Workplace Distress and Ethical Dilemmas in Neuroscience Nursing

Marit Silén, Ping Fen Tang, Barbro Wadensten, Gerd Ahlström

Abstract: This study concerns Swedish nurses’ experiences of workplace stress and the occurrence of ethical dilemmas in a neurological setting. Qualitative interviews were conducted with 21 nurses. The interview results were subjected to qualitative latent content analysis and sorted into 4 content areas: workplace distress, ethical dilemmas, managing distress and ethical dilemmas, and quality of nursing. Common workplace stressors were high workload and lack of influence. These were perceived to have negative consequences for the quality of nursing. Ethical dilemmas mainly concerned decision making on initiation or withdrawal of treatment, which was experienced as a troublesome situation where conflicts could arise. The nurses managed the distress and ethical dilemmas by accepting and adjusting to the situation and seeking support from colleagues. They also endeavored to gain new strength in their private lives.

Neuroscience nurses, like other nurses, work in healthcare systems that undergo continual change. In Sweden, the changes in the healthcare system during the past 10 years have led to a greater demand for healthcare services, new discoveries in medicine, and greater demands by better-informed patients and families (Forsberg, 2001). All this contributes to ethical dilemmas and workplace stress, which have increased during recent decades and had a greater impact on nurses (McVicar, 2003). In a review by McVicar, six sources of workplace stress for nurses were identified: workload, relationship with other clinical staff, leadership and management issues, emotional demands of caring, shift working, and lack of reward. Nurses working in different areas of practice reported similar stress levels, but they ranked the stressors differently (McVicar). The workplace stressors are the same from one country to another, according to a cross-cultural study of workplace stressors. The highest-ranked stressors in the countries compared in the study were workload and dealing with death and dying (Lambert et al., 2004). Constant changes in the organizations where nurses work and in job designs also added to workplace stress (Clegg, 2001). Closely related to the concept of workplace stress is role stress, which is the result of unfulfilled role expectations. Factors contributing to role stress include lack of control over the work situation; shortage of resources; concern for the quality of nursing; and lack of cooperation among patients, families, and staff members (Chang, Hancock, Johnson, Daly, & Jackson, 2005).

Ethical dilemmas in nursing have been related to lack of resources such as staff and time, conflicts of interest involving professional hierarchies (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004), difficulties with regard to preserving patients’ integrity (Kälvemark et al.; van der Arend & Remmers-van den Hurk, 1999), and situations where patients are given, or are at risk of being given, unnecessary treatment (Raines, 2000). The research on workplace or role stress and ethical dilemmas has investigated different healthcare settings, but no study has been found that explicitly deals with the stress and dilemmas experienced by nurses working in a neurological setting. Neuroscience nurses care for patients with severe neurological conditions involving a complex mix of sensorimotor, cognitive, and emotional impairments (Banich, 2004; Hickey, 2003). These illnesses have a great impact on patients’ lives and the lives of their families. This means that neuroscience nurses must be proficient in handling life-threatening situations, rehabilitation, and long-term palliative care. A limited number of studies examining Swedish nurses’ experiences of workplace stress and ethical dilemmas have been carried out (Cronqvist, Lützén, & Nyström, 2006; Cronqvist, Theorell, Burns, &
Lützén, 2001, 2004; Hertting, Nilsson, Theorell, & Larsson, 2004; Kälvemark et al.; Olofsson, Bengtsson, & Brink, 2003; Sporrong, Höglund, & Arnetz, 2006), but none of them has dealt with the experiences of nurses working with neurology patients. The aim of this study was therefore to describe Swedish nurses’ experiences of workplace stress and the occurrence of ethical dilemmas in a neurological setting.

**Methods**

**Sample and Participants**

The participants were drawn from two departments at a university hospital in Sweden. The physician in charge gave permission for the study to be performed. The project leader (the fourth author) informed the nurse manager of each department about the study and the procedure of data collection. All 21 nurses working the day shift received a letter with information about the study. The nurse manager informed them about the study orally and asked whether the nurses would be willing to participate in the study. In the written and oral information that preceded the data collection, it was clearly stated that participation was voluntary and confidentiality was assured. Participation in this study was based on informed consent and conducted in accordance with the Swedish act concerning the ethical review of research involving humans (Swedish Code of Statutes, 2003), the ethical principles for medical research involving human subjects (World Medical Association, 2004), and the ethical rules and guidelines established by the Swedish Council for Research in the Humanities and Social Sciences (2007). Completion of the interview was viewed as consent. Participation or refusal to participate was not linked to the individual nurses’ jobs or performance reviews. Of the 21 nurses who were asked to participate, only one did not want to because of a lack of time for an interview. One nurse who mainly worked night shifts but had many years’ experience of working day shifts was then invited to participate and was included in the study. Ultimately, 21 nurses participated in the study. Descriptive data on the study group are shown in Table 1.

**Interviews**

The interviews were performed over a 3-week period. They were carried out as conversations based on an interview guide that included some general questions as well as individualized follow-up questions. The interview guide consisted of the following general questions:

- What upsets you at work?
- When do you feel displeasure at work?
- What situations at work make you sad after a working day?
- Do you experience ethical issues/dilemmas in your work? If yes, can you give an example of a situation where one of these issues/dilemmas appeared?
- If yes on the latter question, how did you try to cope with this situation?
- How do you perceive the quality of nursing on your unit?
- Do you experience a discrepancy between the actual quality of nursing on your unit and the desirable quality?
- If yes on the latter question, how do you try to cope with this discrepancy?
- What in the working environment is an obstacle to resolving ethical issues/dilemmas at your work?

Follow-up questions were asked, their scope and number depending on how precisely and fully the person had answered the general questions. The

<table>
<thead>
<tr>
<th>Table 1. Background Data of Participating Swedish Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background Variables</strong></td>
</tr>
<tr>
<td><strong>Age in Years (n = 21)</strong></td>
</tr>
<tr>
<td>Mean (SD)</td>
</tr>
<tr>
<td>36.7 (12.0)</td>
</tr>
<tr>
<td>Range</td>
</tr>
<tr>
<td>24–62</td>
</tr>
<tr>
<td><strong>Marital Status (n = 21)</strong></td>
</tr>
<tr>
<td>Married or cohabiting</td>
</tr>
<tr>
<td>15 (71.4)</td>
</tr>
<tr>
<td>Living alone</td>
</tr>
<tr>
<td>4 (19.0)</td>
</tr>
<tr>
<td>Divorced</td>
</tr>
<tr>
<td>1 (4.8)</td>
</tr>
<tr>
<td>Widowed</td>
</tr>
<tr>
<td>1 (4.8)</td>
</tr>
<tr>
<td><strong>Number of Family Members (n = 19)</strong></td>
</tr>
<tr>
<td>2 or fewer</td>
</tr>
<tr>
<td>14 (73.7)</td>
</tr>
<tr>
<td>3 or more</td>
</tr>
<tr>
<td>5 (26.4)</td>
</tr>
<tr>
<td><strong>Satisfaction with Personal Finances (n = 19)</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>16 (84.2)</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>3 (15.8)</td>
</tr>
<tr>
<td><strong>Person Giving Help at Home (n = 19)</strong></td>
</tr>
<tr>
<td>Partner</td>
</tr>
<tr>
<td>9 (47.4)</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>3 (15.8)</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>7 (36.8)</td>
</tr>
<tr>
<td><strong>Nursing Education (n = 19)</strong></td>
</tr>
<tr>
<td>Basic level</td>
</tr>
<tr>
<td>17 (89.5)</td>
</tr>
<tr>
<td>Specialist training</td>
</tr>
<tr>
<td>2 (10.5)</td>
</tr>
<tr>
<td><strong>Years Worked in Neuroscience Nursing (n = 18)</strong></td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>Minimum–maximum</td>
</tr>
<tr>
<td>0.5–31.0</td>
</tr>
<tr>
<td><strong>Total Years Worked in the Field of Nursing (n = 18)</strong></td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>Minimum–maximum</td>
</tr>
<tr>
<td>1–41</td>
</tr>
</tbody>
</table>

a Not all participants answered these questions on the survey.
b Five of these have a bachelor’s degree in nursing.
interviews lasted 45–80 minutes and were audio-recorded. They were transcribed verbatim by an experienced secretary.

**Analytical Procedure**

The interviews were subjected to qualitative latent content analysis, whereby the underlying meaning of the text was interpreted (Downe-Wamboldt, 1992; Graneheim & Lundman, 2004). The analysis had an inductive approach. At first, the interviews were listened to and read through several times to obtain a sense of the whole. Then each interview was divided into meaning units, for example, sentences or paragraphs that related to the same central meaning (Graneheim & Lundman, 2004). In the next step, the meaning units were condensed so that the essential content was clear. The condensed meaning units were abstracted and labeled with codes, and from these codes, subthemes and preliminary themes were generated. The meaning units, codes, subthemes, and preliminary themes were sorted using the framework of content areas (Graneheim & Lundman), which had been developed on the basis of the interview questions. Thereafter, the interpretation of the underlying meaning or latent content of the codes, subthemes, and preliminary themes led to the formulation of themes within each content area. The analysis was discussed at several meetings with the researchers (the first author and CJ) who did the original analysis. The trustworthiness of the results was further guaranteed by critical scrutiny of the analyses by the two other authors experienced in qualitative research (the third and fourth authors). This resulted in a few refinements of codes, subthemes, and themes.

**Findings**

All 21 nurses interviewed experienced ethical dilemmas and distress in their job to some extent (Table 2). In keeping with the aim of this study, the results are grouped according to the themes of the four content areas: workplace distress, ethical dilemmas, managing distress and ethical dilemmas, and quality of nursing.

Notwithstanding the focus on distress and ethical dilemmas, a majority of the nurses (16 out of 21) also expressed satisfaction with components of their working situation. They liked their jobs and thought that neurology was an exciting field in which to work, and they could see how the patients’ medical treatment benefited from developments in the field. There was a positive spirit of camaraderie that was important with regard to coping with the demanding working situation. The communication among the nurses was good, and they supported each other. The work was seen as meaningful, especially when patients recovered and made progress.

**Workplace Distress**

**Demanding and stressful working situation in conjunction with lack of influence.** The nurses described their working situation as physically and mentally demanding. Many of the patients were seriously ill and needed substantial care. The nurses felt that there was insufficient nursing staff in proportion to the patients’ care needs and that the workload was too heavy. The consequences of the heavy workload were fatigue during leisure time, exhaustion, and frustration.

I mean, when patients come to the neurology department, they can have symptoms ranging from vertigo to total hemiparesis and aphasia. And if we’ve got 20 patients like that, and there are just four or five of us on duty one evening, of course you haven’t got the time to do as much as you’d like to. It’s been very hard going for a long time now, which has led to frustration. You can see it by looking at the staff: Everybody’s tired—it’s a burden physically and mentally. And it causes conflicts, that’s plain to see. (Nurse 3)

The nurses felt they could not do their job properly and felt inadequate because they made heavy demands on themselves. Those with limited experience as nurses felt a great deal of tension when they started, and they regretted not having been given an adequate introduction to their new workplace. The stressful working situation had the result, as the nurses saw it, that they constantly had to change their prioritization of the work.

The demands made on them by relatives of the patients were felt to have increased. Relatives would insist on speaking to the physician immediately and did not accept waiting. These sometimes unrealistic demands and dissatisfaction were hard to handle and resulted in sadness and frustration among the nurses interviewed. Another source of stress was the administrative work, which was viewed as burdensome. In particular, planning for the patients’ after-care resulted in increased administrative work and less time spent with the patients. This time allocation was experienced as negative.

The physical working environment was perceived as lacking patient wards that were spacious enough for both patient care and the needs of visiting families. Also, the mental environment was experienced as stressful. This was mainly the result of the impending reorganization and merger of some departments, including their own. This created a lot of uncertainty and required a great deal of energy. The nurses also expressed dissatisfaction with the salary and the new work schedule. They felt that they could not

---

**Notwithstanding the focus on distress and ethical dilemmas, a majority of the nurses (16 out of 21) also expressed satisfaction with components of their working situation. They liked their jobs and thought that neurology was an exciting field in which to work, and they could see how the patients’ medical treatment benefited from developments in the field. There was a positive spirit of camaraderie that was important with regard to coping with the demanding working situation. The communication among the nurses was good, and they supported each other.**

**The work was seen as meaningful, especially when patients recovered and made progress.**

**Workplace Distress**

**Demanding and stressful working situation in conjunction with lack of influence.** The nurses described their working situation as physically and mentally demanding. Many of the patients were seriously ill and needed substantial care. The nurses felt that there was insufficient nursing staff in proportion to the patients’ care needs and that the workload was too heavy. The consequences of the heavy workload were fatigue during leisure time, exhaustion, and frustration.

I mean, when patients come to the neurology department, they can have symptoms ranging from vertigo to total hemiparesis and aphasia. And if we’ve got 20 patients like that, and there are just four or five of us on duty one evening, of course you haven’t got the time to do as much as you’d like to. It’s been very hard going for a long time now, which has led to frustration. You can see it by looking at the staff: Everybody’s tired—it’s a burden physically and mentally. And it causes conflicts, that’s plain to see. (Nurse 3)

The nurses felt they could not do their job properly and felt inadequate because they made heavy demands on themselves. Those with limited experience as nurses felt a great deal of tension when they started, and they regretted not having been given an adequate introduction to their new workplace. The stressful working situation had the result, as the nurses saw it, that they constantly had to change their prioritization of the work.

The demands made on them by relatives of the patients were felt to have increased. Relatives would insist on speaking to the physician immediately and did not accept waiting. These sometimes unrealistic demands and dissatisfaction were hard to handle and resulted in sadness and frustration among the nurses interviewed. Another source of stress was the administrative work, which was viewed as burdensome. In particular, planning for the patients’ after-care resulted in increased administrative work and less time spent with the patients. This time allocation was experienced as negative.

The physical working environment was perceived as lacking patient wards that were spacious enough for both patient care and the needs of visiting families. Also, the mental environment was experienced as stressful. This was mainly the result of the impending reorganization and merger of some departments, including their own. This created a lot of uncertainty and required a great deal of energy. The nurses also expressed dissatisfaction with the salary and the new work schedule. They felt that they could not
influence their working situation—they could not, for example, influence either the fact that there was a shortage of nursing staff on a certain shift or the frequent reorganizations and demands for spending cuts. There were routines, political decisions, and economic factors that they felt hindered them from working the way they wanted.

Lack of communication and cooperation with other healthcare team members. The nurses felt that they were not appreciated by the physicians and not respected as professionals. Their knowledge about the patients was not seen as valuable, and their suggestions were not welcomed by all of the physicians. Usually it’s this way: I’d say, you think that as a nurse, you know the patients well, but then the physicians don’t want to hear what you’ve got to say. And I find that pretty frustrating sometimes. (Nurse 1)

The nurses did not always have the information they needed from the physicians and had to ask for it. In addition, the lack of cooperation and communication was thought to result from a hierarchical structure in which physicians had more power and influence than the nurses. According to the nurses, the cooperation and communication with other members of the nursing staff did not always function satisfactorily. There was a lack of understanding of the nurses’ responsibilities on the part of the assistant nurses, especially when the workload was heavy. The assistant nurses wanted the nurses to help them in the essential care, but the nurses often had medical tasks to perform, and this could result in conflicts. Conflicts also arose between nurses, for example, when it was perceived that not everyone took enough individual responsibility for her or his work, and between nurses and physicians when the nurses thought that the physicians were not treating the patients or families respectfully.

Disagreeing with colleagues made the nurses sad. In difficult situations the nurses had experienced a lack of support from other members of the nursing staff and from the clinic management. Cooperation and communication with the staff in the public community care about the patients’ aftercare was described as dysfunctional and difficult. The nurses did not feel that they could influence decisions, nor did they perceive that their views were seen as useful and important.

Difficulty witnessing the situation of seriously ill patients. When the patients were young and seriously ill, often because of a brain tumor, the nurses felt sad. They felt sympathy for these patients. Sometimes the patients were close in age to the nurses, and then their condition affected the nurses even more; they felt helpless. If these patients had

Table 2. The Swedish Nurses’ Experiences on a Neurological Ward

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Themes</th>
<th>Number of Units of Meaning</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace distress</td>
<td>Demanding and stressful working situation in conjunction with lack of influence</td>
<td>139</td>
<td>1–21</td>
</tr>
<tr>
<td></td>
<td>Lack of communication and cooperation with other healthcare team members</td>
<td>55</td>
<td>1–3, 5–8, 10–16, 18–21</td>
</tr>
<tr>
<td></td>
<td>Difficulty witnessing the situation of seriously ill patients</td>
<td>25</td>
<td>2–4, 6–9, 11, 14, 16–21</td>
</tr>
<tr>
<td>Ethical dilemmas</td>
<td>Troublesome decision making on initiation or withdrawal of treatment</td>
<td>39</td>
<td>1–3, 7–13, 15, 16, 18–21</td>
</tr>
<tr>
<td></td>
<td>Conflicting views on right treatment and decision</td>
<td>38</td>
<td>1–3, 12, 14–19, 21</td>
</tr>
<tr>
<td></td>
<td>Difficulties in providing for patients’ and families’ needs, rights, and desires</td>
<td>22</td>
<td>2, 4, 6–12, 14, 16–21</td>
</tr>
<tr>
<td>Managing distress</td>
<td>Accepting and adjusting to the situation in an active way</td>
<td>36</td>
<td>4–6, 8–12, 14, 17, 19–21</td>
</tr>
<tr>
<td>and ethical dilemmas</td>
<td>Seeking support from colleagues</td>
<td>33</td>
<td>3–6, 8–21</td>
</tr>
<tr>
<td></td>
<td>Striving for new strength in private life</td>
<td>24</td>
<td>1, 3, 5–9, 11–16, 20, 21</td>
</tr>
<tr>
<td></td>
<td>Reflective thinking and previous experiences</td>
<td>23</td>
<td>1–3, 6, 9, 11–14, 18–21</td>
</tr>
<tr>
<td>Quality of nursing</td>
<td>Satisfaction with nursing quality and the individualized care</td>
<td>47</td>
<td>1–4, 6–21</td>
</tr>
<tr>
<td></td>
<td>Lack of nurses and time hinders stable and high nursing quality</td>
<td>40</td>
<td>1–3, 5–9, 11–14, 16, 18–20</td>
</tr>
</tbody>
</table>
small children, the nurses felt that it was especially unfair that they should be stricken with illness because they had their whole lives before them. It could be hard to stop thinking of the patients after work, and the nurses wondered what the future held for those whose prognosis was uncertain. It was very mentally demanding to take care of these patients.

We’ve got a lot of people lying here dying, old and young. We’ve had patients with brain tumors, for example, who’ve been of our own age—it’s very easy to relate to them. There’s a lot of tragedy around you, it’s so saddening. (Nurse 7)

**Ethical Dilemmas**

Troublesome decision making on initiation or withdrawal of treatment. Dilemmas often concerned initiating or withdrawing a certain treatment, and it was felt that each decision was unique.

Well, the classic case, I must say, is when a patient comes in and is in a bad way and can’t eat. Do you give no treatment, or do you put the patient on a drip and use a probe and all that? I think that’s dreadfully difficult. (Nurse 8)

The dilemma was, as the nurses saw it, whether the patient would benefit from the treatment or if the treatment would cause pain or prolong suffering. The nurses believed that treatment should not be initiated or continued just because it was possible. The price the patient had to pay could be too high, and the patient’s quality of life had to be considered. The decision-making process was experienced as difficult, and the nurses felt powerless, for example, when withholding fluid from a patient who could not swallow or when explaining to the family that the patient’s infusions would be discontinued. One distressing situation involved withdrawing life-sustaining treatment, but the patient continued to live. Distress was also involved in caring for a patient where no decision about continued treatment or withdrawal of treatment had been made. The lack of a decision, or an incomprehensible shift between active treatment and no treatment at all, was emotionally difficult to bear. The decision making was perceived to be influenced by a number of factors, such as the physician responsible and the age of the patient. The diagnosis was also a determining factor when deciding about life-sustaining treatment, because it was felt that patients with certain diagnoses received much more treatment than patients with other diagnoses.

Conflicting views on right treatment and decision. Nurses and physicians sometimes held different opinions concerning the right treatment or decision for the patient. When the physician had decided on further treatment, but the nurse thought that the treatment should be terminated, the nurse was frustrated and angry at having to examine and treat a patient who was dying. However, sometimes the nurses thought that the physicians’ decisions to terminate treatment were too rash.

Sometimes there have been patients that you’ve thought were a bit too alert perhaps—yes, a bit too alert, perhaps, for you to discontinue the drip. (Nurse 16)

It was very difficult to nurse a patient who was conscious, but the treatment had been terminated. The physicians did not always include the nurses in the decision making, and the lack of cooperation negatively affected patient care. The family and the nurses could have conflicting views on treatment and decisions, and there arose a dilemma concerning whether the decision should be made in accordance with the relatives’ views or those of the nurses. It could be difficult to resolve such a dilemma because the nurses lacked time and knowledge and because of the physicians’ attitudes.

Difficulties in providing for patients’ and families’ needs, rights, and desires. The nurses indicated that it was difficult to maintain the patient’s integrity. This was the case, given that many of the patients had to share a room, and sometimes they had to be placed in the corridor. At such times it was almost impossible to talk privately to the patient.

Well, when it comes to patients’ integrity, we’ve got a lot of rooms with two beds and just a curtain between. You wash and you dry, and there’s just a curtain between. The other patient’s on the other side of the curtain and can take in what you’re saying—and they hear everything. If you’re doing the rounds, and the other patient’s on the other side, there’s a lot you take up that you know you yourself wouldn’t want taken up under any circumstances if somebody else was listening—very private things. (Nurse 11)

Integrity was also threatened when the nurse had to persuade the patient to accept a new living arrangement. The municipality could not always afford a living arrangement that would be the best for the patient, and the aftercare was thus not directed by the patient’s need. During the coordinated-care-planning meetings, where care staff and the social welfare case officer discussed the aftercare of the patient, there could be a problem because the patient was not included in the discussion. Thus the patient did not play a part in the decision making regarding his or her own care. There was a dilemma when the patient was in too poor a state of health to participate or was too shy to do so. The nurses had an ambivalent view of family participation. On one
hand, nurses wanted families to be more involved in the decision making concerning the care of the patient; on the other hand, the families might have too much influence, and the patient’s care would be provided on their terms.

Managing Distress and Ethical Dilemmas

Accepting and adjusting to the situation in an active way. The nurses accepted the decision about the care of the patient made by the physician or social welfare case officer, but they did not always agree with it. They also accepted the fact that people are of different opinions, and therefore they tried to compromise. They could express their opinions even when they knew that it would not change the decision because they felt it was important to make their own opinions clear as a means of accepting the decision.

You take it up with the physician doing the rounds, for instance. Should that patient have a drip, or not? I try to pass on what the family thinks. But then you adapt to what the physician prescribes, to what gets decided. And then you hide behind that, really: It’s a prescription, I do what the physician says, and then I stop thinking about it. Or: I’ve got my own opinion, but I accept it. Then you sort of just move on. (Nurse 17)

Some of the nurses accepted that it was difficult to influence the decisions and the way of working, and they decided to adjust to that fact and the norms of the group on the ward. Others adjusted to the situation by trying to take control over it, for example, by using the time in the most effective way. They planned and prioritized their work and sought to share their time fairly among their patients, thus giving equal attention to the quiet patients.

Seeking support from colleagues. It was of great value to have the opportunity to talk to colleagues about ethically difficult situations. These conversations could take place during coffee breaks or when reporting to the next shift, but a more formal meeting could be organized when there was a situation that involved the whole staff. The nurses related that the informal discussions involved the nurses and sometimes the physician, while the discussions planned beforehand included the nurses, the physician, and, when necessary, the medical social worker. Both nurses and physicians could initiate these discussions. The subject of discussion was often decisions about life-sustaining treatment. Sometimes the discussions took place before the physician made his or her decision in order to throw light upon as many aspects of the situation as possible. At other times the decision had already been made, but the nursing staff felt that they did not agree with the decision, and therefore they initiated a discussion with the physician to better understand the reasons for the decision.

I think we often make good decisions, I really do. If I don’t agree about this or that, or someone else doesn’t, we talk it through. The physician usually takes part, and then there are the nurses and assistant nurses taking care of the patient, and you’ve got a chance to say all that’s on your mind and in the end feel it’s a joint decision and the best one. (Nurse 20)

Hearing the reasons for the decision helped the nurses to move on and could also result in a reconsideration of their own attitudes. They wished there was a forum, for example, ethics rounds, to discuss difficult situations together.

Striving for new strength in private life. Not taking home thoughts about work and patients was another way to manage distress. This had been difficult when nurses were just starting out, but it had become easier with increased working experience. It was important not to let work influence your private life, but sometimes it was hard to let go. Often, the nurses talked about their work stressors to family or friends. It could be particularly helpful to talk to family members or friends who were nurses themselves because they were likely to have a better understanding of the situation, but sometimes it was a relief to talk to someone not involved in nursing.

I usually talk to my family about it. It can be pretty nice for the very reason that they’re not involved as I am. (Nurse 9)

Off-duty time provided the nurses an opportunity to renew their strength and keep work in proportion by taking care of themselves. An example offered was going for walks to clarify their thoughts.

Reflective thinking and previous experiences. In stressful situations, when there was a heavy workload, the nurses tried to identify their own limitations. They did their best, and at the same time did not see themselves as irreplaceable, trusting that the nurses working the next shift could carry on with the tasks they had not managed to finish.

You try and do your best when you’re there, and then sometimes when you’ve been on the evening shift, you wake up in the night and think: Did I do that? But then you’ve got to say to yourself: OK, but there’s somebody else there now, and they can think as well. I mean, you’ve got to learn to look at it that way. After all, nobody’s perfect, are they? (Nurse 19)

The nurses also recognized their own limitations when they directed the patient or family to another
member of staff. For example, they consulted the medical social worker when they thought that they were not the best suited to handle particular situations. In difficult situations they used every available means to do their best for the patients, and then they would be satisfied with their own work, even if the situation did not have the outcome they desired. Another strategy used by the nurses was to look upon the situation from another person’s point of view to shed new light on it. When the situation involved decision making with regard to life-sustaining treatment, it could be helpful to have a holistic view of the patient to understand the physician’s decision and to give full weight to the patient’s human dignity. More experience as a neuroscience nurse reduced distress and increased confidence in handling different kinds of situations, and it had also made it easier to prioritize. Working experience also enabled the nurse to reflect on ethically difficult situations from different perspectives.

Quality of Nursing

Satisfaction with nursing quality and the individualized care. The quality of nursing care was judged as being high by a large majority of the nurses. They thought they were able to maintain high quality even though sometimes there were not enough nurses, which ultimately did have negative consequences for them. Factors that contributed to high-quality care were well-qualified nurses with specialized knowledge about neurological diseases, a holistic view of the patient and his or her situation, and teamwork with other groups of healthcare providers.

The care’s very good here. All the problems are carefully considered. There’s nutrition, and there’s the problem of pain, and—well, just everything, you might say. Right from the start, I could see that the whole person was cared for here. (Nurse 4)

The nursing staff often received appreciation from families and patients who were satisfied with the care, even though the nurses felt that they had not done much. The satisfaction of families and patients has also been shown in opinion polls, where nurses received good ratings for the care they provided. The care of the patient was individualized as much as possible—each patient, for example, had his or her own training program during rehabilitation. The nurses also took measures to increase the participation of patients in their own care through information and in conjunction with decision making at coordinated care planning meetings. Nurses left the room to allow the patient to take a more active part in the decision making during such a meeting. The high quality of nursing care was also evident in the kind treatment of the families, which was considered an important part of good care. The relatives received individualized information about the patient’s condition, and the nurses lent a sensitive ear to the family’s desires. When the family participated in decision making with regard to the patient’s care, the nurses supported them.

Lack of nurses and time hinders stable and high nursing quality. Although there was a general satisfaction with the nursing quality, there was room for improvement. The quality was thought to be dependent on the workload and the number of nursing staff working. This meant that the quality was thought to be unsatisfactory when the workload was too heavy or there were too few nurses, which could be the case on evening shifts and on weekends. On these occasions, the nurses felt that they could not provide for all patients’ needs, and that scarce resources hindered recovery and rehabilitation. Nurses felt that they did not have time to properly talk to the patients and could not always give them the basic care, despite the fact that the patients were experiencing life-threatening or life-changing diagnoses and needed to share their feelings with the nurses. Nor was there time to do something special, for example, go for a walk with the patient. The nurses’ time for answering the families’ questions was limited and caused them dissatisfaction.

What I miss from the past is that you used to be able to go for a walk with the patient, do crosswords together. Or you could sit and read to the patient, or sit and talk. There’s none of that anymore. I’d like to have it back, that quality. (Nurse 5)

Changing working conditions, such as new work schedules, and the future reorganization of the clinic, were other factors cited by the nurses as causing a decline in the quality of nursing and an interruption to the continuity of care. In conjunction with the reorganization, some of the nurses with specialized knowledge would be transferred to another clinic, and they were concerned that this would negatively affect the quality of nursing care.

Discussion

The aim of this study was to describe Swedish nurses’ experiences of workplace stress and the occurrence of ethical dilemmas in a neurological setting. The results are in line with previous findings; ethical dilemmas cause distress among nurses (Kälvemark et al., 2004). Key components found in all content areas were high workload and nurses’ difficulties with regard to influencing their working environment and decisions regarding patients’ care. The relationships and cooperation with other healthcare team members were described as not
quite satisfactory, and the nurses had an ambivalent view of the role of the family. There was a general satisfaction with the quality of nursing care, but a lack of time and nursing staff always threatened this quality. The nurses described different ways of managing the distress and the dilemmas; they mainly accepted and adjusted to the situation and sought support from colleagues.

The main causes of workplace distress were the demanding working situation and workload and a lack of influence. Distress caused by a heavy workload—due to a shortage of staff in relation to the number of patients—is in line with findings in previous studies (Hertting et al. 2004; Olofsson et al., 2003). This had consequences for the quality of nursing care, which was thought to be unsatisfactory when nurses did not have time to meet patients’ needs. A lack of time may imply that the nurses have to set priorities that are contradictory to their nursing principles (Cronqvist et al., 2001). Nurses are also in a position where they often lack influence over their working situation and the decisions they have to follow through on (Oberle & Hughes, 2001), which was evident in the present study. One kind of stress nurses may experience is moral distress. Jameton (1984) defined moral distress as occurring when “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6).

This definition was further developed by Wilkinson (1987), who defined such 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 behaviors indicated by that decision” (p. 16). The nurses in this study expressed moral distress in terms of wanting to do the best for their patients but being hindered by a shortage of staff, routines, and economic factors. The nurses’ descriptions of fatigue, frustration, and inadequacy are also in line with Wilkinson’s report documenting the negative feelings that moral distress produces. The consequences of moral distress are serious, the most extreme such consequence being that nurses leave the nursing profession altogether (Wilkinson). Chambliss (1996) argued that ethical problems and the resulting distress should not be viewed as isolated incidents or as personal issues, but as systematic issues created by the hospital organization. This perspective is applicable to the present study, because the results indicate a high level of concordance among the nurses regarding what was viewed as stressful, and these issues were mainly related to organizational factors.

The most common ethical dilemmas revolved around making decisions about whether to initiate or withdraw treatment. In accordance with previous research (Oberle & Hughes, 2001), the nurses in this study found the decision-making situation difficult, and the main dilemma to be deciding when suffering outweighed the benefits of treatment. The nurses perceived that in some cases the decision was made too late. This indicates that in their opinion a greater number of patients should receive limited treatment, which is in line with previous studies (Bucknall & Thomas, 1997; Hildén, Louhiala, Honkasalo, & Palo, 2004), but they also expressed the opinion that decisions to limit or withdraw treatment could be made too early. At the same time, the nurses perceived that they were left out of the decision-making process. This may imply that they did not have sufficient information about a physician’s decision, and this resulted in their holding a different opinion regarding the level of treatment. Several studies (Bucknall & Thomas; Ferrand et al., 2003, Manias, 1998; Rocker et al., 2005) have described nurses’ conceptions of being left out of decision making regarding treatment; in the present study the nurses expressed the opinion that this had negative consequences for the care of the patient. The inclusion of nurses in the decision-making process could have several advantages. First, the nurses complement the medical basis for decision making with their knowledge about the patient. If nurses are given the opportunity to discuss decisions with the physician, nurses may find it easier to care for patients even if they do not agree with the physician’s decision. Disagreements regarding aggressiveness of treatment also arose between staff members and family. In this instance, nurses were ambivalent about families’ participation. The view of the family as having too much influence is in line with previous results (Hildén et al.; Viney, 1996). However, the ambivalence about the role of the family was not found in previous research.

When it came to managing distress and ethical dilemmas, the nurses primarily relied on coping strategies, and planned discussions about it were rare. Seeking support from colleagues was a common strategy, which is in accordance with the results in another Swedish study (Cronqvist et al., 2006). Nurses may turn to each other for support because they feel more comfortable with colleagues they know than people unknown to them—as may be the case if these situations are discussed in a larger group. But it may also reflect nurses’ perception that there is a lack of organized support at the workplace.
Systematic clinical nursing supervision has been suggested as one way to handle distress. It has been shown to increase nurses’ moral sensitivity, but on the other hand, nurses who were under clinical supervision reported higher levels of stress than nurses who were not (Severinsson & Kamaker, 1999). Organized discussions on ethical problems may be in the form of ethics rounds, where hearing others share their perspectives and experiences can help clarify one’s own standpoint. The participants listen to one another’s opinions, and in that way values at stake for all concerned are identified (Hansson, 2002). There are few studies that discuss the value of ethics rounds, but in one study (Raines, 2000), the nurses ranked them among the least helpful support resources when dealing with ethical issues. However, this is an area that needs further investigation. If, as Chambliss (1996) argued, nurses’ distress reflects organizational problems, managing the distress cannot solely be a question of enhancing the communication among members of the healthcare team, increasing the amount of education, or holding ethics seminars—changes at the organizational level are also required.

Because little is known about neuroscience nurses’ experiences of workplace distress and ethical dilemmas, a qualitative method was used. This is the method recommended when there is little or no literature describing the population in question (Brink & Wood, 1998). When a qualitative method is used, it is often impossible to generalize the findings to a broader group. Another limitation of this study was that the sample was taken from one hospital. However, the trustworthiness of this study is strengthened by previous research; the main results of this study are in accordance with those in previous studies. Lambert and colleagues (2004) found that nurses working in different countries reported similar workplace stressors, and therefore the findings may be transferable to other neurological departments and healthcare settings similar to the Swedish system.

**Summary**

The results of this study show that workplace distress is a major problem for neuroscience nurses. Too great a workload and lack of time were factors that the nurses perceived as hindering high and stable nursing quality. This caused frustration among the nurses, and they felt powerless because they found it difficult to influence their working conditions. Ethical dilemmas mainly concerned decision making about the initiation or withdrawal of treatment. The nurses perceived that they were left out of the decision-making process and that this negatively influenced the care of the patient. When trying to manage the distress, the nurses mainly used coping strategies and sought support from colleagues, and the nurses regretted that there was no regular forum to discuss ethically difficult situations. The findings of this study indicate a high level of concordance with the results from previous studies conducted in different countries (Bucknall & Thomas, 1997; Hildén et al., 2004; Kälvermark et al., 2004; Oberle & Hughes, 2001), and therefore the results may be transferable to neuroscience nurses outside of Sweden and Europe.

In light of this study’s results, future research should investigate whether such a forum may facilitate the management of distress and the communication and cooperation between professions. It would also be of interest to study the relationship between different coping styles and the nurses’ physical, mental, and social health. Finally, to further emphasize the ethical dimension in moral distress, future studies should explore which ethical principles nurses feel are at stake in specific situations.

**References**


**We Are Making an Impact**

*continued from page 195*

do hope, though, that our readers will think of us first as they choose a journal for publication. Let’s show the scientific world what we can do!

**Acknowledgments**

Our selection as an ISI-rated journal would not have been possible without the guidance and leadership of Chris Stewart-Amidei, our previous editor, who set the standards high and held all of us to them. I also want to thank Kari Lee, JNN’s managing editor, and Katie Bianchi, our former editorial assistant, for the work they did in preparing and submitting our application for approval.

**Reference**