and social aspects. They are all organized step-wise, roughly following along the lines of definition of problem, gathering of facts, analysis and alternatives, making a decision and following it up. Some emphasize that the process is not linear, and that it is possible to go back and forth along the steps. All stipulate that both context and content are important.

A similar method developed in another context is that of Agrawal and Malloy (2002), which deals with business ethics. The process proposed by them has an extra component, compared to the ones mentioned above. It has an existential stage where personal freedom of choice and responsibility is taken into account.

Ethical decision-making methods have been criticized. It has been argued, in relation to clinical pragmatism, that ethical principles (such as those proposed by Beauchamp and Childress) tend to be tried for after a consensus, or different positions, has been arrived at instead of used during the analysis (Tong 1997). There is also the risk that professionals in using these models “reassert physician paternalism over patient autonomy” (Tong 1997 p. 151), i.e. use the methods to convince patients, or their advocates, to go along with the professionals’ choices of action. There is also a risk, as technical/medical aspects are predominant in health care that the “rational” discourse can dominate over the ethical (see for example Wirtz et al. 2003).

The wish (or necessity) to reach consensus, when decisions are made by a group, can per se be risky, as it could lead to groupthink – i.e. “the members’ striving for unanimity override their motivation to realistically appraise alternative courses of action” (Janis 1972, p. 8). Reluctance to take responsi-
bility can make individuals hide behind the group, which can lead to problems not being worked out thoroughly, and an illusory consensus.

Also, emotions can affect ethical decision-making. Severinsson (2003) reports how feelings of inadequacy result in that “the professional simply stops identifying ethical problems because one can no longer cope with all the ethical problems encountered” (Severinsson 2003, p. 61). She describes emotions such as grief, guilt, and fear.

A model to illustrate the relationship between emotions and ethical decision-making (as described by Rest) has been developed by Gaudine and Thorne (2001). They propose that mood/feeling state and level of arousal can be crucial for a person’s ability to identify, judge, decide, and act when faced with an ethical problem. Their conclusion is that “individuals experiencing arousal and positive affect resolve ethical dilemmas in a manner consistent with more sophisticated cognitive moral structures” (Gaudine and Thorne 2001, p. 175). To be aware of one’s emotions, or try to arouse them, may, in accordance with the model, be used to make better judgments.

The methods/models mentioned above are meant to help in ethical decision-making. Even so, ethical decisions are not always thoroughly worked out. In a qualitative study, including nine nurses and nine physicians, Grundstein-Amado concludes that “No matter how much information was sought, in the final analysis the individual decision makers tended to simplify their decision-making processes and to choose the solution that reflected their own ethical stances” (Grundstein-Amado 1993, p. 1708).

Moral distress

Moral distress can be seen as a process starting with a stressor (a moral problem of some sort), working via cognitive and emotional processes, ending with a stress reaction, involving physiological, emotional, cognitive and behavioral responses.

Jameton describes three different types of ethical problems that a nurse can experience in the hospital setting (Jameton 1984, p. 6). These include moral uncertainty “when one is unsure what moral principles or values apply, or even what the moral problem is”; moral dilemmas “when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action”; and moral distress “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action”.

In a later article, Jameton (1993) elaborates on the difference between moral dilemmas and moral distress. On dilemmas he writes, “In the case of moral dilemmas, it is clear to the nurse that different and important values
conflict, but no choice presents itself that preserves both” (Jameton 1993, p. 542).

Based on Jameton, Wilkinson (1987/88, p. 16) defines moral distress as “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision.” The concept has then been further discussed and developed; most criticism has been about the definition being too narrow (Noddings 1984, Webster and Baylis 2000, Corley 2002, Hanna 2004).

To further define the concept, “moral stressors” must be described. A suggestion for what an ethical issue is, as opposed to an issue that has nothing to do with ethics, defines it as an action (or non-action) that can have an impact on human well-being (Wueste 2005). It is a broad definition, and there will be difficulties drawing the line. However, a hypotheses derived from the concept of moral distress could be that when experiencing moral distress a patient is always involved. It has something to do with the professional role as care-giver for someone, of not being able to fulfill obligations towards the patient. This would exclude issues like not having had time to clean up your desk, not having fulfilled administrative duties (non-patient-related), not having learned the new data program, not having time to sit in on staff meetings, not having money to spend on new curtains or social occasions with staff, or disliking your boss. These examples are rather organizational problems, and can of course lead to stress but not moral distress. Even so it may have an impact on patients in the long run.

Another issue is whether there is a difference between moral distress and moral stress, another term used. Moral stress is, according to Lützén et al., “stress with a moral component […] (it) results when an individual person’s moral sensitivity cannot be put into action because of perceived external constraints” (Lützén et al. 2003, p. 316). Lützén et al. conclude that the work on moral distress, as opposed to moral stress, typically accentuates the stress reaction rather than the ethical principles at stake.

Human responses to stressors, moral or not, are – as described above – diverse and also interrelated. Long-term psychological distress can lead to physiological reactions and the other way around, e.g. long-term pain can, as a stressor, lead to depression. In defining moral distress/stress it is necessary to differentiate between stressor and stress reaction. The stressor is some sort of ethical problem. Depending on how the stressor is met a stress reaction can be the consequence. This, in turn, can be physiological, cognitive, or behavioral (stress) or emotional (distress). See Figure 1.
As stated above, stress and distress are sound reactions to an “impossible” situation. Hanna (2004) states that moral distress is something to grow from. A dilemma solved would render positive feelings which could be of importance when next confronting a moral stressor.

Individual coping strategies are not the focus of this thesis. However there are several coping strategies for stress. Two reactions that can be induced by mental stress are the defense and defeat reactions (Folkow 2006). In working life these reactions can lead to behaviors such as leaving the unit, working fewer hours, dropping out of the profession, blaming administration, blaming the system, excusing one’s actions, objectification of patients, overcompensation of patients, or avoiding patient interaction (Mizrahi 1985, Kelly 1998, Raines 2000). In other words, “managing can include minimizing, avoiding, tolerating, and accepting the stressful conditions as well as attempts to master the environment” (Lazarus and Folkman 1984, p. 142)

Kelly, in a qualitative study on newly graduated nurses, reports that “the most pervasive elements of moral distress were self-criticism and self-blame” (Kelly 1998, p. 1141). This was associated with a lowered self-esteem, increasing self-doubt, powerlessness, and self-disappointment.

Even though the concept of moral distress has mostly been developed in nursing, it is still applicable in working life generally (Brytting 2001).
Moral distress and ethical decision-making

It seems that Jameton’s categories of ethical problems can be related to Rest's stages in the moral decision-making model, as shown in Figure 2. Depending on where in the decision-making process the problem occurs, the consequences will differ.

![Figure 2. Moral decision-making (Rest 1994) and categories of ethical problems in nursing (Jameton 1984).](image)

To this can be added the cognitive-affective components, i.e. feeling state and arousal, proposed by Gaudine and Thorne (2001), described above. They suggest that if a person’s feeling state is positive and arousal increased, then recognition of a dilemma is more likely as well as prescriptive judgment and actually complying with ethical intention (i.e. ethical behavior). In their model ethical intention is affected by positive affect, making it more likely that “individuals that feel good like to do ‘good’.” (Gaudine and Thorne, p. 182).

Learning and training ethical competence

I need to discuss difficult decisions (Interview with male physician, cited in Sørlie et al. 2001, p. 663)

Rules, regulations, professional codes, guidelines, and formal education are there to help the practitioner make decisions, e.g. in ethically troubling situations. But this is not enough. The impact of teaching theories of ethics or ethical codes without the process of critical ethical decision-making has been questioned (Agarwal and Malloy 2002).

Situations will always arise where guidelines and the like cannot be easily referred to, or where guidelines contrary to the intention contribute to ethical dilemmas (Mitchell 2001). When dealing with human beings, and the world
we live in today, new situations with new stakeholders appear every day in health care practice. Experience and tacit knowledge will, as time is spent in an occupation, help practitioners to make ethical decisions.

Ethics are part of most professional curricula in the health care field. Many textbooks and more or less theoretical education programs exist, as well as ethical platforms for a number of professions.

According to Rossouw, who has studied business ethics, there are three approaches to teaching ethics. These include cognitive competence, behavioral competence, and managerial competence. The first focuses on intellectual knowledge and skills like moral awareness, understanding, decision-making and so on; the second on affections, willingness, courage, etc. The third approach is based on the two others and focuses on organizations’ and managers’ influence on ethics. After analyzing the three positions Rossouw concludes that they are all needed and cannot be separated in practice (Rossouw 2002).

As ethical competence is formed in a social context, there is a need for workplaces to create arenas were the collective ethical competence of a workplace, or a profession, can be maintained and developed (Brytting 2001).

Several researchers have concluded that health care personnel lack support in dealing with ethical dilemmas and that such support is needed (Corley 1995, Scanlon 1997, van der Arend and Remmers-van den Hurk 1999, Raines 2000, Severinsson 2003, Cronqvist et al. 2004, Nordam et al. 2005). Peter et al. (2004, p. 413) present three possible strategies to “increase the resistance of nurses in situations of ethical compromise or conflict”. These include:
1. Educational preparation of future nurses, focusing on empowerment, confidence in decision-making and the ability to reflect about ethical actions
2. Development of practicing nurses

These strategies are probably valid for other health care professions as well.

Scanlon (1997) proposes parallel action in education, practice, policy-making and research. She argues that, as not enough ethics is taught in primary education (for nurses), it is “in clinical settings that opportunities for bioethics education and skill building must be made available…” (Scanlon 1997, p. 86). She also provides examples of how this can be done, suggesting clinically based education, ethics consultations, ethics rounds, and ethical committees.

The CanMEDS project (Royal College of Physicians and Surgeons of Canada 1996) proposes, among other things, role modeling as well as ethics rounds. DeWolfs Bosek (2002) suggests role modeling, routine ethics rounds and lists of potential resources.
Ethics committees are set up in hospitals in many countries. Their functions differ but have mostly to do with education, recommendations, and case consultations. Ethics consultations by an individual consultant, often with training in bioethics, or a committee, are also widespread (Jonsen et al. 2006).

Clinical supervision is one method by which health care professionals can get support in their practice. It gives opportunities to reflect upon moral issues and develop ethical competence (Magnusson et al. 2002, Berggren et al. 2005).

Ethics rounds (or ethical rounds) is another method that has been proposed to make possible a collective development of the moral competence at a workplace. This method is further described in a separate section below. The methods mentioned here are examples of how support directed at practicing professionals can be implemented and are among Items 2 and 3 above (Development of practicing nurses and Support by institutional management).

Theories on ethical competence, as well as the lack of support described by many researchers, point to managerial responsibilities. Trevino (1986) proposes several ways in which the organization and employer can influence or control the employee:
- Organizational culture, i.e. values and beliefs manifested through, among other things, norms, rituals, and legends.
- The immediate job context: reinforcements and other external pressures like time pressure, scarce resources, and competition.

Among the groups included in this thesis maybe pharmacists, practicing in pharmacies, have undergone the greatest changes lately when it comes to their relationships with patients. From not being allowed to talk to customers about their medication they are now supposed to listen to the customer, to find out what drug-related needs and problems the customer has, and to give advice. There is a clear and deliberate refocus from drugs to the human users. But education and support has not developed accordingly. Droege (2003), in arguing for the “reflective practice”, suggests that environmental, cultural, and social components should be added to pharmacist education and that students must be enabled to “think critically, think creatively, and regulate their behaviour” (Droege 2003, p. 72).

The need for clinical supervision for nurses to help them develop “personal qualities, integrated knowledge and self-awareness” in order to cope with moral stress is emphasized by Severinsson and Kamaker (1999, p. 88). Clinical supervision can add to nurses’ (and probably other health care professions) ability to deal with ethical demands.

Learning and training ethics for the purpose of use in practice can be done in many ways. Both method and content must be taken into account when
deciding which path to take, as well as resources, for example time, and access to ethics expertise.

Ethics rounds

Ethics or ethical rounds is one way to systematically organize ethical discussions purported to give health care professionals an opportunity to deal with an ethical troubling situation in a reflective and conscious way. It resembles clinical rounds in the arrangements, but the discussion is focused on the ethical perspectives of health care (Libow et al. 1992).

The practice of ethics rounds differ. Participants can be staff at a department, in which case different professionals, such as doctors, nurses, auxiliary nurses, or pharmacists and dispensers meet together. But ethics rounds has also been used for a particular profession, e.g. nurses (Davis 1979) or they can be open to all staff at a hospital, i.e. open rounds (Hansson 2002). Patients or their advocates are not often invited, but they can be.

Ethics rounds have their starting points in the lived ethical experience of the participants, and hence are inductive. They can be used as a means of deciding action in an ongoing dilemma, or as a discussion after a closed case. In the latter case the objectives for the round would be to learn from experience, to evaluate performance, to get a better understanding of values and attitudes held by an individual and her/his colleagues. In both cases ethics rounds are assumed to improve ethical competence, nurture an open and reflective climate at the unit, and help treat ethical dilemmas that could otherwise lead to moral distress.

The goal of an ethics round is sometimes to reach consensus (Gerdes and Richter 1999), but this does not have to be the case. Especially when working with closed cases the understanding of various positions and the process of the round in itself is presumed to be helpful for ethical progress, for the individual as well as for the team.

The ethics round will follow some sort of systematic process (e.g. a stepwise ethical decision-making model as described above), where facts are obtained and interpreted, reflections are made, and different solutions to the problem are found.

If a moderator/facilitator is present his/her task would be to help the group concentrate on the matter at hand and also to bridge the gaps and tensions that could arise, due to workplace hierarchies. This is in line with what Glover et al. (1986) defines as the “teacher/consultant” role of the ethicist, namely to “instruct […] on a process of moral reasoning by facilitating and exemplifying it” (p. 15), and “…helping to clarify important ways of looking at the clinical question” (p. 18).

The methodology is influenced by the democratic dialogue model which means that in ethics rounds none of the participants is more of an expert than the others; each person’s values and experiences are equally important. It is
what is said, and not who said it, that matters (Drejhammar 2001). This is opposed to the situation in pure medical rounds where expertise does exist.

In conclusion, ethical dilemmas are evident in health care, and it is necessary to have methods or support systems that can facilitate ethical decision-making when they arise. This is important in several ways – first to get as acceptable decisions as possible, which among other things requires that they have been consciously reflected on. This is primarily essential for patients and their advocates, but also for society in general, so that profound ethical values are not violated. Secondly, it is important as it can help avoiding negative outcomes for the professionals, i.e. moral distress.

Health care practice contains ethical dilemmas that have to be dealt with by the staff. Socio-demographic factors and type of organization influences how these dilemmas are recognized and managed. There are many stake-holders that can have an opinion, both regarding the solution of dilemmas and the behavior of the staff. Encounters with dilemmas can eventually lead to stress reactions, i.e. moral distress.

Improved ethical competence is often suggested as the solution not only for dealing with dilemmas, but also for decreasing moral distress. Ethics rounds and theoretical education in ethics are ways to enhance the various dimensions of ethical competence. There is however a lack of controlled, prospective studies as to the effect of education programs on moral distress.
Aims

The aims of this thesis are:

- To explore the nature of ethical dilemmas and see to what extent moral distress is experienced by health care staff.
- To evaluate the established definitions of moral distress.
- To develop a moral distress scale.
- To evaluate the impact on moral distress of a structured education and training program in ethics for health care staff.
- To explore the interrelationship between context and moral distress.

The thesis explores the following questions:

- What kind of situations do health care providers themselves consider as constituting ethical dilemmas?
- Do health care personnel experience stress in connection with these dilemmas?
- Is moral distress limited, as it has hitherto been suggested, to situations where the health care provider knows what is ethically correct but is prevented from acting in that direction?
- Will a structured ethical training program decrease moral distress?
Science is not a thing but a social activity. (Sayer 1992, p. 16)

A real enrichment of ethics by an empirical understanding […] can only be achieved by the use of both qualitative and quantitative research approaches. Their integration leads to enhanced theoretical insights into the multidimensional nature of reality. (Dierckx de Casterlé et al. 2004, p. 38)

The focus in this thesis is on describing and understanding the concept of moral distress, and specifically on whether an interventional training program would lessen the reported levels of moral distress. An important aspect has been to study this across health care settings and professional groups. The research has been done using different methods.

To get an idea of what ethical dilemmas health care staff in Sweden come across in their day-to-day work, and to get a deeper understanding of how this is experienced and dealt with, a qualitative approach was used. The method chosen was focus groups, and there were several reasons for this. Focus groups are useful when studying attitudes and experiences, which was the intention of this research. As we had a pre-understanding that ethics was not often explicitly talked about in these contexts, focus groups (rather than interviews) allowed participants to be helped by other participants to “get started” on the subject. Also, as each group could be described as preexisting, i.e. they consisted of work colleagues already known to each other, this made it possible to observe at least parts of the natural interaction between group members (Kitzinger 1995), both as individuals and as professionals.

In the next step, to see whether the qualitative data obtained was applicable to a larger group and evaluate the intervention, a quantitative assessment method was required and self-administered questionnaires were used. This included an already established instrument, the Quality Work Competence (QWC) psychosocial questionnaire (Arnetz 1996, Arnetz 1997, Arnetz 1999, Anderzén and Arnetz 2005). A self-administered questionnaire also makes it possible for respondents to answer questions when and where they find it convenient, and considerations can be made for anonymity.

In brief, focus groups were used for two reasons – to explore moral distress in different settings and work groups, and to develop a moral distress questionnaire. The questionnaire was also used for multiple reasons – to get
an answer to whether the results from the focus groups were applicable for larger groups, i.e. to get quantitative figures on the qualitative work, and to evaluate the training program.

Design

When starting the empirical work, three pharmacies and five clinical departments were approached. The project, both the content and the design, was described to senior managers. It was explained that randomization would decide what departments would be asked to participate in focus groups and what departments would obtain interventions (one pharmacy and one department). One department declined to participate, referring to workload reasons. The pharmacies were chosen as they were about the same size in regard to numbers of staff and economic turnover. The clinical departments, from three different hospitals, represented one of two specialties, either cardiology or hematology, however they were not equal in size. Two departments (one of each specialty) were of about the same size (numbers of staff), one was almost the double that size, and one was quite small.

After separate randomization to focus groups and intervention the allotment was as described in Table 2.

Table 2. Focus groups, intervention and questionnaire

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n=259

n=184
Ethical aspects

The project was presented to the chairman of the ethics committee in Uppsala, who decided that according to Swedish regulations no permission was needed from the committee. However ethical concerns were fulfilled. Informants in the focus groups were included after informed consent. No personal identification was used on the questionnaires; they could only be identified as to which workplace they came from.

Focus groups

Focus groups are group interviews useful for exploring the experiences and beliefs of people and also to give insights into how they think. The interaction within the group helps in the process of articulating the views of participants. The focus group technique has been described as follows:

The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview. [...] When group dynamics work well the participants work alongside the researcher, taking the research in new and often unexpected directions. (Kitzinger 1995, p. 299)

The earliest use of the focus group method in research was probably in the 1950s by Robert Merton, a sociologist (Sim 1998). Advantages of the method is its high face validity, as participants can directly confirm, complement, or contradict what is said by others (Webb and Kevern 2000), and also misunderstandings can be avoided as the moderator or participants can ask for further explanations.

Some aspects to be aware of when conducting focus groups are the dependence on the moderator, and power imbalances within the group (Sim 1998). The moderator must balance both the communication in the group and her/his own role in the discussion. She/he must be as unbiased as possible, both towards the participants and what they communicate. Group dynamics may lead to some participants not expressing their (alternative) views, making the data “false” as the attitudes of the group are not overt, and hence not available to the researchers.

Focus group interviews were carried out with three groups of staff from three different settings; all took place at the actual workplaces. Included were one clinical department of cardiology in a hospital, one clinical department of hematology in another hospital and one pharmacy, all located in central Sweden. In each focus group five to seven persons participated, and their professions were physicians, nurses, auxiliary nurses, and medical secretaries (hospital departments), and pharmacists, dispensers, and pharmacy assistants (pharmacy). The participants were chosen from the staff by a con-
tact person at the clinic/pharmacy. These had instructions to form a group of individuals with different occupations, backgrounds, ages, genders (not applicable in the pharmacy), and work experience.

The focus groups were led by an experienced moderator (Sofia Kälve-mark Sporrong); a co-researcher was also present (Anna T Höglund), who monitored the audiotape equipment and took notes. A manual had been developed beforehand (see Appendix 1) taking former definitions of moral distress as a starting point. The discussions were based around the manual, but participants were allowed, up to a certain point, to deviate from this. Additional questions were asked by the moderator to follow up or clarify discussions. The sittings lasted from 1½ to 2 hours; they were recorded and transcribed verbatim.

The focus groups started off with the moderator presenting the researchers, the theme of the focus group (ethics and stress in working life), what was expected from the participants (that it was their own experiences, opinions and feelings that were sought) and also confidentiality – that no one beside the two researchers would know the exact workplace visited and that transcriptions of the recordings would be anonymous as to workplace and hence individuals. Then followed the actual interview; after the official interview was over there was a continuing discussion with all or some of the participants. No incentives were given, but all participants took part in the interviews either on regular work time or, if not, were given compensation for the time spent.

Some problems with the focus group method were presented above. In order to avoid those problems as far as possible, some measures were taken. One was using a moderator with substantial experience of conducting focus groups, and hence an understanding of how group dynamics work in these circumstances. Also, the two researchers discussed each focus group immediately after it had been carried out including questions like: What could have been done better? What was group dynamics like? Did anyone seem to be very uncomfortable? Was there any particular question that seemed threatening to interviewees?

The analysis of the data was done by the same two researchers that conducted the focus groups. In a first step the transcriptions were read several times to find passages that actually dealt with experiences of ethical dilemmas and connected areas. These passages were roughly grouped into themes. The next step was a comparison between the themes of the two independent analyses, which were worked through until a shared interpretation was reached.
Questionnaire

When you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind (Lord Kelvin)

When you can measure it, when you can express it in numbers, your knowledge is still of a meagre and unsatisfactory kind (Jacob Viner)

(quoted in Sayer 1992, p. 175)

A structured questionnaire is a research method much used in social science research and other fields, for example marketing. Among its advantages are relatively low costs, no interviewer bias, and anonymity. Disadvantages include that the absence if an interviewer gives no opportunities for explanations, that questions are fixed and may not be relevant to all respondents, and that no new aspects of concepts will be communicated from the interviewees. Also not all subjects are appropriate for quantification (Sayer 1992, Wärneryd 1990).

A questionnaire was distributed to all seven departments involved in the study on two occasions, in April-May 2002 and 2003.

Items in the questionnaire were derived from the focus groups. More precise statements were searched for, explicitly situations described as involving ethical dilemmas. These were identified and grouped independently by the two researchers. After a consensus round 15 items were found for the hospital and pharmacy settings respectively, of which eight were found to be relevant for both settings. One difference remained; the word “patient” was used in the hospital setting and the word “customer” in the pharmacy setting. Also added were questions dealing with relationships between colleagues regarding values and moral discussions.

There was a four-point response alternative ranging from “not at all stressful” to “very stressful”, which was supplemented with a “no opinion” alternative.

In addition to the moral distress scale, respondents answered questions from an established instrument, the QWC (Quality Work Competence) psychosocial questionnaire on leadership, participation, skills development, work environment and so on (Arnetz 1996, Arnetz 1997, Arnetz 1999, Andersén and Arnetz 2005).

Clarity and content validity were tested through an assessment by experienced professionals, and minor changes were made as a result. In the questionnaire the respondents were asked whether the questions were relevant to their work situation, which 82 percent answered was the case.
Statistics
The moral distress items were subjected to an exploratory factor analysis. To estimate internal consistency reliability, Cronbach’s alpha was used. To analyze differences between groups, t-tests and ANOVA were used, and to analyze correlations with the QWC subscales, linear regression was used. Significant levels were set at a two-tailed p<0.05. For further details, please see the respective article.

The intervention
The training program consisted of three lectures on ethics, and three ethics rounds at each of the two intervention sites. It was performed by two experienced ethicists (Mats G Hansson and Anna T Höglund).

Each lecture lasted for about three hours, and covered themes including ethical theory as a tool in ethical decision-making, theories of human dignity, and aspects of medical ethics, such as priority setting in health care practice.

The lectures were followed by three seminars held in the form of ethics rounds, each lasting for about one hour. The ethics rounds method is characterized by being based on the ethical experience of the participants in real-life workplace situations. Therefore, before each round one or two of the participants were asked to prepare an authentic case to be discussed. The discussions were moderated by the lecturers. The objective of the ethics rounds were not to come to a consensus, but rather to discuss closed cases and learn from them. In addition a better understanding of values and reasoning of colleagues was tried for, as described in the Ethics rounds section.

Reflections on methods
Collecting empirical data when working with qualitative methods is often supposed to continue until saturation is reached. When this will happen is evidently hard to establish. It is assumed that when no more substantial information is gained in the last interviews, focus groups, or observations, the material is saturated. With three focus groups in such different settings as in this case are conducted, saturation is probably not reached. But still the groups consisted of 19 persons in total, which is a reasonable quantity. They also represented different occupations, ages, and years of working in occupations, though gender and ethnicity was unequally distributed. Even so, focus groups can be dominated by a few persons and the experiences, values, and reflections of all may not have been expressed. Even though many themes
emerged in all three groups in different ways, suggesting that experiences are similar, this is a limitation of this part of the study.

To capture attitudes and sometimes subconscious feelings with a quantitative research method is hard, if it is possible at all. “Context-dependent actions or properties such as attitudes might […] be considered unsuitable for quantification” (Sayer 1992, p. 177). Nevertheless, the moral distress scale presented in this thesis has been developed from qualitative data, and the questions were appraised as relevant from a vast majority of respondents.

The randomized allocation among clinics/pharmacies to focus group and intervention respectively when designing the intervention was such that three of the control departments happened to obtain the focus groups. As the focus groups reinforced, ethical problems are not discussed in a structured way at the workplaces in the project; it actually seemed that this interventional education was the first such discussion in these specific staff groups. It is conceivable that the focus groups had an “intervention impact”. It has been shown that in-depth interviews with patients can have a therapeutic effect (Morecroft et al. 2004), and also that focus groups members get new insights about their own experiences (Stevens 1996). Bringing these issues to light and, facilitated by the moderator, discussing them at some length – could that be considered as a simpler version of an ethics round?

Response rates for the questionnaire dropped a good deal between baseline and follow-up. This can be explained to a certain extent by outside factors, but it is noteworthy that the intervention departments also dropped in this aspect. It could be hypothesized that they would feel more committed as they had appreciated the intervention (as stated in the evaluations in the last sittings). It must, however, be made clear that the questionnaire was sent with a missive signed by two researchers (Bengt Arnetz and Sofia Kälve-mark Sporrong) that were not engaged directly in the intervention.
Summary of findings

Study 1

The first paper (Kälvermark et al. 2004) presents the result of a qualitative study on moral distress in the Swedish health care setting. Central questions were: What kind of situations do health care providers themselves consider involve ethical dilemmas? and Do they experience stress in connection with these dilemmas?

The analysis of the focus groups resulted in four categories associated with moral distress (with sub-categories), namely:

- **Resources**
  - Lack of time/staff: The present patient versus the future patient
  - Lack of time/staff: The patients versus administrative work
  - Lack of beds – choosing between patients
  - Economic concerns

- **Rules versus praxis**
  - Difficult (impossible) to act according to guidelines
  - Voluntarily breaking the rules
  - Forced to act according to regulations
  - Justifying breaking the rules

- **Conflicts of interest**
  - Patient’s integrity, professional secrecy
  - Professional relations – conflicts in values and hierarchy
  - Patients versus colleagues

- **Lack of supporting structures**

The results suggest that moral distress does occur for many health care professions and not merely in dramatic situations, like dealing with life and death, but also in daily practice. Not only institutional constraints generate moral distress, as suggested in the earlier definitions of moral distress. As a consequence an expanded definition of moral distress was suggested:

Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake.
Study 2

In the second paper (Kälvemark Sporrong et al. 2005) the focus is on ethics in the community pharmacy setting. As compared to the hospital setting few studies have concentrated on ethically troubling situations in pharmacies. The extended role of pharmacy personnel has led to more interaction with, and increased responsibilities towards customers, and hence more and other types of ethical dilemmas.

The central questions in the article are: What situations do pharmacy staff consider to be ethically troubling? To what extent do they experience negative stress in these situations?

Results of a questionnaire show that many of the situations that were seen as most troubling had to do with the lack of resources (e.g. lack of time), the reimbursement system and other economical factors. Younger personnel also reported more distress than the older. No differences could be seen between the three pharmacies regarding levels of distress. There also seemed to be a lack of supporting structures in all pharmacies.

From the study it can be concluded that ethical dilemmas occur in pharmacies and that they do generate moral distress. In pharmacies, personnel meet the customer on a more neutral ground than in hospitals and this makes the customer more autonomous, less dependent, than in other health care arenas.

There is a need for pharmacy organizations (employers) to take ethical problems into consideration and to develop ethical support systems to assist employees when they encounter ethical dilemmas. Ethical guidelines and individual coping strategies exist, but not enough of them.
Study 3

In the third article (Kälvemark Sporrong et al. 2006) the development, validation and application of a moral distress scale is presented. The questionnaire was, as mentioned above, derived from the focus groups and adapted to the two settings. The objective was to find an instrument that could be used in different settings in the health care sector that would measure levels of moral distress in everyday practice.

A total of 259 persons from seven departments (of which three were pharmacies) completed the questionnaire; the response rate was approximately 71 percent.

There were twelve statements concerning moral distress and moral work environment in the questionnaire. A factor analysis resulted in two factors: Factor 1 – level of moral distress, and Factor 2 – tolerance/openness. After removal of items, Factor 1 contained six items, and Factor 2 contained three items. Cronbach’s alpha was 0.78 and 0.62 respectively.

Differences in levels of moral distress were found between pharmacies and hospital departments and between the oldest and youngest age groups, with hospital staff and the youngest group experiencing more moral distress.

Both factors were tested with a linear regression model in order to look for association with the QWC subscales (leadership excluded). The tolerance/openness factor was significantly related to the social climate subscale in QWC.

The instrument worked fairly well but needs to be further developed. One item, “I am sometimes forced to act against my conscience” had a high number of “no opinion” answers and needs to be reformulated.

The strengths of the instrument are that it can be used in different health care settings and that its focus is on everyday ethical dilemmas.
Study 4

A controlled prospective study was carried out in order to evaluate a structured vocational training program in ethics for its effects on moral distress. The results of the evaluation are presented in paper 4 (Kälvemark et al., submitted).

The training program was designed to provide opportunities for developing ethical competence, thus incorporating theory as well as possibilities to train understanding, awareness, and reflection skills.

The settings for the intervention were one hospital clinic and one pharmacy. The educational training program consisted of three lectures on ethics and three ethics rounds, to offer the staff a method for dealing with ethical dilemmas.

To evaluate the intervention, the questionnaire described above in Study 3 was completed by the personnel at the clinic/pharmacy before and after the intervention, with one year in between. Staff at two other hospital departments and two pharmacies served as control groups and were asked to complete the questionnaire on the same occasions as the intervention groups. A total of 259 persons completed the questionnaire at baseline and 184 at follow-up.

The training program was appreciated by the participating staff, but no statistically significant changes were displayed in reported levels of moral distress, neither when looking at before-after differences nor compared to the control groups.

Interpretations of the results show that the intervention had, as such, no impact on moral distress or it was too short to have an impact; the assessment instrument was not sensitive enough; or management was not sufficiently involved in and dedicated to the method learned.

There is a lack of prospective controlled evaluations of ethical competence development programs. Future studies can take into account the lessons learned in this study.
Discussion

The overall aim of this thesis was to explore the nature and extent of moral distress in some health care units in Sweden (including pharmacies), and to evaluate whether vocational training in ethics decreases perceived levels of moral distress.

First a qualitative study was done in order to get a deeper understanding and description of moral distress in the Swedish context. As pharmacies are less studied than other health care settings in this aspect a further exploration of this was made. The focus group discussions and subsequent analysis indicated a need to expand the hitherto traditional definition of what entails moral distress. In order to be able to evaluate the intervention (a structured education and training program in ethics) a moral distress questionnaire was developed and validated. The vocational training program was carried out at two workplaces. The evaluation was designed as a prospective, controlled study. It was not able to identify any statistical significant effects from the intervention program on the levels of moral distress as compared to control groups, not offered the intervention.

Ethical issues in health care can be and have been studied from various perspectives. This includes both who is exposed to ethical concerns, the characteristics of ethical dilemmas, and the individual’s process from being exposed to making a decision.

In this research the perspective has been that of the professional, and focus has predominantly been on the concept of moral distress. However, in the course of the research many other aspects have appeared. These include health care ethics and occupational stress in a broader sense, the impact of factors such as organization, education and socio-demography, ethical competence and education, and work place support structures (including regulations and guidelines), just to mention a few.
Figure 3. The relationship between society, organization, profession, and individual.

The above figure is an attempt to illustrate the relationship between the three levels of society, organization, and individual in regard to values, ethics and moral distress.

*Society* has an impact on individuals, in this case health care professionals and organizations through direct intervention (laws, regulations, financing), but also through the development that takes place in society, for example technical progress or changes related to socio-demographic factors. The latter include influences from other societies, through globalization in general or immigration, and empowerment of oppressed groups such as women and homosexuals.

As laws and regulations directly (Kälvemark et al. 2004) or indirectly (through generating institutional barriers, Jameton 1993) are sources of ethical dilemmas and hence moral distress, society also has an impact on those factors.
The health care organization, in analogy with what is stated above has an impact on ethical dilemmas and moral distress. Furthermore the organization can influence ethical decision-making, for instance by providing or not providing resources and opportunities for ethical supervision, ethics rounds, or ethical committees.

The professional value system also affects the individual professional. This happens during initial education, training, and throughout working life. Ethical guidelines are important to protect the patients, but also for protecting the reputation of the profession, i.e. keeping the individual professional in the collective value system. The lower right corner of the figure has been explained in the moral distress section of Background.

As shown in Figure 3, ethics in health care is not an isolated area. It is part of, reliant on, and interwoven with other structures in society, the organization, the professional body, and individuals.

As stated in the Background section, the concept of moral distress has been discussed and redefined during the years since it was introduced by Jameton. The definition of moral distress developed in the present thesis is: Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake (Kälvemark et al. 2004, p. 1082ff). In this definition what Jameton categorizes as moral dilemmas and moral distress have not been separated as they seem, in practice, to be very much alike. Even if it is clear that they appear in different stages of the moral decision process, there are some similarities; both dilemmas and distress situations deal with difficult choices, and they can both lead to stress reactions. This could be described thus:

Jameton (1993) provides some examples of situations to illustrate the differences between moral dilemmas and moral distress. In the first case a patient does not want to get out of bed after surgery, which to the nurse appears unwise for the patient’s health. This is a dilemma; the nurse is torn between two conflicting principles – that of beneficence, caring for the health of the patient, and that of autonomy, respecting the patient’s wishes. In every such case one principle must come out on top of the other; which one does may differ, but there is a choice to be made. Another example concerns an infant in a neonatal intensive care unit. The infant has poor prospects and in such cases the infant is sometimes allowed to die. In this example the physician pursues aggressive therapy which means that the nurse has to perform procedures that are painful to the infant. If allowed to make his/her decisions the nurse would not go through with this. Jameton gives this as an example of moral distress; the nurse cannot act according to his/her ethical intention because he/she is forced to follow the physician’s orders, performing procedures he/she objects to. There is an underlying ethical dilemma between
beneficence and nonmaleficence, but in this case, as opposed to the first one, the nurse knows what he/she thinks would be the right moral action.

In the first case the nurse probably can not force the patient to get up. In the second, though, there is a choice to be made between obeying the physician’s order (performing procedures) or going against them (not performing procedures). So, even if it is not easy to go against orders (in Jameton’s words: difficult or impossible), the choice is still there. (There is a difference of gravity in the two cases, but that is another issue.)

In the examples above, who is to say that going against the wish of the physician is harder than going against the wish of the patient? In a dilemma situation, where two or more values are at stake, at least one has to go. Even if a decision is made based on good arguments, there is still the loss of a value. The point to be made is that both the dilemma and the distress situation can probably lead to stress reactions.

Criticism in line with the last point has also been emphasized by Hanna, who argues that moral distress should be more widely defined, in fact it could serve as an “umbrella category that contains the other two” (2004, p. 74), i.e. moral uncertainty and moral dilemmas. The main reason for this is the use of the word “distress”. The fact that one knows what action to take, which is the difference between moral distress and the other two categories, is not per se enough to make ethically troubling situations accompanied by distress.

That the original definition of moral distress is too narrow has also been pointed out by Webster and Baylis (2000). They highlight that not only organizational factors can be hindrances but also aspects such as personal failings, e.g. cowardice, expediency, or other non-organizational circumstances.

On the other hand some research suggests that ethical problems arise less often than non-ethical, and that organizational problems are more burdensome for nurses than ethical (Georges and Grypdonck 2002). But then again, as organizational factors are one of the origins of ethical dilemmas, or at least can aggravate them (see, for example, Jameton 1993, Raines 2000, Corley 2002, Kälvemark Sporrong et al. 2004) then the differentiation is hard to make.

It could even be questioned whether all stress experienced in health care in one way or another can be described as having ethical origins. Hanna suggests that “Harming the purpose of another person, living creature, object, or situation is an immoral act. Experiencing such harm can produce moral distress.” (Hanna 2004, p. 77) Many tasks in health care do, in one way or another, have an impact on other human beings, especially patients. The concept of moral distress and other related concepts still need to be defined as to what an ethical issue is and what is not. Otherwise the idea of moral distress may not be very useful but rather just another word for occupational stress. One proposal is to discuss dilemmas or problems that have ethical aspects in them rather than “pure” ethical dilemmas and problems. Then the ethical
dimension could be subject to ethical analysis and reflection rather than the problem as such.

Having said that, it can be concluded from this and other research, that Swedish health care staff do experience ethical dilemmas in their daily practice, and that some of these experiences eventually can lead to stress responses. This does not happen only when dramatic situations appear; the daily wear-and-tear situations with ethical dimensions can also have unhealthy consequences.

When an ethical dilemma, or a dilemma with an ethical dimension, arises and is dealt with, societal, organizational as well as individual factors can influence whether the outcome is negative or not for the professional involved. A dilemma that is dealt with in a constructive way can lead to growth. Ethical dilemmas or stress, as such, are not by definition negative.

In this research the following differences in levels of moral distress were found; younger professionals experience a higher degree of moral distress than the older ones and professionals working in the pharmacy context experience less moral distress than do their colleagues working in hospitals.

That moral distress diminishes with age is in line with other research and can be explained by older persons gaining security (Sørlie et al. 2000), experience (Corely et al. 2005), and that their moral cognitive capacities increase (Gaudine and Thorne 2001). Experience entails maturity and a more pragmatic view, especially on what kind of responsibilities can be undertaken.

Context has also been shown in previous research to have an impact on ethical issues. Leadership, behavior of peers, and type of organization are among the factors that have an effect on moral behavior. In this study there was a significant difference in experiences of moral distress between those working in pharmacies and those working in hospital departments. In the pharmacy the patient may be less vulnerable, apart from on economic issues, and hence less dependent on the professional – giving opportunities for a slightly more equal relationship. Even though pharmacy personnel in one way are dependent on prescribers (typically physicians), there are less professions present in the pharmacy, which may give less room for hierarchical constructions.

In this research no significant differences were found between professions, not even between physicians and nurses, where differences have been found in other aspects of ethics. It may be that moral distress is equally distributed along professions. However, the number of members of each profession in the study was fairly low, and statistical power may not have been enough to show existing differences. Further research could investigate whether, even if levels of moral distress are the same, other aspects of moral distress, such as types of dilemmas and coping strategies, differ between
professions. Also, hierarchies between professions in health care are evident and this also impacts the ways in which ethical dilemmas can be tackled.

A weakness in the empirical part of the study is that neither gender nor other socio-demographic factors was included in the analysis. As has been explained before, very few men work in the pharmacies and therefore anonymity could not be guaranteed. Gender and other factors such as ethnicity, sexual orientation, religion, and social background are probably very important for what is perceived as a moral dilemma, and how it is dealt with. Cultures and sub-cultures have varying understandings of what is ethical. One example from daily practice is the ongoing disagreement in the pharmacy sector, where some professionals are willing to dispense “morning-after-pills” and some are not, based on religious convictions.

Learning and training ethics has repeatedly been promoted as a remedy to lessen negative outcomes of ethical dilemmas (Corely 1995, Scanlon 1997, van der Arend and Remmers-van den Hurk 1999, Raines 2000, Severinsson 2003, Cronqvist et al. 2004, Peter et al. 2004, Nordam et al. 2005). One aim of this thesis has been to find out if a training program in ethics, combining enhancement of theoretical knowledge and training ethical decision-making, does lead to better outcomes in terms of moral distress. Although participants appreciated the program, no significant effects on moral distress were observed.

The program was designed to cover the different aspects of ethical competence development. It consisted of lectures where ethical theory was presented, the teaching of a structured method to deal with ethical decisions, and opportunities for reflection. By drawing attention to ethics and ethical dilemmas in everyday practice, a chance to develop ethical sensitivity was also given. The fact that ethics rounds did not continue at any of the intervention sites where it was taught is of course a shortcoming of the intervention. A deeper understanding is needed of why methods such as this are not put into practice after the enthusiastic first phase. Are ethics rounds or the like not needed in health care settings? Are they too time-consuming in relation to the outcome? Is it a threat to managers, as they can lead to increased demands from employees?

Development as a group and as an individual takes time. Ethical maturity and courage are needed to dare to confront oneself and one’s colleagues with the ethical dimension of situations, a willingness to dive into deep waters, to admit that there sometimes are no certain answers to difficult questions. It could be questioned whether the time that elapsed between intervention and follow-up was too short for groups and individuals to cultivate their ethical competence in these aspects.

Ethics rounds, as carried out in this project, did not directly involve the patient or any other stakeholder outside the professional group. As it provides opportunities for deeper reflection and clarifying of positions that the
patient (or his/her advocate) does not have, there is a risk that the rounds will strengthen the professionals’ power over the patient (Tong 1997), which is contrary to current development in health care. Another danger to look out for is that there may be a bias towards medical facts, as opposed to other facts such as social and emotional, when health care professionals discuss ethical dilemmas (Wirtz et al. 2003). This could be expected as the medical or pharmaceutical perspective and terminology are what the professional is used to and comfortable with. The advantage of a moderator/facilitator (preferably with another academic background) is that he/she can help avoiding these pitfalls and also help in articulating and rephrasing what is said.

Moral problems seem to be unavoidable when working in health care. Ever so competent and experienced professionals will still – from time to time – find themselves in situations where no (easy) solutions can be found. Regardless of guidelines and support systems of various kinds, the unexpected will happen. Every such new situation is from one viewpoint something to learn from, but it is also important for the individual, colleagues, employer and society at large, to understand under what circumstances and in what context decisions have to be made and carried out. And in the end it is important, as long as committed professionals have tried their best, to be able to forgive.

Future research

There are many aspects of ethics, ethical competence and moral distress in health care. More knowledge is required in the area in order to improve care, working environments and organizational effectiveness. First, the discourse on what is an ethical dilemma, and what is not needs to continue. Is there a distinction to be made, or is it a question of degree of the ethical dimension in dilemmas?

As stated before, socio-demographic factors such as gender, ethnicity, sexual orientation, and social background, are important for different aspects of ethics. There is a need for research in the field of ethics to take these factors into consideration.

There seem to be differences in level of moral distress between organizations. In the research presented here pharmacy staff reported less moral distress than hospital staff. More research is needed to find out which factors actually impact on the levels of moral distress. Is it, for example, education, professional role, relationship to patient/customer, how the workplace is
managed and organized, employment status, support system, professional value system, peer support, hierarchies within the workplace, a combination of these, or something else?

There is a need for further empirical research on the relationship between ethical competence and aspects such as ethical reasoning and moral distress. Of special interest are evaluations of different interventions and support systems aimed at improving not only competence but also behavioral aspects. This is with the aim of finding out what the most efficient means are to enhance skills in dealing with ethical dilemmas. In order to carry out evaluations qualitative as well as quantitative methods should be used; the first to describe and better understand the context and process of ethical education, the latter to detect changes and make comparisons between various methods. Even if ethics rounds did not seem to have an observable impact on moral distress as assessed in this study, the intervention could be modified, based on the experiences gained from the current study, and then tried again. For example, an intervention also directed to support management may obtain other results.

The moral distress questionnaire presented in this thesis needs further development, as described in Study 3. Also, the categories of dilemmas found in the qualitative phase of this study could be tested as to their relevancy in other settings than the ones studied here. Are they sustainable when tried out in other contexts and cultures?

In this thesis community pharmacies were included, but little is known about what kind of ethical dilemmas pharmacists working in hospitals come across. In what way are they similar to or different from the ones encountered by other pharmacists and other health care professions in the hospital? Pharmacy practice and clinical pharmacy are areas where there is a lack of research on different perspectives of ethics (as pointed out by Wingfield et al. 2004). This is important especially if the results of Latif (2000) are true for others than pharmacists in the southeastern US (where his sample was drawn), specifically that community pharmacists score lower on ethical reasoning than other health professionals do.

In Sweden the pharmacy system will probably change fundamentally in the near future, especially regarding ownership and the number of commercial actors. This, among other things, will raise a question already existing in other countries and areas – how is the relationship between private profit, third-party payers, and a good and equally distributed healthcare to be managed?
Conclusion

Ethical dilemmas are present for health care professionals in their daily practice and may eventually lead to moral distress. It is assumed that enhanced ethical competence can help decrease the negative effects of ethical dilemmas (and increase quality in decisions), which in turn would contribute to preventing symptoms of stress, i.e. moral distress.

Ethical dilemmas can stem from opposing demands, conflicts of interest, lack of resources, or a mismatch between demands and resources. To this pressures can be added the professional obligations of conduct and quality in all aspects of health care.

The problems have to be acknowledged by society on different levels, and employers need to find ways to enhance ethical awareness and competence, and support employees in recognizing, reflecting on, and making decisions in ethically difficult situations.

To do this there are no short cuts. Developing an ethical culture in work groups as well as maturity in individuals takes time and effort. This research has shown that a condensed educational and training intervention has no measurable effects on perceived levels of moral distress, at least not in the short term.

There is a need to further refine the various aspects of ethical dilemmas in the clinical settings, and to evaluate the most efficient means to enhance skills in dealing with ethical dilemmas, for the benefit of staff, patients, institutions, and society in its entirety.
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Summary in Swedish

Etisk kompetens och moralisk stress inom hälso- och sjukvården
En prospektiv utvärdering av etikronder

Hälso- och sjukvården i västvärlden har genomgått, och genomgår fortlöpande, strukturella och finansiella förändringar. Teknisk utveckling, ökad komplexitet i terapier, organisatoriska reformer, förändrade finansieringsprinciper, en mer utbildad befolkning och kulturell mångfald är några av de faktorer som påverkar verksamheten. Samtidigt, och delvis förstärkt av utvecklingen, uppkommer ofta etiska dilemma för hälso- och sjukvårdens personal.

Det finns många intressenter när det gäller etiska ställningstaganden i sjukvården, några av dessa är;

- samhället, som genom lagar och förordningar ställer krav på bl.a. en god vård på lika villkor, patientens autonomi och principer för prioriteringar
- arbetsgivaren genom till exempel etiska regler och policys,
- vårdprofessioner och deras organisationer genom etiska riktlinjer,
- patienter och anhöriga som har uppfattningar om vad som är etiskt riktigt.

Den enskilda hälso- och sjukvårdspersonalen måste förhålla sig till allt detta, men också till sin egen uppfattning om vad som är etiskt. Det är inte alltid alla dessa regler, riktlinjer och viljor sammanfaller, eller går att överföra i praktiken.

Etiska dilemma kan i förlängningen leda till stressreaktioner som kan vara fysiologiska, känslomässiga, kognitiva och beteendemässiga. Stressreaktioner förknippade med etiska frågeställningar benämnings moralisk stress.

För att kunna fatta så väl övervägda etiska beslut som möjligt behöver hälso- och sjukvårdspersonal såväl etisk kompetens som kunskap och tränning i metoder för etiskt beslutsfattande. Etisk kompetens innefattar både teoretisk kunskap om etik och etiska riktlinjer, och medvetenhet kring och förmåga att reflektera över moraliskt svåra situationer. Dessutom måste man kunna, och våga, handla utifrån den kompetens man har.

Etikronder är en, av flera, metoder som kan användas för att öka den etiska kompetensen och bidra till ett bättre etiskt beslutsfattande. Etikronder

Syftet med avhandlingen har dels varit att utforska etiska dilemman och begreppet moralisk stress inom svensk hälso- och sjukvård där även apotek inkluderas. Dessutom har syftet varit att genomföra och utvärdera en intervention, med föreläsningar i etik och etikronder, avseende effekter på moralisk stress. Interventionen syftade till att höja den etiska kompetensen och därmed minska den moraliska stressen.

I en första kvalitativ fas genomfördes fokusgrupper på tre arbetsplatser, två sjukhuskliniker och ett apotek, dels för att undersöka vilka typer av situationer som är etiskt svåra och kan leda till moralisk stress, och dels för att få underlag till en enkät (se nedan).

Resultaten från fokusgrupperna visar att följande situationer är associerade med moralisk stress:

- Resurser; brist på tid, personal, sängplatser, pengar. Detta leder till att prioriteringar måste göras mellan patienter samt mellan patienter och administrativt arbete.
- Regler kontra praxis; kan innebära att man har svårt att följa regler, att man tvingas följa regler man inte vill följa eller att man väljer att bryta mot regler.
- Intressekonflikter; exempelvis kan patientens intressen ställas mot kollegornas och olika professioners intressen mot varandra.

Dessutom framkom att det råder en brist på stödjande strukturer, t.ex. i form av etisk handledning eller etiska ronder, på arbetsplatserna.

Utifrån dessa resultat föreslogs följande definition av moralisk stress:

Traditionella negativa stresssymtom som uppstår på grund av situationer som innefattar etiska dimensioner och där vårdpersonalen upplever att hon/han inte kan upprätthålla alla intressen och värden som står på spel.

Utifrån fokusgrupperna utvecklades och validerades en moralisk stress-skala i enkätförformat. Tillsammans med en befintlig arbetsmiljöenkät (QWC) distribuerades den till all personal med patient/kund-kontakt på fyra sjukhuskliniker och tre apotek som förmåningen i en prospektiv studie. Därefter genomfördes en intervention på ett apotek och en klinik, övriga fungerade som kontrollgrupper. Interventionen bestod av föreläsningar i etik samt tre etikronder; detta i syfte att både bidra till en ökad teoretisk kunskap, men också för att utveckla andra delar av etisk kompetens som medvetenhet och reflek-

Resultaten från den kvantitativa mätningen visade att personal vid sjukhusklinikerna upplevde mer moralisk stress än apotekspersonalen. Dock uppvisades inga statistiskt signifikanta effekter av interventionen. Det senare kan ha flera orsaker; interventionen var inte tillräckligt lång eller på andra sätt ineffektiv, sambandet mellan moralisk stress och etisk kompetens är inte så starkt som antagits, moralisk stress-skalan är inte tillräckligt känslig eller ledningen på arbetsplatserna var inte tillräckligt involverade.

Några av de slutsatser som kan dras av studien är att moralisk stress drabbar samtliga undersökta yrkeskategorier och att det är viktigt att de etiska frågeställningarna synliggörs på arbetsplatserna inom svensk hälso- och sjukvård, eftersom etiska dilemma oftast uppstår i vårdens vardag. För att förbättra möjligheterna för hälso- och sjukvårdens personal att leva med och hantera etiska dilemma och följderna av dessa krävs fler insatser och dessutom studier som utvärderar och visar vilka metoder som ger ett effektivt stöd i reflektion och beslutsfattande samt minimerar den moraliska stressen. Detta blir till gagn för såväl patienter, personal, hälso- och sjukvårdens organisationer som samhället i stort.
References

Agarwal J, Malloy DC. 2002 An integrated model of ethical decision-making: A proposed pedagogical framework for a marketing ethics curriculum. Teaching Business Ethics, 6(2), 245-268


Arnetz B. 2001. Psychosocial challenges facing physicians of today. Social Science and Medicine, 52(2), 203-213


Beagan BL. 2000. Neutralizing differences: Producing neutral doctors for (almost) neutral patients. Social Science and Medicine, 51(8), 1253-1265


Brown C, Arnetz B, Petersson O. 2003. Downsizing within a hospital: Cutting care or just costs? Social Science and Medicine, 57(9), 1539-1546


DeWolf Bosek MS. 2002. Effective communication skills. The key to preventing and resolving ethical situations. *JONA’s Healthcare Law, Ethics, and Regulation*, 4(4), 93-97


Drew N. 2006. Bridging the distance between the objectivism of research and the subjectivity of the researcher. *Advances in Nursing Science*, 29(2), 181-191


Habermas J. 1966. Knowledge and interest. *Inquiry*, 9, 285-300


Kitzinger J. 1995. Qualitative research: introducing focus groups. *British Medical Journal*, 311(7000), 299-302


Magnusson A, Lützén K. 1999. Intrusion into patient privacy: A moral concern in the home care of persons with chronic mental illness. *Nursing Ethics, 6*(5), 399-410


Mebane EW, Oman RF, Kroonen LT, Goldstein MK. 1999. The influence of physician race, age, and gender on physician attitudes toward advance care directives and preferences for end-of-life decision-making. *Journal of the American Geriatrics Society, 47*(5), 579-591


63


Torjuul K, Nordam A, Sørlie V. 2005a. Ethical challenges in surgery as narrated by practicing surgeons. BMC Medical Ethics, 6(2)

Torjuul K, Nordam A, Sørlie V. 2005b. Action ethical dilemmas in surgery: an interview of practicing surgeons. BMC Medical Ethics, 6(7)


Wirtz V, Cribb A, Barber N. 2003. Understanding the role of “the hidden curriculum” in resource allocation – the case of the UK NHS. Health Care Analysis, 11(4), 295-300


Wärneryd B. (ed). 1990. Att fråga. Om frågekonstruktion vid intervjuundersökningar och postenäkter. (To question. On question design in interview studies and postal questionnaires.) Statistiska Centralbyrån (Statistics Sweden), Stockholm


Appendix 1

Manual for Focus groups used in the current study

1. Examples of occasions when you have acted against your conscience/beliefs?
   What happened? How did it feel?
2. What is important when meeting a patient?
3. What is good care?
4. Relations to patients
   What do the relations look like? How deeply involved do you get (examples)?
   Empathy, perceptiveness? The patients’ life stories? The patients’ right to autonomy? Are there conflicts between this and the professionalism of staff?
5. Prioritizing
   What working tasks are “sacred” – cannot be left undone?
   What can you discard? What/who will suffer from this?
   Are there principles/guidelines?
   - in theory (officially)?
   - in practice (unofficially)?
   Hierarchies - officially and unofficially: who decides what is “right”? Factual knowledge contra experiences?
   Relations between staff, and patient – staff. What are the loyalties?
   Financial responsibilities – does that affect the daily work? Who have/takes that responsibility?
   Stress related to issues above?
6. Regulations
   Do you ever break rules/regulations? When and how do you account for that, do you tell at all? How do you react when/if other people break rules?
   Own responsibility and conviction contra regulations, “should” you break regulations more often?
   How does it feel – what happens to you?
7. Behavior/action
   What behaviors/actions are not acceptable/ permitted?
   - how do you know?
   - what happens if somebody crosses the border lines?
   How does it feel – what happens to you?
8. Emotions
   Emotions in relation to work?
Is it permitted to have feelings related to work?
Possibilities to debrief – as a group or individually. How?

9. Work environment/stress
How do you experience the work environment (psychosocial) at the clinic/pharmacy?
Are there demands that are hard to comply with and/or incompatible demands?
Relation between demands – rewards.
Is there a discrepancy between what you say and what behaviors are permitted?
Social support, what support do you get from colleagues and management?

10. Wrapping up
Knowledge, regulations, and feelings for patients – are they always possible to bring together?
Do you avoid certain situations? In that case, why, in what way (thoughts, feelings)?
Do you discuss ethical issues at the workplace? Is there a forum for collective reflection/dialogue about what is accepted, about ethics?
Is there respect for differences in values (that can be seen through behavior)?
A doctoral dissertation from the Faculty of Medicine, Uppsala University, is usually a summary of a number of papers. A few copies of the complete dissertation are kept at major Swedish research libraries, while the summary alone is distributed internationally through the series Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine. (Prior to January, 2005, the series was published under the title “Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”.)