

Living with ethical dilemmas

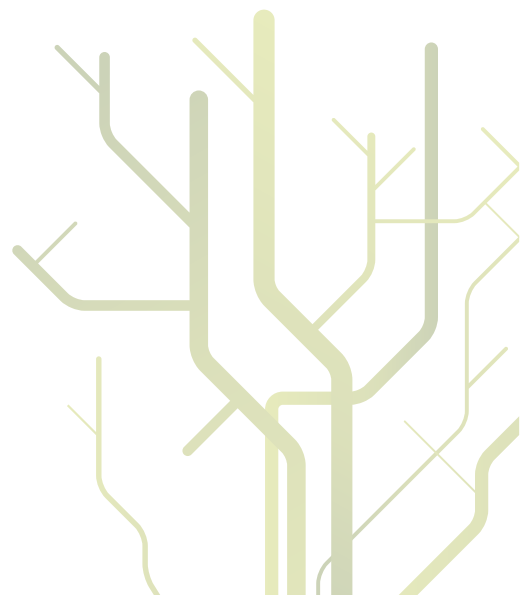
The ethical reasoning of surgeons and nurses in surgical units



Kirsti Torjuul

Avhandling levert for graden Philosophiae Doctor

September 2009



Contents

1	Abstract	5
2	Original papers	6
3	Introduction	7
4	Background	10
	4.1 <i>Ethical practices in surgical units</i>	10
	4.2 <i>Surgeons</i>	12
	4.3 <i>Nurses in surgical units</i>	14
5	The aims of the study.....	17
6	Ethical principles and practices	18
	6.1 <i>Ethical principles</i>	18
	6.2 <i>Ethical practices</i>	19
	6.3 <i>The perspective of this study</i>	22
7	Methodological framework.....	24
	7.1 <i>Phenomenology</i>	24
	7.2 <i>Hermeneutics</i>	26
8	The study	30
	8.1 <i>The setting</i>	30
	8.2 <i>The sample</i>	30
	8.3 <i>Ethical considerations</i>	31
	8.4 <i>Interviews</i>	32
	8.5 <i>Interpretation</i>	33
	8.6 <i>Methodological considerations</i>	38
9	Main findings in Papers I- IV	43
	9.1 <i>Surgeons</i>	43
	9.2 <i>Nurses</i>	45
10	Interpretation and discussion	49
	10.1 <i>Autonomy, respect and trust</i>	49
	10.2 <i>Rescuing and sustaining life</i>	51
	10.3 <i>Ethics and confirmation</i>	54
	10.4 <i>Living with ethical dilemmas</i>	60
11	Concluding remarks	66
12	References.....	68
13	Acknowledgements	86
14	Papers I-IV	87

1 Abstract

The aim of this thesis is to illuminate surgeons' and nurses' experiences of living with ethical dilemmas in their work. The thesis comprises the kinds of ethical dilemmas experienced from the practitioners' own point of view, and explores their way of reasoning, deliberating and acting in ethically difficult situations, including the meaning they assign to their experiences. The data collection consists of open-ended narrative interviews with ten surgeons and ten registered nurses at a university hospital in Norway. The transcribed interview texts were subjected to a phenomenological hermeneutical interpretation.

The main ethical dilemmas experienced by surgeons and nurses concerned the respecting patients' right to decide their own treatment and care, and act accordingly. Taking appropriate actions to rescue and sustain patients' lives, and maintain patients' hopes and efforts to fight the disease were important concerns for surgeons and nurses. Being responsible for particular patients in life threatening and decisive circumstances made profound impressions on surgeons and nurses and challenged their outlook on life as well as their professional conduct.

Situations when ethical dilemmas occur are characterized by complexity, uncertainty and ambiguity about the correct and best thing to do and what constitutes an ethically satisfying solution to the problem. Surgeons and nurses emphasized the importance of collegial recognition and support in order to live with the responsibility and emotional burden of experiencing ethical dilemmas. Discussing and resolving ethical problems in the team, and sharing thoughts and feelings with their peers was experienced as a relief. Social confirmation and recognition by the patients, relatives, colleagues, and their knowledge that the needs of patients and relatives were attended to in a morally and professionally satisfying manner increased the surgeons' and nurses' confidence and satisfaction in their work, and their courage to live with the responsibility for being and acting in ethically difficult situations.

Experiencing the continuous abundance of ethical difficulties in the unit provided surgeons and nurses with opportunities of learning. The kind of ethical knowledge acquired included the acceptance of ethical dilemmas as an inseparable and unavoidable feature of practice, and coming to terms both with the contingencies of human life, and their own limitations and fallibility when trying to provide high quality professional treatment. Acceptance of personal and professional limitations did not mean that surgeons and nurses had abandoned their ethical and professional commitment of trying to maintain and improve the quality of treatment and care to the patients in the unit.

Keywords: Empirical research report, ethical dilemmas, ethics, medical ethics, narrative interviews, nursing ethics, phenomenological hermeneutics, surgical care, surgery

2 Original papers

The thesis is based on the following papers, which will be referred to in the text by their roman numerals:

- I Torjuul K, Nordam A, Sørli V (2005a) Ethical challenges in surgery as narrated by practicing surgeons. *BMC Medical Ethics* 6:2.
- II Torjuul K, Nordam A, Sørli V (2005b) Action ethical dilemmas in surgery: an interview study of practicing surgeons. *BMC Medical Ethics* 6: 7.
- III Torjuul K, Sørli V (2006) Nursing is different than medicine: ethical difficulties in the process of care in surgical units. *Journal of Advanced Nursing* 56 (4):404-413.
- IV Torjuul K, Elstad I, Sørli V (2007) Compassion and responsibility in surgical care. *Nursing Ethics* 14(4):522-534.

The papers have been printed with the kind permission of the respective journals.

3 Introduction

Medicine is, I have found, a strange and in many ways disturbing business. The stakes are high, the liberties taken tremendous. We drug people, put needles and tubes into them, manipulate their chemistry, biology, and physics, lay them unconscious and open their bodies up to the world. We do so out of an abiding confidence in our know-how as a profession. In some way, it may be in the nature of surgery itself to want to come to grips with the uncertainties and dilemmas of practical medicine (Gawande 2002:4)

The present study is part of a comprehensive investigation aiming to illuminate the meaning of care providers' lived experience of being in ethically difficult care situations by means of narrative interviews (Sørli 2001b). Previous studies have been conducted with different occupational groups working in various areas of health care, for instance in the care of older people in hospitals (Nordam et al. 2003, 2005), oncology and internal medicine (Udén et al. 1992), intensive care (Söderberg et al. 1993, 1996, Söderberg 1999), oncology (Åström et al. 1995), paediatric care (Sørli et al. 2000, 2001a, 2003 a, 2003b), acute care wards (Sørli et al. 2004, 2005), and surgical care (Udén et al. 1995). These studies elucidate the many and complex ethically difficult situations experienced by care providers in various health care fields, their reasoning about what constitutes ethical difficulties in clinical practice and how they can or should be resolved as well as the meanings of being in these situations. The results of these studies contribute to the discourse among health care providers, health care researchers, social scientists and ethicists about what constitutes ethical concerns and activities in today's health care practice.

The reasons for doing this study into the field of surgical treatment and care are various. Most of these reasons will be apparent in the first chapter of this thesis which consists of a survey of the literature on characteristic features of surgery and surgical nursing and the ethical dilemmas involved in this part of health care service. As in the comprehensive study, the purpose of the study is to elucidate the ethical dilemmas of practicing from surgeons' and nurses' point of view and their ways of reasoning, deliberating and acting in ethically difficult situations. As the frequency of surgical treatment has expanded in step with the opportunities created by the constantly growing scientific knowledge and technology, surgeons and nurses are the principal contributors in today's health service and are present in situations where ethical dilemmas arise, are discussed and difficult decisions have to be taken. Thus, they have extensive experience about the ethical dilemmas of modern health care that can inform the ethical discourse about these issues. In addition, the accumulated effects of living and working with ethical dilemmas on a daily basis has had limited attention in the bioethical discourse.

In-depth knowledge about the ethical dilemmas of health care and how they are experienced by those who work and live with them on a daily basis may be of interest to the health providers themselves. It is also important in the education of health care providers, and to managers of hospitals and politicians, who share the responsibility for the quality of care delivered as well as the working conditions and welfare of the employees. Equally important, ethical dilemmas concern the life and welfare of patients and families in extremely vulnerable life circumstances. As potential patients and relatives, it may be of interest to all of us to know something about the ethical understandings and actions of those we entrust our fragile bodies to and future prospects in times of sickness. In short, the ethical ends and dilemmas of surgery

and surgical nursing may have public interest because it concerns us all, as few of us live through life without the experience of being a patient, relative or a visitor in a surgical unit.

The first part of this thesis goes into the background of this study. A survey of the literature on characteristic features of surgery and nursing and the ethical dilemmas in surgical treatment and care is presented and the context within the work is done. Next, the ethical codes and principles of medicine and nursing are presented and their advantages and limitations regarding ethically difficult situations. In this study I use the concepts “ethical dilemmas” and “ethically difficult situations” interchangeably as dilemmas and difficult situations may be regarded as much the same. I will return to this question at the end of the chapter. Finally, the philosophical basis of this study is presented; i.e. the phenomenological hermeneutic philosophy of Ricoeur (1976) and Gadamer (2003).

In the second part of this thesis I describe the way this study was carried out; the setting, participants, the interviews and the phenomenological hermeneutical interpretation. The ethical considerations of this study are also presented as well as methodological considerations concerning the trustworthiness of the findings and of the interpretation.

In the third part of this thesis, a summary of the findings of the interviews with surgeons and nurses is presented. Three of the themes that pervaded the interviews with both surgeons and nurses are then discussed. The first theme concerns ethical commitments and dilemmas constituted in the treatment and care of patients. The second theme is about the importance of social recognition and confirmation from colleagues, and self confirmation and conscience when faced with ethical dilemmas. The third theme discussed is the meaning of living with ethical dilemmas while practicing. Finally the results of this thesis are summarized and some recommendations are made about how the results can inform the ethical discourse between practitioners, managers, ethicists and the public about the ethical ends and dilemmas of health care practice.

The reason for choosing the two samples of surgeons and nurses was based on my preunderstanding of nursing and surgery in general, and the ethics of working with and for patients in surgical units in particular. Though there are important differences between the professional responsibilities of surgeons and nurses, they work closely together as a team and share the ethical (and legal) end of acting in the best interests of particular patients and families. Thus, it was interesting to study similarities and differences between surgeons and nurses concerning the ethical difficulties they face in their work, their way of reasoning and acting in those situations and how they live and deal with them. The composition of the two samples was based on previous research that suggests the way people reason about ethical problems and try to resolve them may vary according to professional background, the degree of professional experience, gender and the health care setting in which they work, although the results are conflicting (Gilligan 1982, Norberg & Udén 1995, Sørli et al. 2000, 2001a, 2003a, 2003b, Nordam et al. 2003, 2005a, 2005b, Henriksen & Hansen 2004).

Before I finish this introduction, I will add a few words about my personal background for carrying out this study. I am educated as a nurse, but have never worked in surgical units, and have therefore no clinical experience to inform this study. I have been a surgical patient twice, and a visitor to close relatives and friends in surgical units several times. I have not experienced any ethical dilemmas on these occasions. In the last 25 years I have worked as a teacher for nursing students, and as their supervisor in surgical units as well as in other parts of health care. The students and their clinical mentors have over the years told me numerous stories about ethically difficult care episodes which have strengthened my interest in the issue and my belief in the importance of carrying out this research and suggested its methodical direction.

4 Background

4.1 *Ethical practices in surgical units*

Surgeons and nurses are morally and professionally responsible for all activities related to patients' treatment and care in surgical units. The motivation for entering the professions of medicine and nursing is a desire to help others (Arnetz 2001, Rognstad et al. 2004), and it is therefore important for surgeons and nurses to practice in a morally good and upright manner, that is in the best interests of patients (Lindseth 1992, Benner et al. 1999, Christiansen 2008). However, one characteristic feature of surgery is that it harms patients before it eventually helps and heals them. Surgical intervention is by nature invasive and distinctive; it systematically violates our bodies during moments of unconsciousness, with the aim of rescuing life, restoring our health and functioning or easing our pains. The aftermath of successful surgery often brings new difficulties; undergoing major surgery may change people's lives, and leave permanent physical, psycho-social and existential "scars". Surgeons and nurses temporarily inflict and increase the suffering of patients while attending to their needs for diagnostic and treatment purposes (McCullough et al. 1998, Benner et al. 1999, Little 2002).

The reasons for undergoing surgical treatments are many and vary according to patients' medical condition, the nature of their diseases and injuries, the degree of pain and suffering, and the hopes and expectations of a successful or redemptive outcome (Little 2002, Gawande 2002, 2007, Groopman 2007, Chen 2008). Surgical intervention can rescue life after traumatic injuries and in acute and emergency situations, and are the main treatment option for most cancer diseases. Patients with less acute or chronic diseases undergo planned procedures, or elective surgery as a solution to long standing and distressing health problems, frequently after lengthy waiting (Habiba et al. 2004). In recent years, palliative surgery has increased in order to prevent or treat painful symptoms of patients with advanced and incurable cancer in the terminal stages of the disease (Kørner et al. 2007, Hollingham 2008).

Surgery requires that patients temporarily hand over their autonomy, the power and control of their bodies to the surgeons and nurses of the operating team (McCullough et al. 1998, Axelrod & Goold 2000, Little 2002, Gawande 2002, 2007). In situations where patients' life and health is at stake, the ethical responsibility of surgeons and nurses is to limit the harm they do to patients, and promote an excess of clinical good over harm (McCullough et al. 1998). A great amount of surgeons' and nurses' work consists of activities that contain and minimize patients' experiences of illness, diagnosis and treatments, and prevent and ease the pain and discomfort involved (Benner et al. 1999, Liaschenko 2002, Hawley & Jensen 2007, Christiansen 2008).

The growth in scientific knowledge and technology has given surgeons and nurses new and better diagnostic equipment and treatment opportunities. Improved anaesthetic methods and less invasive surgical techniques have made it possible to perform major operations on patients who are older than before and with important comorbidities like diabetes, heart and lung diseases, and often cancer (McCullough et al. 1998, Beauchamp & Childress 2001, Sundar 2003, Dahl & Andreassen 2003, Rosenberg 2006, Morris 2007). The life-sustaining technologies of the intensive care unit, and new methods of diagnostic technologies like ultrasound, computer tomography (CT), magnetic resonance imaging (MRI), scanners and endoscopes have permitted surgeons to scrutinize nearly every part of the body, and to correct

and replace damaged or diseased body parts with new technological devices (van Dijck 2001, Hollingham 2008).

The development of operating microscopes, fiberoptic endoscopes and three-dimensional computer images have made it possible for surgeons to perform more complex operations with greater precision and tinier incisions, minimizing the risk of damage to surrounding healthy tissues. The purported and perceived benefits of these techniques include earlier and more rapid and complete recovery of functions, less perioperative bleeding, and improved cosmetics (van Dijck 2001, Rosenberg 2006). Less invasive surgery has reduced the incidence of post-operative complications, and thus, less need of intensive beds and shorter hospital stays (Williams 1997, Sundar 2000, Rosenberg 2006). Operations that previously involved major incisions and several days of hospitalization and convalescence have been transformed into 'day surgery' procedures (Le Fanu 1999, Hollingham 2008). Advances in anaesthesia have contributed to this by increasing the proportion of conscious surgery, i.e. surgical procedures performed in local and regional anaesthesia (Mitchell 2008). The contribution of technological innovation has been not only to enlarge the scope of surgical intervention, but also, by simplifying the complex, to enlarge its range as well. Modern surgery has become as high tech as medicine gets, and this development still continues at a rapid rate.

On the one hand, the scientific and technological advances in medicine have made significant contributions to patients' lives; from improving the quality of life to the prolongation of life itself (Hansson 2007). The frequency of surgical treatment has expanded, and many surgical inventions, once unthinkable, is today routinely performed in hospitals around the world, and gives people years of health that they otherwise would not have had (Gawande 2007, Morris 2007). The plethora of new medications, technologies and therapies has also changed the way illnesses are experienced. While the health care system can cure a few illnesses, it has primarily learned to prolong the experience of living with chronic illness and the process of dying. For instance, the medical treatment of many cancer forms has transformed the courses of the diseases into chronic trajectories with a relatively slow decline punctuated by periodic crises (Emanuel et al. 2000).

On the other hand, successful results can make the use of surgical technology and inventions almost too easy, leading to unwarranted investigations and treatment (Le Fanu 1999). Rather surprisingly, the harm inflicted on patients due to excessive or unnecessary diagnostic procedures are seldom discussed in the literature. Today a great amount of the diagnostics and treatments being performed in the health care system may seem trivial and conventional. In medicine, however, there are few if any treatments or diagnostics that are completely safe and without risks of unsuccessful outcomes (Førde 2000, Aasland 2006, Schei 2007, Moniham & Smith 2002). As Gawande (2007:157) says: "We have at our disposal today the remarkable abilities of modern medicine. Learning to use them is difficult enough. But understanding their limits is the most difficult task of all". There is a consensus that the adaptation of new surgical techniques initially results in a greater incidence of complications. This learning curve is well known to surgeons learning a new procedure (Rosenberg 2006, Gawande 2007, Cooper et al. 2008, Liberman et al. 2008).

Principal ethical dilemmas facing surgeons and nurses today are whether to start, withhold or withdraw advanced medical treatment for very old and fragile people, patients having comorbidities like for instance, diabetes, obesity, respiratory or renal diseases, or non-curable cancer (Morris 2007). Medical technologies can take over the function of vital organ systems

in the anticipation of eventual recovery. Withdrawing treatment too early may result in prematurely ending a life that otherwise could have been saved. On the other hand, reluctance to withdraw may result in overtreatment, diverting life sustaining technologies into means of prolonging the pain and suffering of patients in the terminal stage of illness (Lindseth et al. 1994, McCullough et al. 1998, Oberle & Hughes 2001, Førde et al. 2002, Pawlik 2006, Saarni et al. 2008).

There is an ethical uncertainty and even controversy in the literature concerning the distinction between withholding and withdrawing life-sustaining treatment. Several ethicists have concluded that this distinction is morally incoherent, as an act is ethically equivalent to an omission when the agent has the same intent (relieving suffering), and the intent is the same (dignified death) (Beauchamp & Childress 2001, Pawlic 2006). While it can be argued that the distinction does not have intrinsic moral significance, empirical studies suggest that some physicians regard withdrawing treatment as operationally and psychologically different from withholding treatment (Levin & Sprung 2005, Pawlic 2006, Helsedirektoratet 2009). In the face of prognostic uncertainty, continuing life-sustaining therapy in some cases may seem a better option because it allows surgeons, nurses, patients and relatives witness the effects of the treatment and make decisions based on a larger set of clinical data, and an ongoing reassessment of the situation, and to withdraw treatment if and when it becomes evident that it is not in the best interest of patients (Glare et al. 2003, Pawlic 2006, Gawande 2007).

The growth of diagnostic and therapeutic opportunities in modern surgery has placed great demand on resources and made it a high cost endeavour. Economics and politicians often argue that is unacceptable that an increasing amount of public health care expenditures is spent in the last six months of life. On the other hand, nobody knows for sure when these last six months of individual life will occur (Glare et al. 2003, Gawande 2007).

4.2 Surgeons

Physicians in general and surgeons in particular are said to prefer action to inaction (Katz 1999, Gawande 2002, Cassell et al. 2003, Chen 2008, Aasland et al. 2008). The words surgeon and surgery originate from “chirurgia” which is derived from the Greek words ‘cheiros’: hand, and ‘ourgia’: action. So surgeons act with their hands and define their field by what they do (Katz 1999). In situations when surgical intervention seems to be the patient’s only chance of survival or remission, for instance patients with a dissecting (or ruptured) aortic aneurism, surgeons certainly have to do something immediately. The story of Micheal DeBakey, a legendary heart surgeon who devised the operation to repair torn aortas in fact underwent the same operation with a successful result at the age of 97. This is in many ways emblematic of the ethical difficulties that accompany high-risk surgical interventions at the end of life (Altman 2007). To sum up, inaction is not what is expected of surgeons, what they are trained to do or expect from themselves. The physician role demands both acting safely and securely, and the will and courage to take risks in order to help, and to develop the profession, according to Førde (2000).

Nurses often criticize physicians’ for initiating medical treatment and their reluctance to withdraw it when the chances of a successful outcome for patients seems poor, thereby prolonging their suffering and reducing their quality of life. Studies have shown this issue to be a major source of conflicting opinions between physicians and nurses (Söderberg & Norberg 1993, Oberle & Hughes 2001, Sørli et al. 2003a, 2003b, Melia 2004, Puntillo & McAdam 2006, Bolmsjö et al. 2007, Silén et al. 2008). Gawande (2007) writes about meeting

an intensive care nurse who criticised physicians for not knowing when to stop treatment. When asked what she felt the best doctors did, she answered:

Good doctors, she finally said, understand one key thing: This is not about them. It's about the patient. The good doctors didn't always get the answers right, she said. Sometimes they still pushed too long or not long enough. But at least they stopped to wonder, to reconsider the path they were on. They asked colleagues for another perspective. They set aside their egos (Gawande 2007:163-164).

Patients today are often said to expect too much from medical diagnostics and treatment; they not only hope for an easy fix that will erase their problems, but almost take for granted that everything can be easily treated and cured, and that every medical procedure will turn out well (Cassell 1998, Arnetz 2001, Gulbrandsen et al. 2002, Gawande 2007, Cooper et al. 2008, Kodner 2008, Tjora 2008). Popular television series like "Chicago Hope" and "ER" featuring "miracle cases" from emergency departments of modern hospitals may lead the viewing public to have unrealistic impressions of modern medicine and its chances of success (Katz 1999, Groopman 2007).

Especially surgeons are said to experience high expectations from patients, relatives, and the media, and they may even feel pressured to perform surgical procedures which they believe have poor chances of a successful outcome (McCullough et al. 1998, Hendrick & Nelson 2001, Gulbrandsen et al. 2002, Grady 2007, Morris 2007, Saarni et al. 2008). This pressure may take considerable effort for surgeons to resist. When seriously ill or injured, most patients and relatives want and expect surgeons and nurses to take necessary actions and go on fighting, trying to find a way as long as there is the slightest possibility of survival or remission. In the absence of certainty, when the stakes are our lives or the lives of our relatives, and surgery seems to be the only chance we have got, most people want surgeons and nurses to fight, not to give up (Gawande 2002, Little & Sayers 2004, Takman & Severinsson 2005, Altman 2007, Grady 2007, Miljeteig et al. 2008).

The notion of patients' authority in health care has changed considerably in recent years. Only a few decades ago, surgeons and nurses made their decisions concerning treatment and care, and patients were expected to do as they were told. Today, regarding patients as autonomous decision makers is principal in medical as well as in nursing ethics (McCullough et al. 1998, Beauchamp & Childress 2001, Gawande 2002, Den Norske Legeforening 2002, Suhonen et al. 2003, Scheingraber et al. 2004, Norsk Sykepleierforbund 2007). From originally being related to protecting research participants, autonomy and consent requirement have gradually become established as a norm relevant to everyday treatment and care, thus transforming the process of medical decision making (Hoeyer 2009). One may argue that respect for autonomy has changed surgeons' and nurses' relationships with patients in ways that provide overall benefit for patients, especially by forming the basis of the doctrine of informed consent which enables patients to make medical care decisions that reflect their own values and desires (Aunan 2003).

However, both the principle of autonomy and that of informed consent continue to give rise to troublesome and unsettled ethical (and legal) questions for surgeons and nurses. Studies show that physicians and nurses are concerned about patients' decision-making capacity (Hurst et al. 2007), the kind and amount of information they ought to provide (Palmboom et al. 2007, Berman et al. 2008), to what extent, when and how bad news should be delivered, and what patients really need and want to know about the outcome of their diseases (Little et al. 2000, Leino-Kilpi et al. 2002, Gordon & Daugherty 2003, Veerapen 2007, Nolte 2008). Studies

show a disparity between the ideals of the consent process and how it is perceived and experienced by patients (Akkad et al. 2006). Studies from hospitals also show that patients' informational needs and information received often do not correspond (Suhonen et al. 2005). What constitutes relevant information for patients to give their consent to a particular operation, especially about the risks involved, is an ongoing dilemma that surgeons and nurses experience (Samuels 2005, Bernat & Peterson 2006). In the literature arguments both for and against truth-telling are established in terms of autonomy and physical and psychosocial harm. There is also the view that truth-telling is an intrinsic good, a view that is argued against on the grounds of medical uncertainty (Tuckett 2004). Recently, there is a debate in the literature whether patients are entitled to know the hospitals' rates of performance on particular operations and even the surgeons' individual performance rates before giving their consent (or refusal) to surgery (Clarke & Oakly 2004, White 2004, Marasco et al. 2005, Samuels 2005, Burger et al. 2007, Gawande 2007, Schwarze 2007, Veerapen 2007, Pedersen et al. 2007). As a consequence, it has been suggested that in order to keep their mortality rates as low as possible, surgeons may become more reluctant to operate on high risk patients who may be most likely to benefit from the treatment (Haaverstad et al. 2004).

Modern medicine is said to be dominated by the imperative of perfection and errors are consequently unacceptable (Rosenthal et al. 1999, Førde 2000, Gawande 2002, Chen 2008, Kodner 2008). Being responsible for patients means that surgeons and nurses have a duty to strive for perfection, or at least to promote patient safety and reducing the likelihood of error and adverse effects in the patients' course of treatment and care (Warnock 2008). Thus, the training of surgeons requires years of observation, guided practice, and gradually increasing autonomy (Prentice 2007, Chen 2008). The paradox at the heart of medical and surgical practice is that it works so well and yet, never well enough (Gawande 2007). The remarkable abilities of surgery are often overestimated by patients, while the uncertainty and limitations are underestimated. Thus, one of the most difficult ethical problems facing surgeons and nurses today is deciding when taking action is the appropriate thing to do, and when further therapeutic actions means doing more harm than good (Gawande 2002, 2007, Groopman 2007).

According to Gawande (2007), medicine is a trying profession, but less because the difficulties of disease than because of the difficulties of having to work with people under circumstances only partly in physicians' control: "Ours is a team sport, but with two key differences from the kinds with lighted scoreboards: the stakes are people's lives and we have no coaches" (Gawande 2007:253). In spite of accurate diagnostic devices, surgeons frequently have to operate in order to determine or confirm patients' diagnosis; they may be surprised about what they find, and often have to improvise due to anatomical variability and individual deviations within the body and in the evolution of patients' diseases (Nuland 2000, Groopman 2007, Morris 2007). As the boundaries of surgery have expanded to include higher complexities of disease and malfunctions, so have the risks of adverse effects and unsuccessful outcomes. Relatively minor shortcomings in performing high-risk surgery on frail patients may induce a chain of adverse reaction and complications that finally may contribute to death (Hasse 2000).

4.3 Nurses in surgical units

When the seriously sick or wounded and undergo surgery, patients need competent help to live, and to live as well as possible. The continuous facilitating, relief, and protection of individual life during such critical life phases are the special responsibility of nursing (Elstad & Torjuul 2009b). In the nursing literature, the moral responsibility of nurses is described as being grounded in the nurse-patient relationship, established through the daily and nightly care of the ever-present nurse rather than via the episodic consultative nature of patient-physician contact (May 1991, Purtilo et al. 2001, Ferrell 2005, Mauleon et al. 2005). The temporal continuity of nursing enables nurses to observe patients closely, attend to their shifting needs in flexible ways, catch and counteract early signs of complications and declining health taking necessary corrective actions. This requires not only medical and technical knowledge and skills, but also the nurses' ability to form helping relationships with patients and engage in practical ethical reasoning (Benner et al. 1999, Elstad 1995, Minick & Harvey 2003, Elstad & Torjuul 2009a). According to Benner et al. (1999), clinical understanding and judgments of the patients' changing conditions are based upon understanding actual trends and trajectories in the patients' condition and involves thinking in action and reasoning in transition.

The patients' medical conditions vary considerably at the time of admission to surgical units and may change rapidly before, during and immediately after surgery and throughout their hospital stay. Nurses adjust their actions according to these changes in the patients' medical condition, the seriousness and prognosis of the condition, risks of complications etc. While surgeons are responsible for performing the operations and attend to patients' medical treatment, nurses assist surgeons at the operating table and in carrying out the treatment, observe and monitor patients' vital signs and symptoms, and assess patients' medical conditions while attending to their basic needs. Patients undergoing surgery are dependent on the cooperation between competent surgeons and nurses to survive the intervention and attain a favourable outcome. Modern nursing supports and protects patients' life during sickness and diagnostic and surgical interventions simultaneously in order to improve patients' health, functioning, and employs all levels of technology to that end (Elstad & Torjuul 2009b). Benner et al. (1999) provides a comprehensive and detailed description of how nurses work towards this end in critical care and in caring for patients who move from hope of recovery to dying with dignity. In recent years, medical and surgical interventions have increasingly become essential to prevent or relieve painful symptoms of patients at the end of life (Kørner et al. 2007, Chen 2008, Hollingham 2008).

Studies show that nurse staffing levels and quality of care in hospitals influence patient outcomes, especially by reducing the rates of adverse events after major surgery, for instance wounds and urinary tract infection, pneumonia, venous thrombosis and pulmonary embolism (Kovner & Gergen 1998, Needleman et al. 2002, Minick & Harvey 2003). The nurses' wide-ranging and shared knowledge and experience of patients in general, and their knowledge of individual patients and relatives enables them to interpret terse signs of the trajectory of each patient, the early recognition of problems and take the necessary corrective actions to prevent further decline in patients' status and increase the likelihood of a positive health outcome. Experienced nurses often recognize early changes in patients' conditions indicating a medical problem before or without corroborating objective data (Benner et al. 1999, Minick & Harvey 2003), and judge when to summon surgeons to attend to these changes (Benner et al. 1999,

Elstad & Torjuul 2009a). This competence is often crucial in the nursing of patients in life threatening circumstances.

In the technological environment of modern hospital care nurses are said to make a difference to patients (Benner et al. 1999, Hawley & Jensen 2007, McGrath 2008). A Norwegian study of patient satisfaction after hospitalization for surgery, found that patients' experience of the quality of contact with nurses appeared to be the major determinant of both their global treatment satisfaction and satisfaction with the information received (Sørliie T et al. 2005). A recent Norwegian survey shows that people have confidence in nurses and the nursing profession. 82% of the respondents ranged nursing as the most important occupation in the country while physician and medicine finished 3rd with 76% (Kunnskapsdepartementet 2009). Nurses function between patients and physicians and other health care providers, which means communication of health information between multiple people, departments, and agencies within and outside the hospital setting (Liaschenko 2002, Varcoe et al. 2004). Nursing also entails responding to patients' emotional distress by a diagnosis, anxiety about coping with treatments and the effects of disease upon their present and future way of life (Huynh et al. 2008). The communicative and information-exchange tasks that comprise a great part of nursing work are critical to the quality of health care (Björklund 2004, Huynh et al. 2008).

Attending to patients' needs presupposes both professional competencies based on scientific and clinical knowledge and skills, presence at the bedside, and showing respect and compassion (Hasse 2000, Stolt 2000, Shatell 2002, Graber & Mitcham 2004, Sørliie et al. 2006). However, due to the corporate ethos and cost constraint measures in modern hospital settings it has become increasingly difficult for both surgeons and nurses to find sufficient time to talk to patients, get to know them and establishing a trusting relationship (Udén et al. 1995, Little et al. 2000, Little 2002, Aasland 2001, Edwards et al. 2002, Graber & Mitcham 2004, Peter et al. 2004, Sørliie et al. 2005, Rodney & Street 2004, Kodner 2008, Chen 2008). Profound changes in types and configurations of health care institutions and organizational and professional boundaries have increasingly created a business of health care in recent years. Health is increasingly regarded as a commodity or product to be bought and sold, patients are customers or consumers, and surgeons and nurses are providers of a variety of services in a health care marketplace. Being good and doing good is not easy in a system of care whose foremost objective seem to be cost containment (Bruhn 2001, Gulbrandsen et al. 2002, Pepine 2003, Rodney & Street 2004). In a fast-paced hospital environment where surgeons and nurses have to accomplish an abundance of duties while serving numerous patients, caring practices based on the needs of individual patients have become increasingly difficult to sustain (Cronquist et al. 2001, Graber & Mitcham 2004, Grimsmo & Sørensen 2004, Doane & Varcoe 2007, Førde & Aasland 2008, Kodner 2008).

As this survey of the literature demonstrates, nurses and surgeons have to live with ethically difficult situations while working in surgical units. Health care practice is a human enterprise, it's about human life. Thus, moral issues and difficulties are inherent in practicing surgery and nursing, as well as in patients' experience of illness, disease and disability, rather than being solely the results of advances in medical science and technology (Storch & Kenny 2007). There is a vast body of literature into ethical dilemmas embedded in the delivery of health care. Few empirical studies have been found about surgeons' experiences of ethical difficult situations, and that of nurses working in surgical units (Udén et al. 1995, Enns & Gregory 2007). That is the focus of this study.

5 The aims of the study

The overall aim of this thesis is to illuminate surgeons' and nurses' experiences of living with ethical difficulties in their work. This focus comprises both the kinds of ethical dilemmas experienced and the meaning surgeons and nurses assign to their experiences.

The study comprises four papers with the following specific aims:

Paper I: To illuminate the meanings surgeons assign to their experiences of ethical dilemmas in their work.

Paper II: To illuminate the ethical dilemmas experienced by surgeons in practice.

Paper III: To illuminate the ethical dilemmas experienced by nurses working in surgical units.

Paper IV: To illuminate the meanings nurses in surgical units assign to their experiences of ethical dilemmas in their work.

6 Ethical principles and practices

Let us define “ethical intention” as aiming at the “good life” with and for others, in just institutions” (Ricoeur, 1992:172)

This study investigates the ethical dilemmas of practising from surgeons’ and nurses’ points of view and their ways of reasoning, deliberating and acting in ethically difficult situations. The discourse about what constitutes ethical ends and dilemmas in health care practice, how they ought to be addressed and resolved is usually framed by referring to professional codes of conduct or principles of biomedical ethics. This chapter asks if the ethical practices of surgery and nursing can be fully understood from the principles of biomedical ethics or adherence to professional ethical codes of conduct. First, the advantages and limitations of ethical codes and principles in addressing and resolving ethical dilemmas are presented. Next, an ethics of practise is presented, building on the philosophies of Aristotle (1980) and MacIntyre (2002).

6.1 Ethical principles

The principles approach to ethics as described by Beauchamp & Childress (2001), is today the most generally accepted school of thought in medical and nursing ethics; i.e. the principle of autonomy, nonmaleficence, beneficence, and justice. The methodology and the applicability of the four principles approach have been challenged as well as defended as a common framework for biomedical ethics (Walker 1998, Limentani 1999, Peterson & Potter 2004, Thornton 2006, Goldstein et al. 2006).

The myriad of ethical codes and guidelines that exist and continue to emerge in health care reflects both a perception of increasing ethical complexity in this field, and a fundamental belief in codes and guideline as the way to address and resolve ethical problems. Adoptions of ethical codes or guidelines may enhance a common understanding of the ethical features of medical and nursing practice; and the resolving of particular problems such as resuscitation, confidentiality, withdrawal of life-sustaining treatments and organ donations. In addition, principles and guidelines may assist professionals to focus on universal moral problems of practice, and point out ethically salient features in difficult situations.

Professional ethical codes and principles usually describe ethical values and attitudes that are or ought to be shared by health care workers in general or by members of a profession in particular. Thus, they may be of use in educating students or newcomers in a profession (Benner 1984). While codes and principles cannot provide answers to the best and correct actions to take in situations of ethical difficulty, they can provide clear positions on a few ethical issues such as euthanasia (Limentani 1999, Gawande 2007). In addition, they may serve professionals in upholding the principle of justice, i.e. equal treatment of equal or similar cases (Førde et al. 2007). Taken in isolation, ethical principles and guidelines may be perfectly desirable, attractive and morally sound. However, several studies point out that existing guidelines are often not known, accepted or used by those they are supposed to assist, and so, they seem to be of limited value (Verpeet et al. 2005, Førde et al. 2007).

Universal codes and specific guidelines developed for dealing with particular ethical dilemmas may raise unrealistic expectations about their scope and possible impact on resolving ethical dilemmas (Straume 2001). Insofar as physicians and nurses are expected to act in good and correct ways in particular situations, it is necessary to look closer into and

examine carefully each situation and context in order to decide which actions to take rather than ethical principles or professional guidelines (Lindseth 2002).

Ethical principles and the moral rules derived from them are not absolutely binding; their status is *prima facie* (Beauchamp and Childress 2001, McCarthy & Deady 2008, Thornton 2006). In any given situation, each principle has to be specified and weighed relative to the particular context in which it is applied. According to Beauchamp and Childress (2001) a principle is a duty which is binding on all occasions unless it is in conflict with equal or stronger duties. This does not solve the question of how we are to moderate between principles in situations when they are in conflict, as there is nothing intrinsic to *prima facie* principles that determine relative importance. For instance, when there is a need for autonomy, how important is beneficence? And how do we recognize the relevance of a principle in a situation in the first place?

In order to balance the relative importance of ethical principles in a particular situation, it seems that the practitioner ought to refer to a more basic and profound ethical system outside the principles themselves. Whenever there is a moral case or an ethically difficult situation of doubt and uncertainty, the principles are however silent and something beyond principles seems to be required in order to decide the best and correct actions to take.

It seems that the role of ethical codes and principles in practising medicine and nursing is highly influenced by the way ethics in general is conceived by the practitioners. As this study shows, surgeons and nurses related that ethical problems were a significant and inseparable feature of carrying out the clinical work in the unit (Papers I-IV). This suggests that the norms and values of surgery and nursing are already present in practising with and for patients and not something that is added by a further, second step. This is in line with the ethics of Løgstrup (1997), who argues that the fundamental phenomena of ethical life is not norms, but spontaneous expressions of life, designated as “utterances of life”, like trust, openness of speech and charity. These expressions are possibilities, not norms or rules (Løgstrup 1997). At the centre of his ethics is the ethical demand which is unspoken and silent and the person to whom the demand is directed must discover and interpret each particular person and situation in order to decide the content of the demand. Each person has to decide at one’s own risk what the demand requires and how to respond and act in the best interests of the other in particular circumstances. According to Martinsen (1996) the silent demand challenges our perception, imagination, professional insight, and involves interpretation of persons and situations in figuring out the best and correct action to take, or the practical wisdom of the clinician.

6.2 Ethical practices

By interviewing surgeons and nurses about ethically difficult situations in their practice, this study aims to investigate the ways the ethics of surgery and nursing is embedded in the practical, working life of surgeons and nurses. The ethics or morality of practising is recognized as the starting point of all moral philosophy and ethical discourse (Tranøy 1998, Lindseth 2002, Christoffersen 2005). The originator of an ethics founded on human activity and moral experience is Aristotle (384 – 322 B.C.). For Aristotle (1980), inquiry begins by attending to the phenomena, the world as it appears to us. But only phenomena that carry *endoxa* that is worthwhile our attention, i.e. only phenomena that is an opinion shared by everyone or by the wise in a field. Phenomena are experienced by us very broadly (Nussbaum 1986, Allmark 2006). An ethical inquiry into for instance, the ethics of withholding or

withdrawing treatment will include both biomedical and psychosocial knowledge and research into the issue, the experiences and opinions of physicians, nurses, patients and relatives, as well as the writings of ethicists.

In the *Nicomachean ethics*, Aristotle (1980) describes human life as consisting of the pursuit of ends, and the end of which man ought to aim is *eudaimonia*, which is usually translated as happiness. This does not mean that happiness is only a state of feeling. Aristotle (1980) makes clear that *eudaimonia* is activities in accordance with virtue that contribute to the best and most complete human life, in particular intellectual or moral activities.

The concept of virtue is connected with practising since it comes about as a result of habit; by doing certain kinds of activities one becomes virtuous, which means ‘states of character that arise out of like activities’, and taking pleasure in the right things to the right degree. Not all kinds of activities are morally important, only those that contribute to the end of human life, and are chosen for their own sake, are satisfying in themselves, and need no supplement beyond themselves (Aristotle 1980). Aristotle (1980) describes virtue as an intermediate state, but that does not mean that it is always equidistant between two possible extremes. What must be sought is the mean relative to us; the act must be done at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way (Aristotle 1980:38).

Aristotle (1980) says further that no rules to guide us in choosing how to act virtuously can be laid down in advance as the decision depends on perception of the particular occasion. By *phronesis* or practical wisdom, Aristotle (1980) means knowledge of the generally accepted rules of morality as well as an understanding of the reason for them, and concerns how to act well in particular situations. Practical wisdoms are acquired through experience and training of those skills that enable us to practice in ways that are suitable for each occasion (Aristotle 1980).

MacIntyre (2002:187) building on the philosophy of Aristotle, defines a practice as follows:
...any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which is appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of ends and goods involved, are systematically extended.

External goods to a practice, when achieved are always some individual’s property and possession. On the other hand, for the internal goods of a practice, their achievement is a good for the whole community who participates in the practice, according to MacIntyre (2002). Goods internal to a practice concern both the excellence of the products and the excellence of performance. The goods are called internal because they can only be specified in terms of practice and by means of examples from such practices, and the internal goods can only be recognized by the experience of participating in the practice in question. Those who lack the relevant experience are thereby incompetent as judges of internal goods, according to MacIntyre (2002).

A practice is never just a set of technical skills, says MacIntyre (2002). Practices never have just one end or ends fixed for all time; they are transmuted by the history of the activity. Practices must not be confused with institutions, according to MacIntyre (2002), since institutions are characteristically and necessarily concerned with acquiring external goods.

Institutions sustain themselves as well as the practices of which they are the bearers. Still, since institutions are structured in terms of power and status, and distribute money, power and status as rewards, the ends and ideals of practices are always vulnerable to the acquisitiveness of the institution, says MacIntyre (2002). Thus, without moral virtues like justice, courage or truthfulness, practices cannot resist the corrupting power of institutions. Virtues are in turn encouraged by certain types of social institution and endangered by others. MacIntyre (2002:191) defines virtue as:

...an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving such goods.

Those who achieve excellence in a practice characteristically enjoy both their achievement and their activity in achieving, according to MacIntyre (2002). As Aristotle (1980) says, the enjoyment and satisfaction of an activity and the achievement are not the ends at which the agent aims, but the enjoyment supervened upon by successful activity in such a way that the activity achieved and the activity enjoyed are one and the same state. Hence, to aim at the one is to aim at the other, and consequently it is easy to confuse the pursuit of excellence with the pursuit of happiness and satisfaction (MacIntyre 2002).

In contemporary bioethical discourse there seems to be a tension and even controversy between ethical principles and moral as lived, experienced and practised (Kleinman 1988). Accordingly, different approaches offer different solutions to what constitute ethical concern or dilemmas and how they ought to be resolved in contemporary health care practice. This discourse has been described in different ways by different philosophers, often as a dichotomy between deontological (Kantian) and virtue (Aristotelian) ethics, or between the ethics of justice and the ethics of care and responsibility (Gilligan 1982, Walker 1998). While both perspectives have much to offer in understanding and resolving ethical dilemmas, they have been criticized for focusing too much on choice, responsibility, judgment and justification in ethically difficult situations and less on the good embedded in everyday skilful ethical comportment because only instances of breakdown are held up for scrutiny.

The taken-for-granted understanding of what constitutes the good and appropriate practice or what usually takes place in a particular line of work is similarly overlooked, according to Dreyfus et al. (1996). Benner and co-workers (1996, 1999) consider ethical comportment as just one kind of expertise developed through years of clinical experience and entails acting spontaneously upon the intuition that results out of experience in the specialized practice. According to Dreyfus et al. (1996), experts do not normally solve problems. They neither reason nor even act deliberately. The act springs from the immediate perception of salient features of the particular situation. When confronted with an ethical dilemma and torn between two equally compelling decisions even the expert may have to deliberate over the case and which actions to take:

In familiar but problematic situations, therefore, rather than standing back and applying abstract principles, the expert deliberates about the appropriateness of his *intuitions* (Dreyfus et al. 1996:269).

The distinction between action and relational ethics perspectives was used in interpretation of the results in two of the papers (Papers I and II). The distinction was not pursued further, as the findings suggested that these perspectives were not mutually exclusive, but rather interdependent aspects or dimensions of recounting the particular situation. As the results show (Papers I-IV), surgeons and nurses did not differentiate between action and relational

perspectives in their narration, but underlined their dual responsibility for taking actions in certain circumstances as well as their way of being in relationships with patients. According to studies by Brown et al. (1989), people are able to shift their focus of attention in particular situations, for instance from justice to care. As their definitions of what constitutes a moral problem changes, the situation may in consequence be regarded differently.

In this study I use the terms ethics and morality more or less interchangeably. In philosophical discourse however, “ethics” principally means reflections on “morality”, understood as our actual pattern of behaviour in particular circumstances, though there is no clear distinction between these terms neither in moral philosophy nor in everyday language (Tranøy 1998, Syse 2005, Vetlesen 2007). Ricoeur (1992:170) points to the twofold connotations of ethics and morality; that which is considered to be good and that which imposes itself as obligatory. At the same time he argues that ethics has primacy over morality, which means that ethical ends or telos are actualized in particular actions. The primacy of ethics also means the necessity to consider the ethical ends whenever norms lead to dilemmas or conflicts in practice. According to Ricoeur (1992), referring to Aristotle, ‘the good life’ means that people investigate the particulars of each situation before acting, rather than attempt to act on acontextual, metaphysical theories and guidelines.

In this study I use the concepts “ethical dilemmas” and “ethically difficult situations” interchangeably. An ethical dilemma may be regarded as a conflict between different courses of actions that results from following general and mutually exclusive ethical principles within an ethical system or a moral code (Beauchamp & Childress 2001). In this view dilemmas are resolved by applying (general) principles or procedures to cases that appropriately yield impersonally justified judgments about what any moral agent in such a case should do (Peterson & Potter 2004, Goldstein et al. 2006). In a broader sense, a dilemma may mean a conflict between an indeterminate number of features in a particular situation and the context of deciding the best and correct actions to take (Bruhn 2001, Volker 2003, Källemark et al. 2004). A dilemma may also mean conflicts of interests, responsibilities and differences of opinions when the life and welfare of particular persons are at stake. In broad and practical sense dilemmas mean more or less the same as ethically difficult situations, and this is the way it is used in this study.

6.3 The perspective of this study

This study investigates the ethical reasoning of surgeons and nurses and their narrative accounts of difficult situations. In my view, stories of real-life experiences permit and invite exploration of particular cases of commitments and responsibilities, institutional practices and moral traditions in different areas of professional work. While ethical principles, concepts or theories often focus on the general features of situations of ethical difficulties, real-life stories to a greater degree emphasize the ambiguity, complexity and suffering of human beings in particular circumstances, adding enrichment of context to ethical discourse (Walker 1993).

Telling stories about experienced dilemmas, surgeons and nurses try to make sense of their deliberations and actions, what they do or do not care about, and who they are. Stories of ethical dilemmas also reveal how values acquire meaning both individually and socially, and how those meanings evolve and acquire layers of intelligibility and acceptability as practitioners try to make sense of their professional and personal lives (Walker 1998, Code 2002). Last, but equally important, telling stories about real-life episodes are essential in keeping moral justification coherent within and between us, according to Walker (1998).

Moral justification (as ethics in general) is from the first and the last interpersonal and requires people to account to one another about the value and impact of what they do and care about in matters of importance (Walker 1998).

In summary, there are several reasons why surgeons and nurses in this study were asked to tell stories about their experiences of ethically difficult situations rather than stories about ethically good and correct ways of practice. First, when experiencing ethical dilemmas, they become aware of aspects of practice that are usually tacitly understood and taken for granted in the usual course of events in the unit and make them subjects of reflection and reconsideration. Second, while wide-ranging discussions about ethics and morality often tend to run idle, real-life dilemmas are, as argued touchstones of professional and personal ethical perspectives, attitudes and standards of practising. Thus, ethical dilemmas may infuse life, engagement and meaning into ethical deliberations and discussions, increase ethical awareness and challenge surgeons' and nurses' way of thinking and practising in more direct and decisive ways. The proper course to follow to grasp the ethically good and correct ways of practice is not necessarily to focus on the good (Nydal & Solberg 2006). The path to follow may rather be to examine carefully the dilemmas of real-life or situations when practising in the best interests of patients is difficult to accomplish.

7 Methodological framework

Experience can be said, it demands to be said. To bring it to language is not to change it into something else, but in articulating and developing it, to make it become itself (Ricoeur 1981:115).

The philosophical foundation that have inspired and guided this study and the method used has not been elaborated upon in the published papers, and will be presented in the following. Since the aim of this study is to illuminate the meaning of ethical dilemmas experienced by surgeons and nurses, I focus on how understanding and interpreting *meaning* can be accomplished according to various traditions of phenomenological hermeneutical philosophy, especially the works of Ricoeur (1976, 1981) and Gadamer (2003). The purpose is to clarify my own perspective and the ways it has developed as a result of reading philosophical texts and methodological reflections during the research process. In particular, this study has to some extent has shifted from a phenomenological to a hermeneutical approach, or from exploring the essential meaning of being in ethically difficult situations to analysing these situations and the experiences themselves. This in turn will be outlined in this chapter.

7.1 Phenomenology

The concept of meaning is ambiguous and allows several interpretations according to varying philosophical traditions in phenomenology and hermeneutics (Gulddal & Møller 1999). In the tradition of Husserl, the founder of the phenomenological movement, consciousness is intentionality, and the main purpose of phenomenological research is to illuminate the *essential* meaning of a particular phenomenon of intentional experience. Lived experience is used as access to descriptions of phenomena in their primordial or original form, and requires that descriptions of experience be sought as it occurs before reflection.

The essential meaning of a phenomenon is accomplished through two coordinated abstractions, or reductions, that serve to zero in on the pure intentional content as such. The first, the transcendental reduction, or *epochê*, consists in directing one's attention away from the transcendent world back to the immanent contents of consciousness, and takes us from the natural attitude of the external world to the inner domain of the mental. In this reduction our everyday life experiences are bracketed including the question if the phenomenon exists or not. The second reduction, the *eidetic*, points towards the ideal, normative aspects of the mental content. This reduction moves us away from our factual psychological reality towards an a-temporal conceptual and semantic content, or from facts to essences (Carman & Hansen 2005). The main purpose of the reduction method is to ignore the accidental or unessential features of and connections between phenomena in order to focus on the essential which shows itself through the reductions (Nicolaisen 2003).

Lindseth and Norberg (2004) recommend researchers to dispense of their tacit understanding or the 'taken for granted' existence and meanings of the phenomenon under study, or conduct a shift from a natural to a phenomenological attitude in which the essence of a phenomenon is allowed to appear to the mind in its meaning structure. This would in principle entail a Husserlian double reduction, but the nature and scope of the bracketing of real-life experiences is difficult to accomplish in the context of an empirical study (Paley 1997, Yegdich 2000). According to Sokolowski (2000:189):

This is reflection with a vengeance; it is wholesale reflection. Nothing is left out. We take a distance to everything, even to the world as such and ourselves as having a world.

The task of phenomenology, according to Husserl, is to produce an exact description of primordial phenomena, and this is what he means by his maxim 'back to the things themselves' (Paley 1997). In a radical sense phenomenological philosophy goes beyond mere reflection on and clarification of the meaning or sense which is reached through propositional reflection (questioning the state of affairs), says Sokolowski (2000).

The transcendental and eidetic reduction has been criticized and rejected by the philosophers Heidegger (1996), Gadamer (2003), and Carman & Hansen (2005). Heidegger (1996) considered Husserl's phenomenological reductions an abstract, theory-driven distortion of phenomena and human experience. For Heidegger (1996) phenomenology can only be ontology. According to Heidegger (1996, Nicolaisen 2003), the world is not to be conceived as something outside Dasein, but as something that belongs to Dasein's way of being.

Ricoeur's work has been characterized as a philosophical mediation (Kaplan 2008) or reconciliation (Amdal 2001), in this instance between the philosophical traditions of Husserl and Heidegger. In his theory of interpretation Ricoeur (1976, 1981) attempted to graft textual interpretation to contemporary ontological insights in phenomenology (Geanellos 2000). Accordingly, he describes phenomenology as a presupposition of hermeneutics and vice versa.

As soon as we start thinking, we discover we are already living in and by the means of worlds of representations, idealities, norms. As far as that goes we move in two worlds: the pre-given world which is the other's limit and ground, and a world of symbols and rules through which the world has already been interpreted when we begin to think (Ricoeur 1980, quoted in Abel 2008:185).

This study is not phenomenological in Husserl's sense since no bracketing or phenomenological epoché was performed in the interpretation of the interviews. Thus, the themes and subthemes presented in the papers are not essences as a result of transcendental or eidetic reductions. Phenomenology is not about objects that exist in the real world, but a method of studying how these objects and our real world are constituted in our consciousness. Skjervheim (1976), referring to the works of Husserl, distinguishes between transcendental or constitutive phenomenology and mundane or descriptive phenomenology, which he regards as a supplement to traditional empirical research methods. He means that empirical investigations into human affairs presuppose an implicit or explicit understanding of what constitutes human nature and existence as such, i.e. the a priori or transcendental conditions of human existence that do not require any reference to experience or empirical evidence.

This study may be characterized as phenomenological in the mundane or descriptive sense as outlined above. Its aim was from the onset to interpret the meaning of ethical dilemmas as recounted by surgeons and nurses, not to constitute essential meaning. Still, ethical phenomena may be regarded as essentials in a phenomenological sense. For instance, the sovereign expressions of life described by Løgstrup (1997), like trust, openness of speech, responsibility and mercy may be regarded as essences in a phenomenological sense because they are ontological and constitute a priori condition of human life and rather independent of our individual efforts. On the other hand, the meaning of for instance trust and honesty and their expressions in particular circumstances or relationships between particular persons is however an empirical issue that has to be determined in each case, that is, subject to interpretation (Skjervheim 1976). For instance, the meaning of trust may vary depending on the nature of the relationships between people and the particular situation and context they understand themselves to be in. In this case, the experience and meaning of trust is obviously

different to patients, surgeons and nurses in surgical units (Walker 2003). Meaning, says Mishler (1986:3) is always “contextually grounded - inherently and irremediably”, and in order to understand the meaning of a person’s reply to an interview question, the researcher has to acquire some understanding of the context from which the interviewee has come.

The way in which a moral problem is constructed, however, also depends on the context, e.g., who is involved, the relationships between the persons involved –their relative power vis-à-vis each other as well as the strength of the connection between them – where the situation takes place, what role the narrator plays in the conflict, and the personal and cultural history of the narrator. We have observed that when different elements of context and different aspects or qualities of relationships are defined and represented as salient in similar conflicts, what is seen as the central moral issue in a situation may shift, and different actions may be defined as moral and immoral, as right or wrong (Brown et al. 1989:145).

Thus, a hermeneutic approach to interpretation inspired by Ricoeur (1976) and Gadamer (2003) of the interview texts was performed.

7.2 Hermeneutics

Philosophical hermeneutics according to the tradition after Heidegger presupposes that a basic feature of human life is always being in a process of understanding (of which misunderstanding and non-understanding are variants), and the task of hermeneutics is to clarify the conditions in which understanding and interpretations take place (Gadamer 2003). In a methodological sense, hermeneutics is an approach to interpretation and understanding as such and as it unfolds in all spheres of human life; the understanding of texts, works of art, social situations and interaction, or what Dilthey called expressions of life (Gulddal & Møller 1999).

Central to hermeneutical philosophy is the thesis that interpretation always constitutes a hermeneutic circle. It was Schleiermacher that first stated that our interpretation of parts of a text is shaped by our understanding as a whole, while the latter is subject to modification in the light of our reading of the parts (Gulddal & Møller 1999, Westphal 2008). Heidegger (1996, Nicolaisen 2003) insists that interpretation is never presuppositionless; our life world is already given in language, and also always already there before any interpretation. Fore-understanding is contextual, given in language, perception, and the traditions of social relationships and practices, and is a continuous presupposition for new understanding which challenges and transcends it.

Our understanding is set in motion when something addresses us, says Gadamer (2003). Understanding is a matter of interpretation rather than intuition, and can be regarded as a dialogue between a text and a reader or an expression of opinion and a listener. The reader meets the texts with expectations, questions and pre-understandings that makes him or her prepared to understand some dimensions or aspects of the text, and rather unprepared to others. Thus, our understanding presupposes openness and willingness to revise our pre-understanding, which means that something is at stake in our interpretation of a text or an expression (Gadamer 2003). “The task of hermeneutics to clarify this miracle of understanding, which is not a mysterious communion of souls, but a sharing of a common meaning”, states Gadamer (2003:292).

According to Gadamer (2003) the hermeneutic circle of understanding is not methodological, but describes the ontological structure of all understanding as such. The circle, then, is not formal in nature; it is neither subjective nor objective.

Tradition is not simply a permanent precondition; rather, we produce it ourselves, inasmuch as we understand, participate in the evolution of tradition and hence further determine it ourselves. Thus the circle is not a “methodological” circle, but describes an element of the ontological structure of understanding (Gadamer 2003:293).

The significance of the circle, which is fundamental to all understanding, has a further hermeneutic consequence which Gadamer (2003) has described as the “fore-conception of completeness”, which states that only what really constitutes a unity of meaning is intelligible. An ethics of understanding is implied in interpretation i.e. that any text should be met with an initial expectation that what it talks about is important, that its message conveys some possible meaning or truth about the world that can be grasped and understood. It also means that the text should not be judged or ignored without sufficient reasons or grounds, and that it is the reader’s obligation to search for something in the text that we recollect as fundamental truths about the lives we live (Gadamer 2003).

When trying to understand a text, we do not transpose ourselves into the authors’ minds, but into the perspectives or experiences within which the authors formed their views. We are rather moving into a dimension of meaning that is intelligible in itself and as such offers no reason for going back to the subjectivity of the author, according to Gadamer (2003). Understanding primarily means to understand the content of what is said, and only secondary to isolate and understand another’s meaning as such. Ricoeur (1976) distinguishes between the utterance meaning and the utterer’s meaning in any speech event. This concept of meaning allows two interpretations which reflect the main dialectic between event and meaning. Discourse is both about something and to someone. To mean is both what the speaker means, i.e. what he or she intends to say, and what the sentence means, according to Ricoeur (1976, 1981).

The reference relates language to the world and is another name for discourse’s claim to be true, according to Ricoeur (1976). Language has a reference only when it is used, i.e. the same sense may or may not refer depending on the situations of the act of discourse. To refer is both what the sentence does in a certain situation and according to a certain use and what speakers do when they apply their words to reality. That someone refers to something at a certain time is an event, a speech event, according to Ricoeur (1976:20-21):

Language is not a world of its own. It is not even the world. But because we are in the world, because we are affected by situations, and because we orient ourselves comprehensively in those situations, we have something to say, we have experience to bring to language. Discourse refers back to its speaker at the same time that it refers to the world.

When spoken discourse is written down like the interviews in this study, the “said” of speaking is fixated and its meaning becomes detached or distanced from the speech event, according to Ricoeur (1976). The disconnection of the intention of the speaker from the meaning of the text which is the result of writing is what Ricoeur (1976) calls the semantic autonomy of the text. By this he means that the text’s career to a certain extent escapes the finite horizon lived by its author, and what the text means now matters more than what the speaker meant when he or she uttered it. Distanciation is not a methodological imposition; rather it is constitutive of the phenomenon of the text as written (Ricoeur 1976). The results

lead to a distancing of the text from its author, from the situation of discourse, and from the original context and its audience. Thus, distanciation allows interpreters to approach the text with less concern for the authorial intent so that its meanings can be appropriated by any reader (Ricoeur 1976). Methodologically, distanciation allows researchers to move beyond the notion that only the research participants' understanding is meaningful or correct. It also allows interpreters to interpret the same text faithfully yet somewhat differently because it is acknowledged that texts have many meanings (Geanellos 2000).

The question may be raised, however, to what extent the knowledge of the speaker or author of a text and the context in which it was spoken or written down is to be taken into account in the interpretation process (Amdal 2001). In this study, for instance, the texts were produced by surgeons and nurses and about ethically difficult situations that occurred at a particular place and time. This had to be taken into account in interpreting the texts. The transcribed interviews were not originally put in writing, but the result of conversations or discourses about the participants' experiences of situations, searching out their understandings, thoughts and meanings as they emerged in a dialogue with the interviewer. According to Ricoeur (1976), it is the contextual function of discourse to reduce misunderstandings and the ambiguity of discourse resulting from the polysemy of words used and the plurality of possible interpretations of what is expressed.

Appropriation of a text also means making it one's own. This may be elucidated by Gadamer's (2003) concept of tradition; i.e. the familiar world to which we belong, our common world of shared history, language and culture that prefigures understanding. Tradition is not alien, but something into which we have grown and appropriated through engaged living (Geanellos 2000), in this case: the practices of the surgical units, the experiences of surgeons and nurses, the professional disciplines, etc. When interpreters appropriate the meaning of the text, the world of the text becomes familiar or one's own, and as a result the horizon of the interpreter is expanded. Appropriation and distanciation provide a dialectic of interpretation of textual meaning between the near and the far, the familiar and unfamiliar, between the known and foreign (Ricoeur 1976, Geanellos 2000), which is yet another formulation of the hermeneutic circle.

In interpreting the text we should avoid making two kinds of fallacies, according to Ricoeur (1976). The intentional fallacy means to overlook the semantic authority of the text and hold the author's intention as the criterion for any valid interpretation of the text. The other is to hypostasize the text as an authorless entity, which means to forget that a text remains a discourse told by somebody to someone else about something (Ricoeur 1976).

When Ricoeur (1976) speaks of the "autonomy of the text", of the meaning of the text which is to be found hidden "behind" the text, and the possibility of new meanings opening up new worlds unfolded by the text, this seems related to the phenomenological epochê (Abel 2008, Westphal 2008). In addition, understanding for Ricoeur (1981:56) "...is not concerned with grasping a fact but with apprehending a possibility of being... to understand a text, we shall say, is not to find a lifeless sense which is contained therein, but to unfold the possibility of being indicated by the text".

We may ask if Ricoeur's interpretation theory is equally appropriate for all kinds of texts. His thesis that texts disclose a world may not be equally valid for trivial texts or science texts as for poetic and literary texts (Amdal 2001, Abel 2008). The referential function of literary discourse differs from the descriptive function of stories of experiences recounted in everyday

and scientific discourse. The semantic autonomy of a text may also vary according to the context or the world of the written work itself. If ethically difficult situations in surgical units are understood as highly dependent on the context, the interview texts do not exhibit a high degree of semantic autonomy, but are relatively context-dependent. This does not mean that they are personal or private, on the contrary.

When we try to understand a text, we do not try to recapture the author's attitude of mind but, if this is the terminology we are to use, we try to recapture the perspective within which he has formed his views. But this means simply that we try to accept the objective validity of what he is saying (Gadamer 2003:292).

Gadamer (2003) defines the concept of 'situation' by saying that it represents a standpoint that limits the possibility of a vision. Hence an essential part of the concept of situation is the concept of 'horizon'. The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Every encounter with tradition that takes place within historical consciousness involves the experience of the tension between the texts of the present. In the process of understanding there takes place a real fusion of horizons, which means that as the historical horizon is projected, it is simultaneously removed.

To "make one's own" what was previously "foreign" remains the ultimate aim for all hermeneutics, according to Ricoeur (1976:91), as interpretation in its last stage wants to equalize, to re-enter contemporaneous, to assimilate in the sense of making similar. This is close to Gadamer's concept of fusion of horizons where the world horizon of the reader is fused with the world horizon of the writer. "Not occasionally only, but always, the meaning of a text goes beyond its author. That is why understanding is not merely a reproductive, but always a productive attitude as well", according to Gadamer (2003: 296).

8 The study

The study was conducted with ten physicians (MDs) and ten registered nurses (RNs) working in one and the same surgical units at one university hospital in Norway. An overview of the studies and papers comprising this thesis is shown in Table 1.

Table 1: Overview of the studies of surgeons and nurses and papers I- IV

Study	Participants	Data collection	Method of interpretation	Papers	Focus of the papers
Surgeons	Ten surgeons (MDs)	Narrative interviews (2004)	Phenomenological hermeneutics	Paper I	The meanings of ethical dilemmas
				Paper II	Ethical dilemmas experienced
Nurses	Ten nurses (RNs)	Narrative interviews (2006)	Phenomenological hermeneutics	Paper III	Ethical dilemmas experienced
				Paper IV	The meanings of ethical dilemmas

8.1 The setting

The university hospital where this study was conducted has 964 beds, and approximately 56 193 patients are admitted to the hospital each year, 64% of them with acute and emergency conditions. The mean length of patients' stay in the hospital is around 4.7 days. Approximately 8000 people are employed in the somatic part of the hospital (data from 2006).

The surgical clinic has 112 beds in four surgical units, an operating unit with ten operation rooms, one out-patient unit with two operation rooms, and a surgical polyclinic. The clinic admits adult patients with gastroenterological, vascular, endocrine and urological conditions, and children in need of surgical treatment. Breast and plastic, reconstructive surgery is also performed. The units have beds designated for intensive treatment and cooperate with the intensive and emergency department in the hospital. Approximately 6000 patients a year receive surgical treatment in the surgical units.

8.2 The sample

Surgeons and nurses were selected as participants in this study due to clinical experience and ability to inform the issue; these professionals share the professional and moral responsibility for patients' treatment and care, their health and welfare during their stay in the unit. Other criteria for selection were long-lasting experience in surgical treatment and care, willingness to participate and gender distribution. Selection of participants was based on previous research that suggested that the way people reason about ethical problems and try to resolve them may vary according to professional background, the degree of professional experience, gender and the health care setting in which they work (Gilligan 1982, Norberg & Udén 1995, Sørliie et al. 2001b, 2004, 2005, Nordam et al. 2003, 2005a, 2005b, Henriksen & Hansen 2004).

Decisions related to sample size and selection of participants in qualitative research is not straightforward (Milne & Oberle 2005). The reason for selecting ten participants from each professional group was to gain as many rich and detailed narratives as possible. The decision also reflected the need to balance the time available to perform the interviews (the participants were at work when the interviews were conducted) and the aim of the study (Whitehead 2004). In order to ensure both indepth understanding and a variety of experiences, both men and women were invited to participate. This purpose was achieved in the sample of surgeons. When selecting the sample of nurses though, the head nurse informed the researcher that the male nurses employed in the unit had less experience than the female nurses. The decision was then made to include only the female nurses in the sample. In addition, the analyses of the interviews with surgeons had previously shown no differences in ethical reasoning between male and female surgeons (Papers I, II).

The medical head of the surgical clinic and the head nurse of the hospital were contacted and gave their permission to carry out the research. They provided the interviewer with a list of names of experienced surgeons and nurses that might be interested in participating. The interviewees were then approached personally and asked to participate. Of those asked, all but one agreed to participate. The interviews were conducted when the participants were on duty, at the time and place determined by the interviewees.

8.2.1 The sample of surgeons (MDs)

Five male and five female surgeons participated in the study. Their age ranged from 37 – 51 years (median 46.5). All were experienced and had been working in health care from 9 to 31 years (median = 21.5), and in surgery between 5 to 21 years (median= 13).

8.2.2 The sample of registered nurses (RNs)

Ten female registered nurses participated in the study. Their age ranged from 35 – 51 years (median 45). Nursing experience in health care ranged from 21 to 30 years (median = 19), and in surgical units from 6 to 24 years (median = 12.5).

Table II: Overview of the participants

Participants	Sex	Age	Experience in health care	Experience in surgical units
Surgeons	5 male 5 female	37 – 51years (median 46.5)	9 - 31 years (median = 21.5)	5 - 21 years (median = 13)
Nurses	10 female	35 - 51 years (median 45)	21 - 30 years (median = 19)	6 - 24 years (median = 12.5)

8.3 Ethical considerations

The Ethics Committee of the 5th Health Region of Norway (§ 41/1991, 31.10.91) approved the overall study of health care practitioners working in different health care settings (Sørli 2001b). The ethical considerations throughout the research process was guided by their policy and written formulae in addition to the ethical guidelines for nursing research in the Nordic countries (Northern Nurses' Federation 2003) and ethical principles for medical research involving human subjects, the Declaration of Helsinki (World Medical Association 2000).

A short information sheet was distributed to potential participants informing them about the aim and background of the study, and that the interviews would be tape recorded and written out verbatim. This information was repeated at the start of the interviews, and confidentiality about participation and anonymity in relation to publication were emphasized. Participants were also told that they could withdraw their consent any time during or after the interview. All interviewees gave their written, informed consent to participate in the study.

The ethical guidelines for nursing and medical research underline the duty of the researcher to protect the life, health, privacy, dignity and respect for all participants in a study, and the special attention required to safeguard vulnerable and disadvantaged persons from the potential risks of the study and the discomfort it may entail. Social and health care scientists have traditionally studied people with less power and status than themselves. Less is written about how to “study up” or conduct interviews with people of equal or more privileged status (Cassell 1998, Høye & Severinson 2007). The participants in this study neither belonged to any vulnerable or underprivileged group in society, nor can they be said to be in need of ‘special’ protection from the researcher. However, patients and relatives played an important role in stories of the ethically difficult situations that surgeons and nurses related. This did not cause any problem since all participants took care to preserve the anonymity and confidentiality of patients and relatives as well as their colleagues. No names were disclosed in the interviews, and participants occasionally omitted details from their stories, referring to being bound by professional secrecy.

8.4 Interviews

The data collection (Papers I- IV) consists of open-ended narrative interviews (Mishler 1986). The interviews were conducted in three parts. First, the researcher introduced herself and repeated the aims of the study. Next, the procedure for carrying out the interviews was presented, the role of the interviewer and what she expected of the participants. Participants were invited to ask questions about the study and the interview procedure. Personal information about the participants was obtained and written down before the interviews continued.

The surgeons and nurses were asked to tell about one or more ethically difficult situations that they had experienced in their work. What constituted an ethically difficult situation was not defined, allowing the interviewees to determine what they considered ethically difficult and to tell their stories in whichever way they wished. The aim of the interviews was to obtain as many rich narratives about their experience as possible without interrupting the interviewees’ narrative flow and reflection, and to understand the situations and the difficulties and choices they presented. No topic guide was developed to allow participants to tell the stories in their own way, and ensuring participant driven data (Milne & Oberle 2005). Follow-up questions were determined by the course of the conversation, for instance when the interviewer wanted the interviewees to elaborate on the circumstances described in the stories and their experiences or had difficulty understanding the narration. Questions referred to the interviewees’ thoughts, feelings, and actions, e.g. what did you do, how did you think or feel then? According to Mishler (1986:69):

We are more likely to find stories reported in studies using relatively unstructured interviews where respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their responses. Nonetheless respondents may also tell stories in response to direct, specific questions if they are not interrupted by interviewers trying to keep them to the “point”.

If the interviewees did not spontaneously reflect on the events they talked about, their reflections were sought. Notes were taken during the interviews to aid the interviewer's memory and in order to make it possible to understand the interview text in relation to its context, e.g. arrangements and interruptions. Nonverbal communications that seemed relevant were also noted, such as laughter, interruptions or long pauses. The transcribed text was compared with the notes and adjusted if necessary.

The interviews were concluded when participants spontaneously or after being asked by the interviewer, said that they could not remember anything more to tell. The interviewer then summed up and asked participants about their experience of the interview situations.

All interviews were conducted by the author (Papers I-IV). The interviews with surgeons (Papers I, II) lasted from 35 to 75 minutes (median = 55). The interviews with the nurses (Papers III, IV) lasted from 45 to 65 minutes (median = 60). The interviews were tape recorded and subsequently transcribed verbatim.

8.5 Interpretation

The method of interpretation used was inspired by Ricoeur's phenomenological hermeneutics (1976), and developed at the University of Tromsø (Norway) and Umeå University (Sweden), and has been used in several studies, for instance by Sørli et al. (2004, 2005, 2006) Nordam et al. (2003, 2005a, 2005b), Talseth et al. (2001), Normann et al. (1999), and Udén et al. (1995). This method of analysis is used to elucidate people's experiences (Ricoeur 1981, Lindseth & Norberg 2004)¹.

Each interview was regarded as a text and subjected to a phenomenological hermeneutical interpretation. The interpretation of the interview text proceeded through three phases, and constitute a dialectical movement between the whole and the parts of the text, between understanding and explanation, and between what the text is saying (its meaning or sense) and what it speaks about (its reference) (Ricoeur 1976). Explanation is directed towards analysis of the internal connections between the parts of the text while understanding is directed towards grasping the meanings disclosed by the text; i.e. understanding the whole of the text in relations to its parts.

8.5.1 Naïve reading

First, a *naïve reading* was made by all transcribed interviews to gain an initial graspe or a surface interpretation of the text as a whole, and what it was saying about the interviewees' experiences. The repeated reading was made as open-minded as possible, without attempting any deliberate analysis. The naïve reading guides or provides direction for further analysis of the text. "In the beginning, understanding is a guess", says Ricoeur (1976:74). It may later be rejected, or confirmed and expanded as understanding proceeds and deepens by the subsequent structural analysis (Lindseth & Norberg 2004). Gadamer (2003) describes interpretation of a text as a matter of asking questions to the text while remaining open for the text to disclose its meaning.

In this study, our first guess (preunderstanding) was based on conclusions of previous research, that the way surgeons and nurses talk about ethical problems and try to resolve them

¹ I was introduced to his method of research and interpretation by attending courses at Umeå University and Örebro University held by Anders Lindseth and Astrid Norberg who developed this method in cooperation with Giggi Udén and Venke Sørli, my methodical adviser and supervisor throughout this study.

may vary according to gender. However, neither careful repeated reading of the interviews as a whole nor of male and female surgeons separately revealed such differences. With one exception, none of the surgeons mentioned the issue of gender. The exception was a surgeon stating that being a woman was an asset when treating female patients from unfamiliar cultural backgrounds. The overall interpretation concerning gender similarities was shared by all three researchers. It was agreed not to analyse the interviews of the men and women separately, but together. Already in this phase of interpretation, understanding necessitated selection and interpretation of significant parts of the text to examine further in the structural analysis.

The naïve reading further revealed two perspectives in the narratives; the *first* consisted of many detailed narratives about difficult situations and ethical dilemmas experienced by surgeons and nurses while in practice; the *second* concerned the ways they were existentially challenged by these dilemmas and strived to live and deal with them. It was agreed upon that the two perspectives in the texts could be interpreted in accordance with the distinction between the action ethics and relational ethics perspectives, described by Lindseth (1992, 2002), and found in previous studies about being in ethically difficult situations (Söderberg & Norberg 1993, Sørli 2001b, Nordam et al. 2003). On the one hand surgeons and nurses focused on their relationships with patients and colleagues and their moral self in describing the ethical challenges in their work. On the other hand, they focused on the ethical dilemmas; the persons involved, and features of the situations and the hospital or social context they considered it important in trying to resolve them. The two perspectives in the interviews may also be interpreted in line with Ödman (2007) who distinguishes between interpretations about the external reality of an issue, searching out what actually happened in situations of ethical difficulties, and the texts as expressions of an existential situation, i.e. the meaning or significance of ethical dilemmas of practising.

There was agreement between the researchers to conduct two structural analyses according to the method described below and presented in two papers about the surgeons (Papers I and II). The same perspectives were found in the narratives of the nurses and the text was subjected to two structural analysis (Papers III and IV). The naïve readings of the texts was written down, discussed and agreed upon between the researchers before proceeding to conduct the structural analyses. One example of a naïve reading is given in Table III.

Table III: Naïve reading of the interview text with surgeons (Paper I)

The repeated reading of the individual interview texts revealed that the surgeons focused on their relationships with patients and colleagues when relating the ethical challenges in their work. Existential problems whether to start or withhold treatment, continue or withdraw treatment were the main ethical dilemmas in the narratives. Respecting patients' autonomy and acting according to patients' expectation of the outcome of surgery was also mentioned as ethically problematic.

In a relational ethical perspective surgeons narrated about becoming personally involved in their relationship with patients through an open and honest dialogue. Talking frankly with patients about life and death issues, the possible benefits, risks and unsuccessful outcomes of surgery was experienced both as a personal burden and a necessary part of practice that surgeons had to learn to live with in order to be and act in good and correct way.

Discussing ethical dilemmas in an including and accepting milieu, shared deliberation and decision making between trusted colleagues made ethically difficult situations easier to manage for surgeons, being alone and having individual responsibility for making decisions in acute and life-threatening situations. In formal and informal social arenas where the surgeons usually reach consensus, they also learn from sharing experiences with each other and giving and receiving personal and professional support.

Surgeons do not only experience personal responsibility for making the right decisions in ethically difficult situations, they also have to 'live with' the consequences of their decisions and actions. Living with ethical difficult situations means being confident and humble, and accepting the complexity, uncertainty and fallibility and when dealing with the existential realities of life.

8.5.2 Structural analysis

The second phase of this method of interpretation, the *structural analysis* includes various examinations of the parts of the text in order to understand and explain what it says and how it is said. It may be regarded as a stage between a naïve and comprehensive interpretation, or between a surface and a deep interpretation (Söderberg 1999). The task of structural analysis consists of performing a segmentation (splitting into segments) of the text into narrative meaning units and then establishing various levels of integration of the parts (Ricoeur 1976, 1981). According to Lindseth and Norberg (2004) structural analysis constitutes the methodical instance of interpretation that can be carried out in different ways. In this study, a thematic structural analysis was performed, i.e. the researchers identified and formulated ethical themes and subthemes that penetrated the interview text. A *theme* may be regarded as one thread of meaning that penetrates the text as a whole or parts of it.

The interviews were read several times, and were divided into meaningful parts and patterns, i.e. one sentence, parts of a sentence, or a whole paragraph with a related meaning. The meaning units were then compared, condensed, reflected upon and discussed among the authors, and then, themes and subthemes were identified (Lindseth & Norberg 2004). The process of reading, identifying and discussing themes was repeated until an interpretative

agreement was reached among the authors, and the themes considered satisfactory according to our interpretations of the texts. The structural analysis can be regarded as the objective part of the interpretation process as the meaning units are de-contextualized from the individual accounts and the text as a whole, i.e. parts and units are considered independent from their context in the interviews (Lindseth & Norberg 2004). In re-contextualizing, the units of meaning were grouped together and into preliminary themes according to our interpretation of the whole (naïve reading). At last, our interpretations were confirmed through repeated reading and comparisons between the themes, the meaning units and the text as a whole (naïve reading) and changed if necessary.

Two structural analyses of the texts were performed according to the method described above. The structural analysis of the texts varied according to the objects of research.

8.5.3 First structural analysis

The aim of the first structural analysis was to illuminate the ethical dilemmas experienced by surgeons (Paper II) and nurses (Paper III) in practice. This analysis can be characterized as more descriptive than the second structural analysis. According to Ricoeur (1976), texts have two kinds of references; references of the first order that describe reality while references of the second order re-describe or transcend reality. We may say that the first structural analysis did not transcend reality, but rather illuminated the manifest substance content of what was said by the interviewees. This is illustrated by the following meaning unit from the interviews with surgeons concerning the dilemma of withholding or withdrawing treatment.

If the patients are able to express that they do not want any more [treatment], then the decision is simple. But if they are unable to express themselves, it is very difficult to end an ongoing treatment.

Both surgeons and nurses related many and detailed narratives about the situations and ethical dilemmas they had experienced, the features of situations and the context, patients, relative and colleagues involved ways of trying to resolve them (Papers II and III).

8.5.4 Second structural analysis

The aim of the second structural analysis was to illuminate the meanings or significance surgeons and nurses assigned to their experiences of ethical dilemmas in their work, or the ways they were existentially challenged by these dilemmas and strived to live and deal with them while in practice. The meaning units searched for in this structural analysis was experiences that carried ethical bearings on practice with and for patients and colleagues.

The process of interpreting and selecting suitable meaning units is not straightforward, but requires careful and repeated reading, reflection and comparison with the overall interpretation (naïve reading). Meaning units that are too broad, for instance several paragraphs are likely to contain various meanings. On the other hand too narrow meaning units, for example only a word or a sentence, may result in fragmentation. In both cases there is the risk of missing meanings in the texts. Still, single words or expressions in the text may point to some significant meaning, and direct the interpretation in a new and different direction than anticipated. In this study for instance, the expression used by surgeons and nurses: “we have to live with ethical dilemmas” made the researchers halt, re-read the text and ask: What are they talking about? What does it mean and why is it important? The interpretation may also commence by reading the texts with particular questions in mind and

by permitting the text to point out or shed light on something important (Lindseth & Norberg 2004).

Ricoeur (1976) says an interpretive construction relies on clues contained within the text that point to their meaning. These clues permit an interpretation because they make sense or inhibit it because they do not fit. Because there are multiple possible meanings within a text it requires interpreters to make choices about competing interpretations and ways of framing and naming them. The themes and sub-themes or the interpreted meanings in this study was usually named by using words that was used by participants or words that contained ethical meaning. An example that shows the relationship between interview excerpts, sub-themes and themes is provided in Table III below. Other interpreters may have given different names to the themes or they may have found other or more sophisticated meanings in the text, which is the nature of textual plurality and multiplicity. For instance, the theme moral perception may have been named moral or ethical sensitivity, which has been used by other researchers (Nortvedt 1998, Weaver et al. 2008). We chose to name it moral perception in order to capture the cognitive and ethical understanding and judgment of the patients' condition in life is an inseparable part of perception as well as sensation. The nurses' moral reply to the suffering of patients was equally difficult to name. Empathy, sympathy and mercy are concepts used in the literature with a family resemblance to compassion. After several readings of the texts and ethical literature (Vetlesen 1994, Nussbaum 2001), the authors decided that compassion best captured the ethical meanings expressed in the text. However, our final analysis and understanding is not absolute or static, but reflects our interpretations at a certain point of time; interpretation is always incomplete, perspectival and changing (Gadamer 2003).

Table IV: Example of one structural analysis the interview text with nurses (Paper IV)

Excerpts from the interview texts with nurses	Sub-theme	Theme
<p>You do painful things with patients, for instance suctioning and bagging. You keep on working, and see that it is very uncomfortable for patients, even though you try as much as you can to reduce their agony.</p> <p>The anguish you see in the patients' eyes is not a pleasant feeling, but you have to do it because it is a part of the treatment. It is painful to the patient, and of course, it moves us.</p>	<p><i>Closeness to suffering</i></p> <p><i>Compassion</i></p>	<p><i>Moral perception</i></p>
<p>The suffering you witness over time... I think the boundary for raising the issue; to talk about and discuss it... we do that before the physicians, because we are not willing to endure watching the suffering; what patients are subjected to.</p> <p>If it [the treatment] is not in the patients' best interest, you feel that you ought to be their advocate and ask the physicians, for instance, is it right to initiate resuscitation if this patient should have cardiac arrest?</p>	<p><i>Commitment to act</i></p>	<p><i>Nursing responsibility</i></p>

8.5.5 Comprehensive understanding

In the third phase, a *comprehensive understanding* was developed, which is a comprehensive interpretation based on the authors' pre-understanding, the naïve reading, the structural analysis, and relevant literature. The themes are reflected upon in relation to the research question and the context of the study (Lindseth & Norberg 2004). The aim of this phase is to gain a deeper or different understanding of the interviews as a whole, i.e. the re-contextualized text (Ricoeur 1976). Methodologically, interpretation allows actualizations of the meanings of the text and for Ricoeur (1976) this occurs through appropriation; making one's own what was previously foreign. When the world of the texts is appropriated, the horizon of the interpretator is expanded, which opens up the possibility of seeing things differently and orienting oneself differently in the world. This link between experience, understanding and self-understanding grounds Ricoeur's interpretation theory in existence (Ricoeur 1976, Geanellos 2000).

In this study, the text was interpreted in relation to ethical theories, relevant literature in health care ethics and previous investigations into ethically difficult situations in health care in general and surgical practice in particular (Lindseth & Norberg 2004). The comprehensive understanding was presented under the heading 'Discussion' in the respective papers (Papers I-IV).

8.6 Methodological considerations

What constitutes quality of qualitative research and the means by which research quality is determined or enhanced has been a subject of debate and controversy in recent years (Emden & Sandelowski 1998, 1999, Witt & Ploeg 2006, Milne & Oberle 2005, Høye & Severinsson

2007). Matters of dispute have primarily to do with reliability and validity, by which standards that are a firm part of qualitative research should be determined, the appropriateness of criteria developed for evaluative purposes, and the value of such criteria per se. The array of criteria and terminology used make this discourse problematic and rather complicated (Emden & Sandelowski 1998, 1999, Milne & Oberle 2005, Høye & Severinsson 2007). In addition, it can be argued that there are no single set of philosophical and methodological presuppositions to underpin a qualitative paradigm, nor is there an uncontested collection of methods and or standard for reporting and evaluating qualitative research (Emden & Sandelowski 1998, Lomborg & Kirkevold 2003).

Still, the credibility or trustworthiness of the results of a study have to be warranted by conforming to some generally accepted scientific standards. These include methodological congruence, auditability or rigour in documenting and explanation of the research process, ethical rigour, and the credibility and fittingness of interpretation of data (Sandelowski 1986, Milne & Oberle 2005, Høye & Severinsson 2007). An attempt to establish methodological congruence has already been conducted in the description of the philosophical underpinnings of the study and the method. In the rest of this chapter, trustworthiness will be improved by describing the possible limitation of trustworthiness in this study, and how it was managed in conducting the interviews and in the process of interpretation of the interview texts, hence adding to the credibility of the findings.

8.6.1 Trustworthiness of interviews

The overall purpose of this study was to illuminate the lived experience of participants. Thus, trustworthiness of the study depends in part on the researcher and the interview situation and how the interviewer and interviewee engage and understand each other. Allowing participants to relate what they believe is important can be challenging, and requires the ability to remain silent and stay in the background while participants follow their own thoughts and work out their stories. Ensuring that participants' voices were heard and their stories told, and to diminish the role of the interviewer required a careful balance between being in the background and the foreground of conversations (Milne & Oberle 2005). Making brief notes as a reminder to return to a question of interest at a more appropriate time later or at the end of the interview, was somewhat helpful.

Trustworthiness was also promoted by trying to create a permissive and non- judging climate in the interview situation, allowing the interviewee to narrate as free and honestly as possible about their experiences (Lindseth & Norberg 2004). The aim was to capture as many features and dimensions of the participants' experience as possible, to ensure authenticity of data, and that data were not superficial (Milne & Oberle 2005). Still, the interviewees may not be willing or dare to narrate stories, they may not remember or are having difficulties finding the right words to express what they think and feel (Lindseth & Norberg 2004). In addition to probing, this requires careful attention to cues that suggests that an interviewee has more or something else to tell. The research interview is also a situation where participants enact their identities in talk, and want to present themselves as experienced, knowledgeable, and moral (Ricoeur 1992, Gullestad 1996, Jordens & Little 2004). Thus, they may withhold experiences that could prove otherwise. However, the results in this study showed that each participant was willing to share many detailed narratives of ethical difficulties in their work and their thoughts and feelings of ambiguity and vulnerability in these situations. The interviewer was unknown to the interviewees which may have been an advantage when focusing on personal experiences of situations of ethical difficulties.

Participants live, talk and act out their norms, values and ethical commitments in practising surgery and nursing. The ethics of surgery and nursing are often taken for granted as a common understanding about the right and good in this practice. Given the familiarity or taken for granted nature of ethics that are embedded in the life world in general and in practising surgery and nursing in particular, surgeons and nurses may have omitted some stories because they were considered unimportant.

The narratives are not real events or recordings of what actually occurred in the ethically difficult situations. They are rather purposive recounts of past events constituted as problematic, told to an inquirer who solicited their production through questioning. Ethical dilemmas as narrated belong to the realm of discourse rather than as lived (Kaufman 1997, Jordens & Little 2004). Still, the discourse is about their experience of being and acting in situations of ethical difficulty. There is a challenge to understand the relationship between practical performance and talking about and recounting the same performance (Paley 2005, Nergård 2006). In the interviews the surgeons and nurses related their experiences and reflected upon them, i.e. they searched out their actions, thoughts, feelings and reasons.

8.6.2 Trustworthiness of interpretations

The three phases that comprise the process of interpretation of the interview text was described in the previous chapter. What constitutes trustworthiness or quality of a phenomenological hermeneutical interpretation is not straightforward; neither which pathway to follow to ensure high quality interpretation, nor which standards or criteria is appropriate to evaluate trustworthiness. Several criteria have been suggested, especially concerning procedural rigour and auditability of the analysis of data (Maggs-Rapport 2001, Whitehead 2004, Witt & Ploeg 2006, Høye & Severinsson 2007). In order to arrive at as truthful and trustworthy an analysis of the text as possible the process of interpretation must be strict, according to Lindseth & Norberg (2004), which means consistency; that there is a logical line between the aim of the study, theories, methods and results, which leads to new insights. This is in line with a criterion that is widely used, i.e. that the researchers should describe in detail how the interpretations were produced, make visible what they did, and specify how successive transformations were accomplished (Riessmann 1993, Maggs-Rapport 2001, Whitehead 2004, Høye and Severinsson 2007). This is hopefully carried out in the papers and this thesis.

The principle of authenticity claims that the voices of participants demands attention, and that in order to remain true to the phenomenon under study it is required that the interpretation should embrace all collected data. Thus, if an interpretation leaves essential parts of the text unexplained, this interpretation cannot be accepted as a valid description of the reality to which the data are referring (Söderberg 1999, Milne & Oberle 2005). In this study, this was accomplished by conducting two structural analyses of the texts. In this way, the interpretations presented in papers I-IV embraces and are grounded in the majority of the collected data.

The researcher is inextricably linked to all aspects of a qualitative study, which has implications when considering the trustworthiness of the analyses performed and produced. To ensure authenticity and trustworthiness of interpretations it is important to remain true to the experiences of participants throughout the interpretation process, and to try to ensure that themes and subthemes are grounded in and developed from the data rather than being

superimposed on them by the researchers (Milne & Oberle 2005). Fittingness is a criterion of trustworthiness in qualitative research that is underlined by several authors (Sandelowski 1986, Høye & Severinsson 2007). It requires on-going and in-depth reflection and dialogue with the text, a critical examination of the emerging themes according to the text as a whole, and examining possible sources of bias that might influence the interpretation.

Trustworthiness was improved by the fact that several authors conducted the analysis and agreed the interpretation as likely to be the most useful understanding of the interview texts, and that the interpretations were grounded in the data. Several interpreters and authors with different backgrounds and pre-understanding provided grounds for a wider frame of reference for interpretation, and hopefully, greater fittingness and trustworthiness was achieved through this critical dialogue (Sørli 2001b). The use of direct quotations increased the authors' confidence in the interpretations and emergent themes, and allows readers of the papers to judge the credibility of the interpretations (Milne & Oberle 2005).

Still, the interpretations made are influenced by the researchers' background and preunderstanding which may have served to reify our conclusions and made us blind to other possible interpretations (Armour et al. 2009). In this study, the interpretation of the interviews with surgeons was performed by nurses. Physicians and especially surgeons may have interpreted the text differently or added other perspectives to our interpretations. Researchers who are not familiar in a field may overlook certain nuances and ambiguities of data because of lack of understanding of the work and the setting.

Respondent validation, or member checking, is recommended by several authors as a way to increase the trustworthiness of the interpretation of qualitative data, and involves going back to participants to review the findings and checking that they agree with the researchers' interpretation as being consistent with their experiences, generally when the analysis is completed (Riessmann 1993, Sandelowski 1993, Milne & Oberle 2005, Tuckett 2005). This was not done in the present study. In this phenomenological hermeneutical approach, validation is accomplished by means of the structural analysis as the objective part of the interpretation process (Lindseth & Norberg 2004). I may add that the interviews allowed the participants to tell their stories, and reflect upon their experiences, thoughts and feelings and reasons about the situations and experiences, and involved probing to clarify what participants said during the interviews. In this way member checking was conducted in creating the texts when participants were asked to elaborate on particular circumstances and the significance of their experiences, and to clarify the interviewer's understanding of the narration.

Several authors have argued that the benefit to be gained by member checking is questionable (Sandelowski 1993, Koch & Harrington 1998, Armour et al. 2009). In the structural analysis performed in this study, the interviews were taken apart and put together again in ways that subsumed individual statements and stories under different themes, making it difficult for the participant to identify his or her contribution. In addition, self-reflection and learning that occurs during and after the interview situation may have altered their perceptions. It is also argued that participants have their own agendas, and desire to present themselves in a positive light which has to be weighted as their feedback is considered (Sandelowski 1993, Armour et al. 2009). According to Sandelowski (1993) member checking can turn research into a negotiation or consensus-seeking endeavour, and that some voices may get privileged over others.

Still, the many and complex ethical dilemmas surgeons and nurses experience and their reflection on the meaning of living with them while practising may be difficult to recapture in relatively brief interviews. Follow up studies, inviting participants to reflect and elaborate on their previous stories may have strengthened this study, making it possible to gain a deeper understanding of the themes and their meanings and if and how they develop and change in time (Lindseth et al. 1994, Åström et al. 1995).

Ricoeur (1976) states that a text may have two kinds of references; references of the first order describe reality while references of the second order re-describe or transcend reality. This means that the interpretation is based on an interpretation of the meaning in the text which the interviewees might even be unaware of.

According to Ricoeur (1976) a text has multiple but not infinite meanings. Thus, the interpretations presented in papers I- IV and in this thesis should therefore be seen as one of several possible interpretations and as arguments put into ongoing discourses, in this case about the lived experience of ethically difficult situations in surgical units or in other health care fields. The stories told neither reveal all facts about ethically difficult situations in this context nor the good and correct actions to take for patients in these situations (Code 2002). Hopefully, the interpretation presented in this study may have brought us closer to the *lived truth* rather than correctness about the ethical life of practising surgeons and nurses (Lindseth & Norberg 2004).

Although the results cannot be generalized and transferred to other contexts, they can be regarded as credible if surgeons, physicians and nurses with similar experience can recognize the descriptions or interpretations as their own (Sandelowski 1993). The interpretation can at best produce a deeper or different understanding of ethically difficult situations. Still, if and when our outlook on situations and ethical phenomena changes, we may change our conduct towards others and ourselves. In this way the results can be transferred to similar situations (Ricoeur 1976, Sørli 2001b, Lindseth & Norberg 2004, Paley 2005).

9 Main findings in Papers I- IV

The overall aim of this thesis is to illuminate surgeons- and nurses' experiences of living with ethical dilemmas in surgical units. The main findings of this study of surgeons and nurses are presented chronologically, e.g. in order of publishing. The themes and subthemes of each paper are presented in Tables IV, V, VI and VII.

9.1 Surgeons

Paper I: The meanings surgeons assign to their experiences of ethical dilemmas in their work.

The narratives of surgeons concerned ethical challenges and decision making in situations when patients' life and quality of life was at stake. The lives of patients are fragile; undergoing surgery has risks as well as benefits, and the aftermath of surgery is often impossible to predict. The surgeons live and work with the inherent uncertainty of the course of the disease, patients' chances of survival, the risk of serious and fatal complications and the possibility of diminishing patients' quality of life after major surgery. Dialogue with patients and being involved in situations were important for surgeons in order to understand patients' experience of life, their present situation, and their hopes and expectations for the future. Open and honest disclosure of all aspects of patients' condition, treatment and care were important when talking to patients about their conditions, treatment options and life prospects. Collegial recognition and support were important for surgeons in order to live with the personal responsibility and the emotional burden of ethical decision-making under uncertainty. An open and honest dialogue between colleagues presupposes an atmosphere of acceptance, recognition and trust that allows surgeons to freely voice their opinion and be listened to without fear of personal repercussions. Talking frankly about personal limitations and errors was considered a prerequisite for improving surgical procedures and routines.

The surgeons were personally challenged by the existential realities of human life in practice. Ethically difficult situations were experienced as inherent in practising surgery, and surgeons have to live with them in ways that are confirmed both socially and personally. This meant acknowledging their personal and professional responsibility as well as their limitations; being uncertain, being fallible and humble. Living with the ethical challenges of surgery made surgeons both confident and vulnerable in their professional role.

Table V: Overview of the themes and subthemes that emerged from the structural analysis of the interviews with surgeons (Paper I)

Themes	Subthemes
Dialogue with patients	<i>Openness and honesty</i> <i>Involvement</i>
Social confirmation	<i>Professional recognition</i> <i>Open dialogue</i>
Self confirmation	<i>Responsibility</i> <i>Uncertainty</i> <i>Fallibility</i> <i>Confidence</i> <i>Humility</i>

Paper II: The ethical dilemmas experienced by surgeons in practice.

The main ethical dilemmas related by surgeons concerned finding the right level of treatment that benefitted patients most in situations of uncertainty. Performing high risk surgery on fragile patients with poor chances of a positive outcome gave rise to ethical dilemmas concerning starting or withholding treatment, continuing or withdrawing treatment and overtreatment. The surgeons usually initiated medical treatment in order to give the patients' a chance whenever there was the slightest possibility of survival or a successful outcome. Trying to fulfil patients' expectations and respecting patients' right to decide their own medical treatment was important to surgeons, and they found it difficult to go against patients' expectations when beyond what they considered reasonable.

The surgeons felt responsible for providing sufficient information about the disease, the risks and benefits of surgery; presenting treatment recommendations and assisting patients in making the 'right' decision about treatment and care. To determine the risks and benefits of surgery in individual cases was experienced as difficult. It was also difficult to determine the right amount of information to present to patients, when and how, and in the right way. The surgeons were concerned that patients gave their approval to surgery without sufficient understanding of the consequences.

Surgeons experienced ethical problems about whether they should act according to their own ethical convictions or according to the opinions of principal surgeons or physicians from other departments. How to respond to incompetent colleagues was experienced as an ethical dilemma by chief surgeons, who are responsible for both their colleagues and for preventing them from doing harm to patients. To determine whether a colleague is performing adequately or not was difficult, as the standards of surgical performance is high, practising surgery involves risks of errors and even the best surgeon is fallible.

The problem of making the right prioritization of limited resources was present in the surgeons' decision-making. Spending a lot of resources on intensive treatment of one patient affected other patients already in the unit and patients on waiting lists for operations. Social laws and regulations represented an ethical problem when they contradicted what surgeons considered to be in patients' or relatives' best interests. The surgeons expressed a global perspective on their work, realizing that they have more resources at their disposal than physicians in other parts of the world. At the same time they found it gratifying having sufficient resources to be of use to patients and society.

Table VI: Overview of the themes and subthemes that emerged from the structural analysis of the interviews with surgeons (Paper II)

Themes	Subthemes
Treatment	<i>Starting or withholding treatment</i> <i>Continuing or withdrawing treatment</i> <i>Overtreatment</i> <i>Respecting the patients</i> <i>Meeting patients' expectations</i>
Resolving differences in opinions	<i>Superior colleagues</i> <i>Colleagues from other departments</i> <i>Incompetent colleagues</i>
Society	<i>Local limited resources</i> <i>Laws and regulations</i> <i>Global limited resources</i>

9.2 Nurses

Paper III: The ethical dilemmas experienced by nurses while working in surgical units.

The ethical problems of nurses concerned patients' treatment and care, cooperation with surgeons, and institutional constraints on the quality of care. Trying to act in right and correct ways towards patients and relatives according to personal and professional standards pervaded the nurses' narratives.

The nurses expressed doubt about how to present information to patients, especially about health problems that might (or might not) emerge after discharge without impoverishing their hopes and quality of life. Not being allowed by the patient to tell their relatives the truth about their diagnoses and prognoses was experienced as difficult, as well as withholding the truth to patients while waiting for surgeons to deliver "bad news" to patients. By not being open and honest, the quality of patient care and the future life of relatives were jeopardized and patient's trust and their own moral integrity compromised.

Sometimes the nurses found it difficult to find the right balance between caring on the one hand and creating limits to patients' behaviour and their personal involvement on the other. In cases when nurses found it difficult to believe in patients' complaints and were exposed to aggressive and threatening conduct from patients, it was difficult for nurses to create the right balance between patients' responsibility for their own lives and nurses' caring responsibility.

The nurses related differences in opinions with surgeons concerning the issue of withholding and withdrawing treatment. While surgeons tended to pursue medical treatment, the nurses were hesitant, and voiced their opinion to withdraw before the surgeons. Nurses complained about surgeons' perspectives of the patients' situation being limited to surgical diagnostics and treatment, and that they were indecisive or did not respond adequately to all of patients' symptoms and complaints. Different opinions and lack of communication between surgeons, and the lack of available surgeons in charge affected the patients' treatment and care in negative ways.

The heavy workload in the unit, lack of time and staffing problems made it difficult for nurses to obtain an overview of the patients they were responsible for; in consequence, it was difficult to prioritize which patients most needed time and attention. The mix of patients in the unit required them to continually shift caring patterns, to hurry between emotionally complicated and trifling tasks, and patients with different diagnoses and a great variety of problems and needs.

Due to lack of beds, ward space and private rooms the patients were constantly moved around, and severely ill and dying patients were transferred to other departments instead of being cared for by familiar staff. Long waiting lists for operations resulted in early discharge of patients, and the nurses were concerned about how patients without an adequate social support system would manage at home. Nurses found it difficult to preserve patients' right to privacy and confidentiality and worried about patients withholding indispensable information, and that health problems were concealed and unattended to. The likelihood of being overheard by others caused the nurses to leave out sensitive questions and subjects in their conversations with patients.

According to nurses, patients and relatives were satisfied with the quality of treatment and care they received, while the nurses believed they could do more, and that they had to reduce their standards of care due to institutional constraints. Nurses experienced it as very unsatisfactory not being allowed to offer patients excellent care according to their personal and professional standards.

Table VII: Overview of the themes and subthemes that emerged from the structural analysis of the interviews with nurses (paper III).

Themes	Subthemes
Patients and relatives	<i>Openness and honesty</i> <i>Trust</i> <i>Limits</i>
Differences in opinions	<i>Withholding or withdrawing treatment</i> <i>Focus of interest</i>
Institutional constraints to quality of care	<i>Prioritization</i> <i>Privacy and confidentiality</i> <i>Standards of care</i>

Paper IV: The meanings nurses in surgical units assign to their experiences of ethical dilemmas in their work.

The main theme in the nurses' narratives was to perceive the suffering of patients and relatives, especially the suffering of patients with little hope of recovery. Being moved by suffering was experienced as a commitment to act for the benefit of patients; to ask surgeons for explanations and justifications of patients' medical treatment, to voice their opinions and ask for an ethical discussion of the case. Nurses felt respected when more experienced, and that their viewpoints were taken into account when surgeons made their decisions. When looking back on the time when they were less experienced, they lacked the courage of convictions and actions.

Their ethical voice or conscience reminded them of their responsibility for patients' well-being, treatment and quality of care, and they asked themselves whether their responsibility had been fulfilled, that nothing had been left undone, overlooked, or neglected, before they were able to "leave the patients behind" at the end of shift. When confirmed by patients, relatives, colleagues, and their conscience that the needs of patients and relatives had been attended to in an ethically and professionally satisfying manner, this increased the nurses' confidence and satisfaction in their work, as well as their strength to live with the burden of being in ethically difficult situations.

Having a satisfying working relationships with colleagues, and discussing and resolving ethical problems in a team of peers made nurses confident and secure, and increased their courage to remain at the bedside in situations of difficulty. Conveying their own needs, sharing thoughts and feelings with trusted peers was experienced as a relief, and receiving collegial support and words of esteem for their strength to linger in situations of difficulty, was important in the nurses' personal and professional lives.

It was essential for the nurses to have confirmation by patients, colleagues and their conscience that they were doing their utmost, although they could never be certain about the

correct and best thing to do in particular situations. They found ethical problems easier to live with as more experienced as they had acquired skills that made them more equipped to deal with them; and to anticipate what might happen. The recollection of former patients, especially successful cases of unexpected recovery, increased nurses' strength to carry on with their work in the unit and in the nursing profession.

Table VII: Overview of the themes and subthemes that emerged from the structural analysis of the interviews with nurses (paper VII).

Themes	Subthemes
Moral perception	<i>Closeness to suffering</i> <i>Compassion</i>
Nursing responsibility	<i>Commitment to act</i> <i>Conscience</i>
Identity	<i>Confirmation</i> <i>Confidence</i>

10 Interpretation and discussion

The main theme that pervaded the narratives of both surgeons and nurses concerned sustaining the life and wellbeing of patients, and acting accordingly. Being responsible for particular patients in life threatening and decisive circumstances made profound impressions on surgeons and nurses and challenged their way of practising; their outlook on life as well as well as their professional conduct. The ethical dilemmas embedded in attending to patients' treatment and care, and ways of resolving them constitute in the first part of the discussion.

Both surgeons and nurses emphasized the importance of social recognition and confirmation from colleagues when faced with ethical dilemmas. In the literature of medical and nursing ethics, colleagues seldom have an important or supporting role. The ethical obligations and dilemmas embedded in the professional – client relationships usually emphasize patient care as a collective responsibility (Park et al. 2007). The second part of this discussion addresses the importance of peer recognition and confirmation in the ethical life of surgeons and nurses, and that of self confirmation and integrity.

Both surgeons and nurses related the importance of “living with” ethical dilemmas in practice. The meaning of this expression seemed to involve finding ways of practising and managing these dilemmas according to ethical and professional standards, and to their professional and personal integrity. I take up this theme in the third and last part of the discussion. Together, I hope, these parts will contribute to a better understanding of the ethical reasoning of surgeons and nurses, derived from narratives of the ethical difficulties of practice in this context.

10.1 *Autonomy, respect and trust*

When surgeons and nurses narrated about the ethically difficult situations they experienced in the unit, the dilemmas they faced, and how they understood and tried to resolve them, they emphasized sustaining the life and welfare of patients. The ethical aim of surgeons and nurses was expressed as being professionally, ethically and personally responsible for patients (Papers II, III). The relationships with patients and relatives seemed to be framed or structured according to their understanding of patients as persons, their experience of illness and disease, and particular needs for treatment and care during hospitalization.

Knowing particular patients seemed to offer ethical guidance into the nature of ethical dilemmas faced in particular circumstances, and the way to manage or resolve them. At the same time, acknowledging ethical commitments made compelling personal claims upon surgeons and nurses which were difficult to ignore, and became sources of personal and professional discomfort as well as satisfaction. How to adequately respond or attend to the needs of patients was also shaped and bounded by the demands of other patients in the unit, anonymous patients on the waiting list for surgery, social laws and regulations, and economic and institutional conditions (Papers II, III).

Both surgeons (Paper I) and nurses (Paper III) emphasized the value of patients' right to decide their own treatment and care, which involved initiating a dialogue with patients, interchanging of different options, being open and frank, and trying to attain mutual understanding and agreement. It seemed that surgeons and nurses aimed at establishing relationships with patients based on the principle of autonomy, i.e. the recognition of patients as autonomous moral agents.

The autonomy of patients and the freedom of choice is a prominent principle in modern bioethics (McCullough et al. 1998, Beauchamp & Childress 2001). According to surgeons and nurses, autonomous patients seemed to be those who listened carefully to the information provided, deliberated about the pros and cons of different treatment options, and chose the most adequate and workable solution in his or her case, taking an active part in an open dialogue. Still, the dilemmas related in the narratives suggest that not all patients approximated to this ideal type. Surgeons and nurses experienced great variability in patients preferences for involvement in medical decision-making, and many and complex elements that seem contrary to this western cultural tradition (Gawande 2002, Gordon & Daugherty 2003, Wirtz et al. 2006, Groopman 2007).

Surgeons did however narrate about encountering such 'ideal' patients, which they experienced as a relief; i.e. patients that seemed to make treatment decisions consistent with their life goals, and gave answers to surgeons' doubts about the right or good thing to do (Papers I and II). Acting according to patients' capability for self determinations or the principle of patient autonomy may be regarded as respecting patients, acknowledging their authority to decide their own treatment and judge their own quality of life (Falkum & Førde 2000, Gulbrandsen et al. 2002, Sullivan 2003, Gallagher 2007). In the narratives of surgeons and nurses, the meaning of respect owed to patients did not only seem to be an obligation or absolute rule in a deontological sense, but was expressed as an ethical aim or demand linked to the dialogical structure of the relationship. By respecting patients' right to decide and acting according to patients' expectations, surgeons and nurses tried to establish a space for dialogue and mutual understanding by involving patients in the decision-making process.

In this context, there did not seem to be a conflict between caring for patients and respecting and enhancing their self-determination capabilities. Still, the issues had to be balanced in particular situations. Surgeons and nurses recognized that patients in need of surgery are often not in a medical condition and position to make good decisions; to reason through the risk and uncertainties involved without the distortion of fear, and often want surgeons and nurses to take burdensome decisions they do not want to make or do not feel able to make themselves.

Even when patients do want to make their own decisions, there are times when the compassionate thing to do is to press hard: to steer them to accept an operation or treatment that they fear, or forgo one that they'd pinned their hopes on (Gawande 2002:224).

The question of who ought to decide remains an ethical challenge; at the same time acknowledging the complexity and uncertainty of the situation and outcome of treatment, and realizing that both patients and professionals are fallible. Moreover, there is the reality of surgical and nursing practice that in spite of uncertainty, some kind of decision or other about which actions to take has to be made (Groopman 2007).

The surgeons and nurses were preoccupied with respecting patients' right to decide while at the same time recognizing patients' vulnerable situation in life. Studies have shown that patients are usually satisfied with the medical treatment and care they receive and consider the hospital as the safe and secure place to be when seriously ill. They voluntarily entrust the responsibility for their life into the hands of surgeons and nurses, and this is usually experienced as something good when seriously ill and dependent on others (Album 1996, Shattell 2002, Walker 2002, Sørli et al. 2006).

Both surgeons and nurses were concerned about how to respond to patients' vulnerability and limited capacity to exercise their autonomy. Patients were often too willing to leave decisions

about appropriate treatment and care to surgeons and nurses, and trusted them to act and decide in their best interest (Papers II, III). By placing their autonomy and significant parts of their life in the hands of others, patients showed and requested a basic trust, which is a phenomenon of ethical life, or a sovereign expression of life, according to Løgstrup (1997). However widespread mistrust occur under certain circumstances (Papers II, III), social life would not exist if trust was not more fundamental than mistrust. While trust needs no reason, there must be some reason, even if unwarranted, for mistrust (Løgstrup 1997).

The basic trust in the relationship was at stake when surgeons encountered patients and relatives with greater expectations than they could fulfil (Paper II). Both surgeons and nurses experienced the dilemma of trusting patients concerning the sincerity and severity of their complaints (Papers II, III). Surgeons and nurses became aware of the importance of the ethical phenomena of trust, openness and frankness when they were difficult to sustain in the relationships with patients (Papers II, III). The dilemmas related by surgeons and nurses revealed that the ethical phenomena of trust constitute a fragile balance that is easily shattered. Still, surgeons and nurses realized the importance of maintaining patients' trust through initiating an open dialogue, acting out of respect or regard for patients' right to self determination and taking their complaints seriously. Ignoring patients' complaints did not only threaten the trust in the relationship, but could cause serious harm and threaten patients' life, according to surgeons and nurses (Papers II, III).

10.2 Rescuing and sustaining life

What you should put first in all the practice of our art is to make the patient well, and if he can be made well in many ways choose the least troublesome (Hippocrates, § 3.383, in Elliot-Binns 1978).

Patients in surgical units are vulnerable, and their future prospects and flourishing are dependent on surgeons' and nurses' knowledge, skills and clinical experience to act on their behalf (or refrain from acting). According to the philosopher Jonas (1984), the existence of mankind and each human being is the first and foremost fundamental ethical commandment; that they live well is the second. Little (2002) argues that rescue is an ethical principle and a special feature of the surgical process and the relationships between surgeons and patients. Throughout the narratives, surgeons and nurses revealed commitment to rescuing and sustaining human life, which may seem as a paradox in view of the many complex ethical demands and dilemmas of human pain and suffering they faced. What constitutes a successful outcome in surgery as a struggle for life, and patients' experience of their quality of life afterwards, is uncertain and impossible to predict for surgeons and nurses as well as patients and relatives.

From patients' point of view surgeons and nurses have the power to rescue life, the means of palliations and to restore health (McCullough et al. 1998, Little 2002). Patients hope and expect to benefit from surgical treatment and care, and assume that surgeons and nurses will respond to their diseases and complaints by taking reasonable steps to ensure a favourable outcome. The ethical aim of 'rescuing' or sustaining human life by "giving the patients' a chance" is underlined by both surgeons (Paper II) and nurses (Paper III) and demonstrate that surgeons, nurses, patients and relatives usually share this ethical aim.

The maintenance of patients' hopes of survival was important to surgeons and nurses (Papers I, III) assuming that hope is needed to battle the disease and postpone death (Paper II). We may say that surgeons and nurses also tried to inspire and maintain hope in patients by their

efforts to pursue medical treatment by giving patients' a chance, and reluctance to withhold and withdraw treatment (Little & Sayers 2004, Elliott & Olver 2007). The surgeons described a seemingly dilemma when engaging in discursive practices that countered patients' unrealistic expectations and hopes for the outcome of surgery. In situations when giving the patients a chance is an option, surgeons and nurses often represent patients with a last and only hope for future life. In medical ethics there is a discussion about whether acknowledging uncertainty and doubt can undermine patients' sense of hope and confidence in the physician and a proposed therapy.

The expectation and hope of therapeutic success is the background understanding which legitimates surgical action, according to Bosk (1979). But to say that there is an expectation of success is to recognize the possibility of failure. The risk taking on patients' behalf implicit in surgical action in circumstances when patients' life is threatened is a double-edged sword. Decisive measures to sustain human life display patterns and behaviours emblematic of the "hero" in modern Western societies. Stories of patients that survived against all odds are preserved in memory as a source of work satisfaction for both surgeons (Paper I) and nurses (Paper IV).

"Giving the patient a chance" or "doing everything possible to rescue life" is both a medical-technical and an ethical issue, recognized by both surgeons (Paper II) and nurses (Paper III). Patients' hopes and expectations and the surgeons' and nurses' expertise are fundamental features in the professional- client relationship. Professionals agree to apply their expertise to clients' problems in a manner that is in their best interests, and takes care not to abuse their clients' helplessness. Despite the surgeons' and nurses' advanced knowledge, skills and modern technological remedies, they cannot and do not promise to rescue and cure (Papers I, II). The most that they can promise is to help to the best of their abilities and in a fashion consistent with the standards of their profession (Bosk 1979, Almond 2005, Jacobs 2005). Still, it is usually important and reassuring for patients and relatives to trust that everything that can be done to sustain patients' lives has been done (Bolmsjö et al. 2007).

Hope plays an important role in medicine for both patients and physicians. Still, the way physicians cling to the hope in practising is often underestimated. Magnusson (2006) links physicians' hope to their therapeutic optimism. Surgeons acting on small chances of a beneficial outcome seem to encompass their hopes as well as their altruistic aims and the rational argument that the patient might survive the surgical intervention. Katz (1999) suggests that patients prefer surgeons who appear confident and assured as such behaviour represents skill, knowledge and experience that counteract patients' fears of undergoing surgery. "They want someone who radiates optimism, because they want hope to replace their fear" (Katz 1999:X).

By taking actions when patients' lives are at stake in order to "give the patients a chance", surgeons and nurses express their ethical and professional commitments towards patients, by placing themselves in the clients' service and being ready to act as the patients' medical conditions and particular situation commands. When surgeons and nurses emphasize the importance of dialogue with patients, acting according to their expectations, hopes and vote of confidence, this may be understood as trying to establish a relationship that is ethical as well as professional. Surgeons' eagerness to initiate treatment and resistance to withhold and withdraw it may be interpreted as a response to the ethical appeal in patients' problems and complaints, and the way patients' hopes and expectations in life are threatened. Taking action

– trying do something good – in order “to give patients a chance” may be an expression of the basic ethical dedication to the service of patients on which the professional surgeon/ nurse-patient relationship is based and enacted (Hafferty 2006, Jones et al. 2006).

Surgeons and nurses are working close to the suffering, anxiety, and the sense of mortality and bodily frailty that patients live through, and the possibility of complications, continuing suffering, and the death of their patients (Lindseth et al. 1994, Söderberg et al. 1996, McCullough et al. 1998, Oberle & Hughes 2001, Gawande 2002, 2007, Chen 2008). Serious bodily diseases are times of extreme uncertainty and vulnerability. The patients, surgeons and nurses in this study remind us that human life is open-ended, and thus, of its inherent structure of possibility (Benner 1984, Elstad 1995). According to Heidegger (1996) for people or Dasein, something is always left unrealised. The undecided is not something new that is connected to Dasein, but is constitutive of Dasein itself as a basic human structure (Elstad & Torjuul 2009a).

This study shows that surgeons and nurses are related in the existential open-endedness in their patients' lives as hope and possibility in situations of uncertainty. Giving patients a chance may be interpreted into an ethics of possibility. The fragility and indeterminism of life processes in illness and disease necessitates continuous observation as basis for surgical and nursing action carefully sought in patients' trajectory. The ancient Greeks used the concept *kairos* to describe the right time or the proper occasion for an action. In this context it may be interpreted as the particular decisive moment that calls for right therapeutic actions (or refraining from actions). The decision whether to start, continue or withdraw treatment in acute and emergency situations may be regarded as moments of *kairos* that are necessarily marked by uncertainty and risk (Nicolaisen, 2003, Bolmsjö et al. 2007). In surgery and nursing, *kairos* it is moreover the particular time of the right actions that is sought within an uncertain and irregular course of disease and treatments (Elstad & Torjuul 2009a).

Surgeons' and nurses' relationships with patients and relatives are professional according to a social and ethical division of labour. As professionals, it is their duty to attend to the interest of their patients; they are expected to use their socially given powers and authority to fulfil their tasks to the utmost, which enables them to contribute to values deemed important by society (Jacobs 2005). In the day-to-day practice patients expect and do usually exact high ethical standards from surgeons and nurses who serve them in a professional capacity. Patients consult professionals because they are believed and expected to be experts (Almond 2005). That professionals sometimes fail to fulfil clients' expectations does not alter the fact that professional and ethical expertise is enacted in particular situations and practices, and that professional standards of conduct are demonstrated in the degree of dedication to patients in day-to-day activities. In a professional practice, special knowledge and competencies are necessary in order to act in ethically appropriate ways towards clients, and to understand and resolve the ethical difficulties imbedded in a particular form of practice.

According to the nurses, surgeons' preference for initiating medical treatment and reluctance to withdraw sometimes resulted in overtreatment, prolonging patients' suffering and reducing their quality of life (Paper III). Surgeons and nurses seemed to hold different opinion about the possibilities and limits of surgical (and medical) treatment in particular cases (Paper III). As nurses spend more time at the bedside, they are said to be working closer to patients' symptom experiences, their concerns and values, and to recognize them before the surgeons (Paper IV). In a study in intensive units, Hamric and Blackhall (2007:427) argue that nurses:

“may tend to focus on the suffering of the many, whereas MDs are more concerned with the survival of the few”. Others suggest that while physicians are faced with the burden of responsibility for making ethically difficult decisions, the nurses are closest to the consequences (Oberle & Hughes 2001, Melia 2004). This may be somewhat different in surgery than in other areas of medicine. The visibility of surgeons’ decisions and actions, the expectations that surround them, and the huge consequences of their actions raises the question of ethical and professional responsibility for surgeons in a very direct way; not only are their successes highly visible, but also their ‘failures’, when complications occur or a patient dies during or immediately after surgery (Bosk 1979, Katz 1999, Gawande 2002, Chen 2008).

The surgeons in this study acknowledged that prolonged suffering could be the result of their preference for initiating and continuing treatment and the reluctance to withdraw. At the same time, they seemed to be concerned that withholding and withdrawal of treatment could prematurely end a life that otherwise could have been saved (Paper II). Patients who unexpectedly improved in response to aggressive treatment were powerful examples used by surgeons (and nurses) as ethical reasons or justifications for initiating and continuing treatment in situations of uncertainty and doubt (Papers II, IV).

10.3 Ethics and confirmation

10.3.1 Social recognition and confirmation

The surgeons (Paper I) and nurses (Paper IV) emphasized the importance of having satisfying relationships with their colleagues both in the usual course of events in the unit, and especially when facing situations of ethical difficulty. Collegial recognition and support were important for surgeons in order to live with the personal responsibility and the emotional burden of ethical decision making (Paper I). Discussing and resolving ethical problems in the team made nurses confident and secure and increased their courage to endure staying in difficult situations. Sharing thoughts and feelings with their peers was experienced as a relief (Paper IV). Contrary to the surgeons (Paper II) the nurses did not mention any ethical problems in their relationships with colleagues, and no differences of opinions between the nurses emerged in their narratives (Paper III). While difficulties in cooperation with surgeons were apparent in the narratives of the nurses (Paper III), surgeons did not mention any ethical difficulties in their relationships with nurses (Paper II).

While nurses often initiated ethical discussions (Paper IV), surgeons were responsible for making the final decisions in each case, although the nurses voiced their opinions, tried to influence the outcomes and sometimes succeeded in making surgeons change their minds (Papers I-IV). We are reminded of the sociological reality that hospitals are places where power relations within and between persons and professions are created and recreated and experienced (Måseide 1983, 1987). The narratives of surgeons about decision making revealed issues of power relations as well as ethics – between less or more experienced surgeons, between surgeons and specialists from other departments (Paper II) – and between surgeons and nurses in the unit (Papers III, IV).

In ethically difficult cases, surgeons emphasized that all involved in the treatment and care of patients should be given the opportunity to express their opinion and their views taken into consideration before a final decision was made. Clinical experience should have a standing in these discussions, especially for the nurses (Papers II, IV). There is generally a tension between two competing systems of legitimation in the medical world: rule by clinical

experience and rule from scientific evidence. Surgeons are both craftsmen and holders of scientific knowledge and place authority on experience and the practical side of medical knowledge (Bosk 1979, Gawande 2002, 2007, Gillett 2004, Groopman 2007).

In situations of ethical difficulties, the salient ethical and medical features are frequently intertwined in complex ways (Paper II). Thus, comprehensive discussions and decisive investigations of the medical facts of patients' condition and prospects cannot be separated from ethical consideration embedded in particular instances. The moral life of surgeons and nurses involves practical reasoning and interpretation and deciding as best they can what constitutes good results for particular patients, and acting accordingly. Those concerns will directly engage with issues of human life or well-being rather than with questions of moral right and wrong (or obligation).

On such view, the most moral thinking doesn't involve thinking about morality, and the morally good person isn't guided by a theory or (agent-based) moral principles or even a sense of rightness as much as by a good heart that seeks to do good for and by people (Slote 2001:42).

On the other hand, ethical difficult situations are characterized by complexity, uncertainty and ambiguity that encourage reflection and dialogue between those involved. In these situations, surgeons and nurses realized that that they needed colleagues to talk to or ask for advice (Papers II, IV). When decisive medical decisions had to be taken with unforeseeable consequences and fused with conflicting values, thoughts and emotions it was experienced as a heavy burden (Papers I, IV). On these occasions surgeons and nurses often acted under double constraints, which mean the absence of a guilt free course amidst the necessity to choose, and no possibility of abstaining from making a choice not contaminated with guilt (Nussbaum 1986, Solbakk 2004, Magnusson 2006).

The importance of social recognition and confirmation when facing ethical difficulties should not be underestimated for several reasons. Increasingly, the day-to-day care of patients is enacted through the cooperative efforts of teams in varying forms (Park et al. 2007). This means that a large number of ethical dilemmas involve teams of professionals and not only individual practitioners. Thus, the collective responsibility and ethical obligation of the team as a whole in discussing and resolving these dilemmas seems important. By narrating their lived experience, surgeons and nurses give meaning to their experiences, and together they try to reach a shared understanding of the realities of the situations, and to reach consensus about what to do that is sufficient for their practical purposes (Album 1996, Melia 2004). They understand themselves as moral agents through the stories they tell and live, as well as through those told about them and by interpreting them (Walker 1998, Ricoeur 1992, Gullestad 1996, Jordens & Little 2004).

What constitutes the ethics of treatment and care in this context is created, recreated and communicated in the social relationships in the unit (Gullestad 1996, Doane 2002). The ethics of surgery and nursing are embedded in practice, and are often taken for granted as a common understanding about the right and good way of acting according to the welfare of particular patients and the standards of the profession. According to MacIntyre (2002) the "standards of excellence" in a practice are rules of comparisons applied to accomplishments in relations to ideals of perfection shared by a given community of practitioners, in relation to ideals by the masters and virtuosi of the practice considered. The ethical considerations embedded in the standards of excellence are learned by participating in a practice and through interactions with experienced and trusted colleagues. As ethical difficulties in surgical units are experienced on

a daily or weekly basis, moral discussions are conducted on an ongoing basis. Though ethical dilemmas and cases are unique with no set answers and have to be handled case by case, situations share common or typical features that can be learned through clinical experience and competence (Delmar 1999, 2006, Martinsen 1996). Such typical features are not only about clinical aspects of being ill and undergoing surgery, but also about salient ethical and existential life-phenomena concerning basic conditions of human life.

The surgeons and nurses related that they found ethical challenges and difficulties easier to live with as experienced as they had acquired skills to handle these situations both personally and professionally (Papers I, IV). The possibility of learning through exchanging and sharing experience with colleagues may be one reason why working in the hospital and in a team was experienced as satisfying by both surgeons and nurses (Papers I, IV).

We may say that dialogue and professional recognitions between colleagues served to create and confirm participants' identities as ethically responsible surgeons and nurses by giving and receiving social confirmation for being good and acting correctly (Papers II, IV). Discussing particular cases, weighting carefully the relevant values, facts, interests and differences of opinion at stake, and reaching consensus may be regarded as a way of addressing and sharing responsibility for which actions to take and for the intelligibility and acceptability of the chosen solutions. Their identities as morally responsible surgeons or nurses were continually created and recreated inside professional relationships between supportive peers who provided opportunities for recognition, self-disclosure, inclusion and dignity despite of shortcomings. Being responsible seemed to be a matter of being confirmed in having a standing in the professional community of eligible participants as being worthy and capable to undertake professional responsibility and answer for their judgments and conduct (Bosk 1979, Gullestad 1996, Walker 1998, Doane 2002).

The way surgeons and nurses were talking about their colleagues revealed bonds of affiliation and interdependence. It is reasonable to assume that sharing common work experiences created and recreated a kind of 'we-identity' between peers. Sharing and establishing common ethical aims and acknowledging that mutual cooperation and support is necessary to provide excellent treatment and care, seemed to strengthen a sense of social commitment and interdependency between members of the respective professions. Appreciating that they were not alone in these situations, and that their uncertainty, thoughts and feelings were shared by others seemed to have a reassuring and comforting effect on surgeons and nurses (Bauman 2001, Little et al. 2003, Eriksen 2004). Some experiences related by surgeons and nurses were extremely difficult and made a profound impression on their personal and professional lives (Papers I, IV). According to Eriksen (2004) the feelings of community and "we-identity" are strengthened when there is most at stake. Kaldjian et al. (2008) found that discussing medical errors with colleagues strengthened physicians' relationships with those colleagues. The knowledge that comes from extreme experiences may be hard to share with those who have not had similar experiences, according to Little et al. (2003:76):

Similarly, emotions such as abjection, fear, depression or elation at the realization of survival, are experienced with an immediacy and intensity that cannot be freely communicated to others who have not had similar experiences.

While Little et al. (2003) for the most part writes about the experiences of cancer patients, the idea that it may be easier to talk to others with similar experiences seems relevant for professionals too, and elucidates why surgeons and nurses prefer talking to trusted peers about difficulties in their work.

According to Baumann (2001) some words have a 'feel' attached to their meaning, and the word community we feel is always good, a 'warm' place to be due to the connotations the word conveys, all of them have "promising pleasures, and more often than not the kinds of pleasures we would like to experience but seem to miss" (Bauman 2001:1). While not being as pessimistic as Bauman (2001) to the possibility of establishing satisfying communities, we may still ask if there are side effects to the privilege of participating in the collegial communities between surgeons and nurses.

Both surgeons and nurses emphasized that courage was needed to voice their personal, professional, and moral opinions (Papers I, IV) and to convey personal needs and feelings of distress in the community (Paper IV). This reminds us of the intimate connection and even tension that exists between trust and vulnerability in our relationships in general and between colleagues in particular. It is when we place trust in others that we expose, or at least acknowledge our vulnerability in hope that those in whom we place our trust can be counted on not to exploit our vulnerability (Løgstrup 1997, Sellman 2007).

According to Bauman (2001) the price to be paid for the privilege of 'being in a community' and gaining safety and security is giving up one's personal freedom and autonomy, or the right to self-assertion. He claims that shared understanding and consensus is an agreement reached by essentially differently minded people, and a product of negotiation and compromises. The community-style, matter of fact understanding does not need to be sought, laboriously created or fought for because that understanding 'is there', ready made to use, so that we understand each other without words and never need to ask 'what do you mean?' The kind of understanding on which community rests proceeds all agreements and disagreements and are the starting point of all togetherness. "It is a reciprocal, binding sentiment" according to Bauman (2001:10).

The relationships between colleagues are in many ways different from surgeons' and nurses' relationships with patients (Papers I, IV). On the one hand, ethical demands and dilemmas concern fundamental ethical and existential phenomena of human life such as trust, openness of speech, and showing respect and consideration to other people (Løgstrup 1997, Delmar 2006). On the other hand, there are important differences. When surgeons and nurses appealed to trusted peers to share their uncertainties and doubts or taxing emotions, to talk about their experiences, to discuss and resolve ethical dilemmas, they could do this without putting important values in the relationship with patients at risk.

When professionals control or manage their display of emotions in the presence of patients and relatives, this may be understood as a defence against the anxiety of being overwhelmed by emotions (Benner et al. 1999, Beauchamp and Childress 2001, Puntillo et al. 2001, Georges et al. 2002, Allan & Barber 2005). While this may be the case, withholding or suppressing emotional responses may also be regarded as the ethically good and correct thing to do, in order to focus on patients' experiences, needs and demands in the particular situations at hand (Graber & Mitcham 2004). Thus, the expressing and managing of emotions, for instance soothing tempers, boosting confidence or comforting are performed with trusted colleagues in the absence of patients. Gropman describes the issue as a paradox. Professionals have to suppress their emotion and detach themselves from anguish that could impede their work. If they erase their emotions or become immune to their impacts, however, they fail to care for patients. "... feelings prevent us from being blind to our patient's soul but risks blinding us to what is wrong with him" (Gropman 2007:54).

In the informal and formal encounters between colleagues, both surgeons and nurses seemed to express worries and matters of concern, warn about possible errors, acknowledge errors and set standards for surgical performance and nursing care. In these arenas where surgeons and nurses reign and patients and families are absent, they also learn what it means to be an ethical surgeon or a nurse.

In this study, both surgeons and nurses related that the relationship with colleagues enabled them to provide good treatment and care to patients (Papers I, IV). To sum up, the relationships between trusted colleagues are based on ongoing mutual recognition and interdependency while the professional client relationships are time regulated and highly asymmetrical and framed according to patients' medical condition and expectations as well as their degree of dependency (Lawler 1991). Still, the results of this study showed differences in opinions and tensions in the relationship between surgeons and nurses. On the one hand, the nurses related that their viewpoints were taken into account when ethically difficult decisions had to be taken and trusted surgeons' decisions to be reasonable and realistic (Papers IV). On the other hand, the cooperation with surgeons in many cases was considered less than satisfying. There were differences in opinions with and between surgeons about treatment, and the absence of surgeons in the unit and limited interests in holistic treatment and care resulted in patients being offered less than optimal treatment and care (Papers III). For the most part surgeons and nurses related common ethical dilemmas, and above all, shared measures for improving and sustaining the life and welfare of patients in the unit.

10.3.2 Self confirmation and conscience

And it is good to look after the sick, to make them well, to care for the healthy, to keep them well, but also to care for one's own self so as to do what is right. (Hippocrates, § 1.319, in Elliot-Binns 1978).

Equally important as receiving social confirmation from patients, relatives and colleagues, surgeons and nurses needed to be confirmed by their individual ethical voice – his or her conscience – about the ethically good and correct actions to take in particular situations. Surgeons related that having the courage of your convictions and a set of personal ethical values was important in order to do a proper and conscientious job. Their standards of conduct and voice of conscience seemed to guide them when deciding which actions were morally right or wrong, to make controversial decisions, and to voice personal moral opinions to colleagues and patients (Paper II).

The nurses narrated about trying to sustain personal standards of care in spite of institutional constraints. These standards and voice of conscience reminded them of their responsibility for patients' well-being, treatment and quality of care, and they had to reach consensus with themselves; being confirmed that they had fulfilled their responsibility before they could finish the shift (Paper IV). Both surgeons and nurses seemed to refer to their conscience as some kind of 'moral compass' (Dahlquist et al. 2007) that guided them regarding the needs of patients, the demands and dilemmas of situations and whether certain actions ought to be carried out or not.

Dahlquist et al. (2007) investigated perceptions of conscience among health care providers and found that conscience is influenced by culture, and can be perceived as an authority, an asset, a burden, a warning signal, and as a demand for sensitivity. In this study conscience may be interpreted as an authority when surgeons expressed their convictions against active euthanasia (Paper I) and ritual circumcision of baby boys (Paper II). The nurses seemed to

adhere to the authority of conscience when feeling compelled to voice their ethical concerns to surgeons when witnessing patients' suffering (Paper IV). For the most part, the 'inner voice' of surgeons and nurses was expressed as a dialogue of deliberating about what to do, expressing uncertainty and ambiguity about the rightness of particular actions, more than consulting an internal (or external) 'authority' that could give ethically good and correct answers to their uncertainty and doubts.

By describing conscience as an 'inner voice' the dialogical and negotiating structure of conscience is underlined, i.e. the questioning, doubting and deliberating about ways of being and acting and resolving ethical demands and dilemmas faced in particular situations. Surgeons and nurses emphasized the uncertainty, ambiguity and complexity of their work in general, and in ethically difficult situations in particular. By opening up for the different voices "within" and enter into a dialogue, one can either reach consensus with oneself or conflict with oneself (Gullestad 1996, Doane 2002). Both surgeons (Paper I) and nurses (Paper IV) emphasized that they could never be certain, that no right answer could be found, that they were fallible and that the possibility of doing harm to patients was always present in practice regardless of their intentions to do good.

Jensen and Lidell (2009) found that nurses considered conscience as an asset that guided them in their effort to provide high quality care in hospitals; both as a driving force, a restricting factor and a source of sensitivity. In this study, the voice of conscience was closely connected to surgeons' and nurses' understanding of their moral responsibilities for patients and how to fulfil these responsibilities according to their ethical and professional standards (Papers I-IV). The content and meaning of responsibilities for particular patients - what ought to be done or not - had to be continually examined, negotiated and attended to in flexible ways, as patients' conditions and needs change rapidly during the pre-, per-, and postoperative stages of surgical treatment and care. In addition, surgeons and nurses perform a lot of work with patients on their own, and have to rely on their own approaches and personal abilities, so parts of their work tends to be self validating and self confirming. This part of their work may be difficult to examine critically since surgeons and nurses have to believe in what they are doing in order to go on practising. These factors encourage personal rather than collective responsibility (McIntyre & Popper 1983).

On the one hand, the conscience of surgeons and nurses may be regarded as ambiguous and uncertain as the ethical demands and dilemmas themselves. Our conscience might offer 'wrong' answers to the questions or negotiations of the ethically good and appropriate thing to do in particular situations. A psychologist, for instance, speaks of cognitive dissonance whenever conduct and principles conflict in a way that threatens our integrity, resulting in inner tension or dissonance, which we try to reduce by changing our beliefs rather than our conduct. The reason for this is that we find out our own beliefs by examining our behaviour, and not the other way round, according to this psychological theory (Fisscher et al. 2003, Treviño et al. 2006). Thus, our conscience needs to be examined against some kind of external and commonly agreed upon reference points. In this study, intra- and multidisciplinary discussions on ethically difficult cases seemed to be equally important as conscience when surgeons and nurses tried to resolve the uncertainty about which actions to pursue. Studies have shown that social pressure affects conscience. At the same time, conscience, integrity or moral courage is required to resist external group pressure to act contrary to one's own beliefs (Fisscher et al. 2003, Treviño et al. 2006).

It is, however, not in every person's power to choose or to act as his or her conscience directs (Gullestad 1996). The surgeons in this study seemed to have a relatively wide range of freedom to act in ways that was confirmed from their patients, colleagues, society and by their inner selves (Papers I, II). On the other hand, the nurses degree of freedom to carry out their work according to their ethical standards seemed to be limited by surgeons' decisions and institutional constraints, on occasion in violation of their individual and professional integrity (Papers III, IV). In a study of female registered nurses in paediatric care, Sørli et al. (2003a) found that nurses were socially confirmed as good nurses when they acted in accordance with the norms of the nursing group, the physicians' decisions and the established routines and culture of the clinic. However, the nurses lacked the confirmation that was given by their own conscience telling them that their actions were good (Sørli et al. 2003a). In a recent Norwegian study by Førde and Aasland (2008) more than half of the physicians expressed moral distress by sometimes having to act against their own conscience.

It is necessary to be a member of a professional community in order to learn the standards of excellence in a profession (Bosk 1979, MacIntyre 2002) and to develop a capacity of assessing ethically difficult situations. The hierarchical structure within the hospital seemed to create problems for nurses, less experienced and subordinate surgeons in acting in accordance with or against their conscience (Papers II, III). All professionals derive "authority" from their skills and knowledge. There seems to be a hierarchy of "authority" between and within professions, based on further acquisitions of knowledge and special skills.

10.4 Living with ethical dilemmas

The surgeons and nurses related that ethically difficult situations were something they had learned to "live with" in order to practice their profession (Papers I, IV). The meaning of "living with" ethical challenges seemed to be connected to an understanding of ethics as an inherent and inescapable feature of their everyday activities and professional life. This expression revealed surgeons' and nurses' experience of ethical dilemmas, and the knowledge and understanding acquired by facing and resolving them throughout the years of (dearly purchased) clinical experience.

Experience informed the ways in which surgeons and nurses practised. Their clinical and ethical reasoning and acting has developed as they have learned from experience and gradually acquired the habits, dispositions, discernment, skills, and emotional responses of excellent practice. Individual professional and ethical responsibility is learned within a practice tradition through education, skill acquisition, and socialization. Individual practitioners are lodged in local practice communities and specific traditions of practice which either offer opportunities for ethical discussions, shared learning and self-improvement or limit individual development and ethical performance (Benner et al. 1996, 1999).

In this study, living with ethically difficult situations was experienced as both frightening and satisfying (Papers I, IV), and seemed to entail some degree of acceptance of the uncertainty, ambiguity and fragility of human life in general and their professional life in particular. The huge amount of ethical demands and dilemmas present and the immense burden of being responsible in situations of uncertainty revealed that the confidence and equanimity that surgeons and nurses expressed were fragile and easily shattered. Living with ethical difficulties as a way of practising seemed to imply living with painful feelings and a troubled conscience (Papers II, IV).

The experience of ethics expressed by surgeons and nurses seemed for the most part to be experience based, particularistic and situational. They did not explicitly refer to any ethical principles, guidelines or theories when relating the kinds of ethical difficulties they faced and their ways of managing and resolving them. Their comprehension of surgical and nursing ethics seemed to be a result of participating in the practical life in the unit. Clinical decision making in practising is ethical because clinical judgments require understanding what are considered good outcomes for particular patients. What ought to be done has for these particular patients, with this disease, in this particular condition, has to be continually examined and determined in each case, thinking forwards and backwards. The patient for whom they are responsible is a living being that is changing continually, and more so when seriously ill, severely damaged or after extensive operations (Elstad & Torjuul 2009a).

Ethical challenges and problems had to be attended to and resolved in some way or other, as they were recurrent and unavoidable in practice. Although these situations were experienced as difficult, they seemed to encourage ongoing ethical reflections, dialogue with patients and relatives, collegial discussions, and negotiations and dialogue within and between professionals. Living with the abundance of ethical difficulties and their continuous presence in the unit included the possibility of learning and acquiring a deeper insight into the ethics of practice and the human condition (Papers I-IV).

Situations of ethical difficulties granted surgeons and nurses an opportunity to learn something from the experience. The kind of knowledge acquired seemed to include a growing insight into the uncertainty, vulnerability, fallibility, and limits of practising and into ways to live and work according to these insights (Papers I, IV). Moreover, the narratives suggest that an approach to ethics as lived and experienced dispels any impression that ethics could be a simple matter and easily understood. A desire for further inquiry and learning was instilled (Solbakk 2004). Through extensive clinical experience the surgeons and nurses seemed to have developed a deeper understanding into the meaning of being human and the human condition; that life is not simply a riddle to be solved, and that there is not and cannot be any correct answers and straightforward solution to ethical demands and dilemmas. Gadamer (2003:357) describes real experience as becoming aware of one's human finitude or one's own historicity:

The truly experienced person is the one who has taken this to heart, who knows that he is master neither of time nor the future. The experienced man knows that all foresight is limited and all plans uncertain.

For Gadamer (2003), experience is not just the passage of time, but a process essentially negative, acquired in situations that neither conform to our expectations nor confirm them. However, negative experience may have productive meaning in informing us about things we hitherto have not dealt with correctly and hence make a correction, and acquire a more comprehensive knowledge. Gadamer (2003) underlines the dialectical element in experience, and refers to Hegel who conceives experience as 'scepticism in action'. Living with ethical difficulties may be interpreted in line with Gadamer's (2003) description of experience as a process by which the experienced person acquires a new openness and orientation to new experiences.

The consummation of his experience, the perfection that we call “being experienced”, does not consist in the fact that someone already knows better than anyone else. Rather, the experienced person proves to be, on the contrary, someone who is radically undogmatic; who, because of the many experiences he has had and the knowledge he has drawn from them, is particularly well equipped to have new experiences and to learn from them (Gadamer 2003:355).

The process of acquiring deeper insights into ethical difficulties and living with them on a regular basis seemed to imply experiencing unpleasant emotions like for instance loneliness, fear, guilt, regret, bereavement and desolation (Papers II, IV). Living with the possibility of making mistakes with detrimental consequences for patients was a central theme by both surgeons and nurses, and seemed to be connected to their understanding of ethical and professional responsibility (Papers II, IV). This result has also been reported in studies of physicians in other specialities (Sørliet et al. 2000, 2001a, Nordam et al. 2003, Henriksen & Hansen 2004, Paulsen & Brattebø 2006). Though most clinicians are aware of the uncertainty and the limitations of practice, their responsibility is to avoid doing harm and reduce the likelihood of medical errors (Hunter 1991, Rosenthal et al. 1999, Førde 2000). The surgeons talked at length about deliberating over alternative and ethically problematic courses of actions to take in complex, uncertain and unpredictable situations (Papers I, II). It seemed that the ethical dilemmas they faced had to be resolved in ways they could live with, i.e. confirmed by their professional and personal convictions, values and conscience. The decisions made and actions taken in particular circumstances seemed to concern their current and future professional and personal life.

According to Beauchamp and Childress (2001:35-36), “moral integrity means soundness, reliability, whole, and integration of moral character”. Surgeons and nurses related that they sometimes had to refuse to comply with the requests of patients and relatives, decisions made by colleagues or social laws and regulations on grounds that to do so would compromise or sacrifice core beliefs or fundamental moral commitments. As external factors and stakeholders increasingly try to influence surgeons’ and nurses’ decisions concerning patients’ treatment and care (McCullough et al. 1998, Källemark et al. 2004, Peter et al. 2004, Nordam et al. 2005b), it has become difficult for both surgeons and nurses to provide treatment and care to patients in manners consistent with their professional and ethical convictions. Especially, the disproportion between the work surgeons and nurses are responsible for doing for patients by society and the resources allocated to carry out their work, threaten integrity, which may ultimately lead to moral distress, health problems and burnout, and the intention of leaving the profession (Sundin-Huard & Fahy 1999, Källemark et al. 2004, Corley et al. 2005, Nordam et al. 2005b, Førde & Aasland 2008, McCarthy & Deady 2008).

Living with ethical dilemmas presupposes institutional structures and working conditions that support surgeons and nurses in trying to achieve what MacIntyre (2002) has described as goods internal to a practice. According to Aristotle (1980), practical wisdom and what counts as ethically appropriate actions in particular situations are learned by doing what those who are already recognized as ethical experts in a field do and approve. Webster and Bayliss (2000) has suggested that compromised integrity that results from being unable to act in appropriate ways due to perceived constraints in the workplace may ultimately alter the self and lead individuals to trivialize or deny any wrongdoing, compartmentalizing the self so that compromising in the workplace is experienced as not impacting on one’s true self. On the other hand, experiencing moral dilemmas or distress may lead to actions to manage or resolve

the negative impact of moral dilemmas and conflicts (Lützén et al. 2003, Peter et al. 2004, Cronquist & Nyström 2007, McCarthy & Deady 2008, Schluter et al. 2008).

As the results of this study suggest, experiencing ethical dilemmas and conflicts may provide an opportunity for transformation and growth when they make individuals or practice communities more sensitive to and reflective about ethical issues including personal and institutional impediments to good practice, and ways to resolve ethical dilemmas. Studies have shown that living with ethical dilemmas in ways that promote ethical learning and growth presuppose support structures at the organizational level (Kälvemark et al. 2004, McCarthy & Deady 2008, Schluter et al. 2008). In this study, the nurses mentioned clinical supervision groups, ethical counselling in particular cases, and regular meetings in the units to address and discuss ethics as somewhat helpful in order to live with ethical dilemmas. Nevertheless, it was the communication and collaboration with patients and trusted colleagues that both surgeons and nurses underlined as crucial in resolving especially difficult ethical dilemmas, and giving and receiving the support they needed, and living with ethical dilemmas on a regular basis. Still, they missed sufficient time to talk to patients, relatives and colleagues due to the persistent heavy workload in the unit (Papers II, III).

In this study, it seemed that participants' clinical experience was of some assistance in coming to terms with and living with the contingencies of human life, and the vulnerability and limitations in carrying out the work in the unit. On the one hand their work originates from the aim of mastering human contingency by *technē*, which in this case means a deliberate application to change some part of the world, with successful management of patients' diseases and needs, and with prediction and control concerning future contingencies, exerting some control over *tuchē* (luck, or events over which human agents lack control) (Nussbaum 1986). On the other hand, surgeons and nurses have to accept and contain human risk and fragility and their own limitations and fallibility when trying to be good and act well.

There seemed to be an irresolvable tension in the narratives between trying to master human contingencies and acceptance of the fundamental ambiguity and uncertainty in practice. The ethical difficulties narrated by surgeons and nurses revealed that the acceptance of human contingency, ambiguity and uncertainty did not come easy and without emotional and psychological costs. Surgeons and nurses have to assimilate and manage the insight that comes from dealing with severe illness and death. As this study shows, they are highly aware of their own vulnerability and finitude. This insight seemed to come clearly to mind when caring for young patients and patients or relatives in similar life circumstances as their own (Papers I, II). It seems that surgeons and nurses had learned to live with the seeming paradox of accepting fallibility without decreasing their commitment to excellence in practice. According to Kaldjian et al. (2008:722), "Perhaps the answer to the paradox of fallibility and excellence is to be found in Osler's insight that fallibility can, if honestly engaged, promote excellence".

Surgeons and nurses expressed confidence and satisfaction when being able to do good; finding a way, and succeeding in their attempt to restore health or save life (Papers I, IV). The clinical experience of deliberating and choosing and finding workable solutions in clinical situations made both surgeons and nurses confident (Papers I - IV). It seemed that clinical experiences were sources of learning and moral development, a process that is also a result of increased self-knowledge and a deeper understanding into the meaning of life (Nussbaum 2001). It may also mean to acquire a deeper and more intuitive understanding of patients'

experiences, how to attend to their needs in appropriate ways and limit themselves in particular situations - insights crucial to professional as well as ethical development.

However, moral growth seems to presuppose and produce some degree of personal willingness and courage to become involved and engaged in patients and participate in situations of ethical difficulty. Remaining open to various features of a situation, trying to see and feel it in all its conflicting many-sidedness seemed to enhance further deliberative efforts by surgeons and nurses. The experience of ethical dilemmas may become times of ethical growth and development when they make surgeons and nurses pause, look closer into the case and rethink what they are doing (Papers I, IV).

As clinical experiences with patients in different life circumstances increase we may assume that surgeons and nurses bring their ethical values and commitments under scrutiny. The values and commitments by which they practice may be reaffirmed, reinterpreted, refined, revised or even replaced as a result (Hughes 2003). This reminds us that ethically difficult situations are episodes in continuing histories of attempted mutual adjustments and understanding among people (Walker 1993). We learn progressively from our moral resolutions and their intelligibility and acceptability to ourselves and others who and how we are and what our moral concepts and standards mean (Walker 1998).

Living with ethical difficulties in daily practice may be interpreted as if surgeons and nurses have developed some degree of resilience (Gillespie et al. 2007) to face and resolve the complex ethically difficult situations while practising in ways they found manageable and satisfying. We may ask if the notion of living with ethically difficult situations is an expression of the moral integrity of surgeons and nurses. Integrity concerns the way we conduct ourselves in general and in situations of difficulty. Integrity is usually used to describe a person who stays firm and remains true to their beliefs, values and actions in times of difficulties, conflict and external pressure (Aasland 2006). Walker (1998) describes integrity as reliability in the accounts we are prepared to give, to act, and stand by, in moral terms. She says that a person shows integrity in taking responsibility for his or her part in the collective work of determining how to live, and by standing up for one's own best judgment under pressures and penalties from other people (Walker 1998).

The uncertainty of practising means an ever present risk of doing more harm than good to patients. Living with the responsibility of practising under uncertainty seems to create a tension between a high level of confidence in order to take actions in situations when risks are high and much is at stake, and coming to terms with the "fragility of goodness" of living and practising (Nussbaum 1986). In her work on ethics in Greek tragedy and philosophy, Nussbaum (1986) shows how the values people pursue in their lives, open them to risk. Caring for someone or something in life puts the person who cherishes them at the mercy of luck or the risk of loss and grief. In the long run health care providers are susceptible to burnout, which consists of emotional exhaustion, depersonalization and reduced perception of personal accomplishments (Halbesleben & Rathert 2008). There may also be contingent conflicts of values that make it difficult to pursue all the things to which they have committed themselves.

Though tragedies of serious injuries and disease, suffering and death are inherent to human existence, this does not mean that vulnerability and fragility are to be prized in their own right, but acknowledging them may offer a supplement and limitation to moral philosophies that portray our life as safe and predictable, and without ambiguity and risk. The surgeons' and nurses' responsibility for deciding between contradictory actions to pursue in situations of complexity, ambiguity and uncertainty, it is always the possibility that tragedy and disaster may be an unintended result of their efforts to do good (Nussbaum 1986).

11 Concluding remarks

In this thesis, I have tried to expand the descriptions of methods, findings and interpretation already presented in the published papers, and to extend and deepen the interpretation of three of the main themes that pervaded the interviews with surgeons and nurses.

The first theme discussed was the ethical commitments and dilemma concerning the treatment and care of patients. The dilemma of respecting patients' rights to decide their own treatment and acknowledging their vulnerable situation in life was first discussed. Surgeons and nurses tried to resolve this dilemma by initiating a dialogue with patients in order to know their values and outlook on life, their hopes and expectations for the future and establishing a trusting relationship. Both surgeons and nurses were committed to the ethical end of rescuing and sustaining patients' life by taking appropriate actions to give patients a chance, and to maintain their hopes and efforts to battle the disease in situations of severe illness and uncertainty. This finding was interpreted as acting according to an ethics of possibility, acknowledging the existential open-endedness and fragility of human life.

The second theme discussed was the importance of social confirmation and integrity when faced with ethical dilemmas. These situations are characterized by complexity, uncertainty and ambiguity about the correct and best thing to do and what constitutes an ethically satisfying solution to the problem. In order to reach consensus about which actions to take, the medical realities and details of the case, what constitute the best interest of the patient and the ethical values and principles at stake were discussed among those involved in the treatment and care of the particular patient. Consensus and confirmation by the patients, relatives, colleagues, and their conscience that the needs of patients and relatives were attended to in a morally and professionally satisfying manner increased the surgeons' and nurses' confidence and satisfaction in their work, and their courage to live with the responsibility for being and acting in ethically difficult situations.

The third theme discussed was the meaning of the expression "living with" ethical dilemmas while practising. When surgeons and nurses were asked to ethically difficult situations they had experienced, they told about an abundance of ethical dilemmas that had to be resolved case by case, but also about how experiencing ethical dilemmas on a daily basis affected them personally and professionally in the long run. "Living with ethical dilemmas" points to the reality that ethics is not only about difficult situations or particular episodes, but also about the professional and personal lives of nurses and surgeons, and their perceptions of the future lives of patients and their relatives. This study shows that the personal and professional responsibility of being regularly in ethically difficult situations is immense. Being responsible for doing harm to fragile patients when trying to help is especially difficult to live with and resolve. In addition surgeons and nurses have to assimilate and manage the insight that comes from relentlessly encountering severe illness, suffering and death of their patients.

Several authors have argued that living and working with moral distress ultimately lead to health problems and burnout, high turnover and physicians and nurses leaving the profession (Sundin-Huard & Fahy 1999, Doane 2002, Austin et al. 2003, Källemark et al. 2004, Corley et al. 2005, Nordam et al. 2005b, Førde & Aasland 2008). The ways surgeons and nurses manage the distress and vulnerability caused by living with ethical dilemmas is less studied, but may be equally important. In this study, the interpretation of expression "living with ethical dilemmas" comprises ways of resolving particular dilemmas at hand as well as

preventing and managing the possible long term distress and vulnerability of being in ethically difficult situations.

To sum up this thesis, several ways of managing the vulnerability of living with ethical dilemmas are suggested by surgeons and nurses in this study. First, discussing and resolving particular dilemmas in a manner that is confirmed by patients, relatives, colleagues and others involved in the case was an important source of confidence and satisfaction. Second, accepting ethical difficulties as an inseparable and unavoidable feature of practice and their working life may be regarded as a way of managing vulnerability. The focus of attention is then transferred from personal vulnerability and fallibility in situations of ethical difficulties to find ways of managing and living with them. Third, sharing difficult thoughts, feelings and experiences of vulnerability with trusted peers and giving and receiving recognition and support was experienced as a source of confirmation and confidence that gave fresh strength to live and deal with the ethical dilemmas of practice. Finally, the vulnerability of living with ethical dilemmas was something surgeons and nurses had acquired through years of clinical experience. However, accepting the professional and personal limitations of practice did not mean that they had abandoned their ethical and professional responsibility for maintaining and improving the standards of performance and quality of treatment and care in the unit.

12 References

- Abel O (2008) Paul Ricoeur's hermeneutics: form critique to poetics. In Kaplan DM (Ed.) *Reading Ricoeur*, State University of New York Press, USA pp183-196.
- Akkad A, Jackson C, Kenyon S, Dixon-Woods M, Taub N & Habiba M (2006) Patients' perception of written consent: Questionnaire study. *BMJ Online First* (Published 31 July 2006).
- Album D (1996) *Nære fremmede. Pasientkulturen i sykehus* (Near strangers. The patient culture in hospitals). TANO A/S, Norway.
- Allan H & Barber D (2005) Emotional boundary work in advanced fertility nursing roles. *Nursing Ethics* 12(4):391-400.
- Allmark P (2006) An argument for the use of Aristotelian method in bioethics. *Medicine, Health Care and Philosophy* 9(1):69-79.
- Almond B (2005) Reasonable partiality in professional relationships. *Ethical Theory and Moral Practice* 8(1-2):155-168.
- Altman LK (2007) The man on the table was 97, but he devised the surgery. In Kolata G (Ed.) *The best American science writing*. Harper Perennial, New York, USA pp 223-233.
- Amdal G (2001) *Explanation and understanding; the hermeneutic arc. Paul Ricoeur's theory of interpretation*. Cand. Philol. thesis. University of Oslo. Department of Philosophy.
- Austin W, Bergum V & Goldberg L (2003) Unable to answer the call of our patients: mental health nurses' experience of moral distress. *Nursing Inquiry* 10(3):177-183.
- Aristotle (1980) *The Nicomachean ethics*. Oxford University Press. The world's classics, UK.
- Armour M, Rivaux SL & Bell H (2009) Using context to build rigor: application to two hermeneutic phenomenological studies. *Qualitative Social Work* 8(1):101-122.
- Arnetz BB (2001) Psychosocial challenges facing physicians of today. *Social Science & Medicine* 52(2):203-213.
- Aunan E (2003) Informert samtykke til kirurgi (Informed consent to surgery). *Tidsskrift for Den Norske legeforening* 123(18):2597-2599.
- Axelrod DA & Goold SD (2000) Maintaining trust in the surgeon-patient relationship. Challenges for the new millennium. *Archives of Surgery* 135(1):55-61.
- Bauman Z (2001) *Community. Seeking safety in an insecure world*. Polity Press, Cambridge UK and USA.

- Beauchamp TL & Childress JF (2001) *Principles of biomedical ethics*. 5th edition. Oxford University Press, UK.
- Benner P (1984) *From novice to expert: excellence and power in clinical nursing practice*. Addison-Wesley, Menlo Park, California, USA.
- Benner P, Tanner CA & Chesla CA (1996) *Expertise in nursing practice. Caring, clinical judgment, and ethics*. Springer Publishing Company Inc., New York, USA.
- Benner P, Hooper-Kyriakidis P & Stannard D (1999) *Clinical wisdom and interventions in critical care*. W.B. Saunders Company, USA.
- Berman L, Dardik A, Bradley EH, Gusberg RJ & Fraenkel L (2008) Informed consent for abdominal aortic aneurysm repair: Assessing variations in surgeons opinion through a national survey. *Journal of Vascular Surgery* 47(2):287-295.
- Bernat JL & Peterson LM (2006) Patient-centered informed consent in surgical practice. *Archives of Surgery* 141(11):86-92.
- Björklund P (2004) Invisibility, moral knowledge and nursing work in the writings of Joan Liaschenko and Patricia Rodney. *Nursing Ethics* 11(2):110-121.
- Bolmsjö IÅ, Nilstun T & Löfmark R (2007) From cure to palliation: agreement, timing and decision making within the staff. *American Journal of Hospice & Palliative Medicine* 24(5):366-370.
- Bosk CL (1979) *Forgive and remember. Managing medical failure*. The University of Chicago Press, Chicago and London.
- Brown LM, Tappan MB, Gilligan C, Miller AM & Argyris DE (1989) Reading for self and moral voice: a method for interpreting narratives of real-life moral conflict and choice. In Packer MH & Addison RB (Eds.) *Entering the circle. Hermeneutic investigation in psychology*. State University of New York Press, USA, pp141-164.
- Bruhn JG (2001) Being good and doing good: the culture of professionalism in the health professions. *Health Care Manager* 19(4):47-58.
- Burger I, Schill K & Goodman S (2007) Disclosure of individual surgeon's performance rates during informed consent. Ethical and epistemological considerations. *Annals of Surgery* 245(4):507-523.
- Carman T & Hansen BN (2005) (Eds.) Introduction. *The Cambridge companion to Merleau-Ponty*. Cambridge University Press, UK, pp 1-25.
- Cassell J (1998) *The woman in the surgeon's body*. Harvard University Press, Cambridge, Massachusetts, London, UK.
- Cassell J, Buchman TG, Streat S & Stewart R (2003) Surgeons, intensivists, and the covenant of care: administrative models and values affecting care at the end of life – Updated. *Critical Care Medicine* 31(5):1551-1559.

- Chen PW (2008) *Final exam. A surgeon's reflections on mortality*. First Vintage Books Edition, USA.
- Christiansen B (2008) Good work – how is it recognised by the nurse? *Journal of Clinical Nursing* 17(12):1645-1651.
- Christoffersen SA (2005) (Ed.) *Profesjonsetikk (Professional ethics)*. Universitetsforlaget, Norway.
- Clarke S & Oakley J (2004) Informed consent and surgeons' performance. *Journal of Medicine and Philosophy* 29(1):11-35.
- Code L (2002) Narratives of responsibility and agency: Reading Margaret Walker's Moral understandings. *Hypatia* 1(17):156-173.
- Cooper JD, Clayman RV, Krummel TM, Schauer PR, Thompson C & Moreno JD (2008) Inside the operating room – balancing the risks and benefits of new surgical procedures. A collection on perspectives and panel discussion. *Cleveland Clinical Journal of Medicine* 75(6 supplement):37-54.
- Corley MC, Minick P, Elswick RK & Jacobs M (2005) Nurse moral distress and ethical work environment. *Nursing Ethics* 12(4): 381-390.
- Cronquist A & Nyström (2007) A theoretical argumentation on the consequences of moral stress. *Journal of Nursing Management* 15:458-465.
- Cronquist A, Theorell T, Burns T & Lützn K (2001) Dissonant imperatives in nursing: a conceptualization of stress in intensive care in Sweden. *Intensive and Critical Care Nursing* 17(4):228-236.
- Dahl PE & Andreassen L (2003) Hjertekirurgi hos pasienter over 80 år (Cardiac surgery in octogenarians) (English summary). *Tidsskrift for Den Norske Legeforening* 123(12):1671-1673.
- Dahlqvist V, Erikson S, Glasberg AL, Lindahl E, Lützn K, Strandberg G, Söderberg A, Sørli V & Norberg A (2007) Development of the perceptions of conscience questionnaire. *Nursing Ethics* 14(2):181-193.
- Delmar C (1999) *Tillid & magt – en moralsk udfordring* (Trust and power – a moral challenge). Munksgaard, København, Denmark.
- Delmar C (2006) The phenomenology of life phenomena – in a nursing context. *Nursing Philosophy* 7(4):235-246.
- Den Norske Legeforening (2002) *Etiske regler for leger*. Vedtatt av landsstyret 1961 med endringer, senest 2002. (The Norwegian Medical Association. Code of ethics for doctors. Adopted by the Representative Body in 1961 and subsequently amended, most recently in 2002) <http://www.legeforeningen.no/index.gan?id=485> (Retrieved 25.03.08).

- Doane GA (2002) Am I still ethical? The socially-mediated process of nurses' moral identity. *Nursing Ethics* 9(6):623-35.
- Doane GH & Varcoe C (2007) Relational practice and nursing obligations. *Advances in Nursing Science* 30(3):192-205.
- Dreyfus HL, Dreyfus SE & Benner P (1996) Implications of the phenomenology of expertise for teaching and learning everyday skilful ethical comportment. In Benner P, Tanner CA & Chesla CA (Eds.) *Expertise in nursing practice. Caring, clinical judgment and ethics*. Springer Publishing Company, New York, USA pp 258- 306.
- Edwards N, Kornacki MJ & Silversin J (2002) Unhappy doctors: what are the causes and what can be done? *British Medical Journal* 324(7341):835-838.
- Elliott JA & Olver IN (2007) Hope and hoping in the talk of dying cancer patients. *Social Science & Medicine* 64(1):138-149.
- Elliott-Binns C (1978) *Medicine: the forgotten art?* Medical Publishing Co. Ltd., UK.
- Elstad I (1995) Er der noko fra før? (What is there in nursing practice?) In Elstad I & Hamran T (Eds.) *Et kvinnefag i moderniseringen. Sykehuspleien mellom fagtradisjon og målstyring (Women's practice modernized: hospital nursing between traditional competence and new management)*. ad Notam Gyldendal, Oslo, Norway pp77-150.
- Elstad I & Torjuul K (2009a) Continuity of nursing and the time of sickness. *Nursing Philosophy* 10(2):91-102
- Elstad I & Torjuul K (2009b) The issue of life: Aristotle in nursing perspective. *Nursing Philosophy*. (2009) 10(4):275–286.
- Emanuel LL, von Gunten CF & Ferris FD (2000) Gaps in end-of-life care. *Archives of Family Medicine* 10(9):1176-1180.
- Emden C & Sandelowski M (1998) The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice* 4(4):206-212.
- Emden C & Sandelowski M (1999) The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice* 5(1):2-7.
- Enns C & Gregory D (2007) Lamentation and loss: expressions of caring in contemporary surgical nurses. *Journal of Advanced Nursing* 58(4):339-347.
- Eriksen TH (2004) *Røtter og føtter. Identitet i en omskiftelig tid* (Roots and feet. Identity in a changeable time). Aschehoug & Co, Norway.
- Falkum E & Førde R (2000) Paternalism, patient autonomy, and moral deliberation in the physician – patient relationship. *Social Science & Medicine* 52(2):239-248.

- Ferrell B (2005) Ethical perspectives on pain and suffering. *Pain Management Nursing* 6(3): 83-90.
- Fisscher O, Nijhof A & Steensma H (2003) Dynamics in responsible behaviour. In search of mechanisms for coping with responsibility. *Journal of Business Ethics* 44(2/3):209-224.
- Førde R (2000) Den kollegiale kulturen og ”medisinske feil” (The collegial culture and “medical errors”). In Syse A, Førde R & Førde OH (Eds.) *Medisinske feil* (Medical errors). Gyldendal Akademisk, Norway pp183- 194.
- Førde R, Aasland OG & Steen PA (2002) Medical end-of-life decisions in Norway. *Resuscitation* 55(3):235-240.
- Førde IS, Berner M, Pedersen R & Førde R (2007) Mangelfull oversikt over etiske retningslinjer (Inadequate overview of ethical guidelines). *Tidsskrift for den Norske Legeforening* 127(10):1394-1396.
- Førde R & Aasland OG (2008) Moral distress among Norwegian doctors. *Journal of Medical Ethics* 34(7):521-525.
- Gadamer HG (2003) *Truth and Method* (Second, revised edition). (German original: Wahrheit und Methode, 1960). (Translation revised by Weinsheimer J & Marshall DG). Continuum, New York, London.
- Gallagher A (2007) The respectful nurse. *Nursing Ethics* 14(3):360-371.
- Gawande A (2002) *Complications. A surgeon’s notes on an imperfect science*. Picador, New York, USA.
- Gawande A (2007) *Better. A surgeon’s notes on performance*. Profile Books, London, UK and USA.
- Geanellos R (2000) Exploring Ricoeur’s hermeneutic theory of interpretation as a method of analysing research text. *Nursing Inquiry* 7(2):112-119.
- Georges J, Grypdonck M & De Casterle BD (2002) Being a palliative care nurse in an academic hospital: a qualitative study about nurses’ perceptions of palliative care nursing. *Journal of Clinical Nursing* 11(6):785-793.
- Gillespie BM, Chaboyer W, Wallis M & Grimbeek P (2007) Resilience in the operating room: developing and testing of a resilience model. *Journal of Advanced Nursing* 59(4):427-438.
- Gillett G (2004) Clinical medicine and the quest for certainty. *Social Science & Medicine* 58(4):727-738.
- Gilligan C (1982) *In a different voice: psychological theory and women’s development*. Harvard University Press, London, UK.

- Glare P, Virik K, Jones M, Hudson M, Eychmuller S, Simes J & Christakis N (2003) A systematic review of physicians' survival predictions in terminally ill cancer patients. *British Medical Journal* 327(26):195-198.
- Goldstein EA, Maestas RR, Fryer-Edwards K, Wenrich MD, Oelschlager AA, Baernstein A & Kimball HR (2006) Professionalism in medical education: an institutional challenge. *Academic Medicine* 81(10):871-876.
- Gordon EJ & Daugherty CK (2003) 'Hitting you over the head': oncologists' disclosure of prognosis to advanced cancer patients. *Bioethics* 17(2):143-168.
- Graber DR & Mitcham MD (2004) Compassionate clinicians take patient care beyond the ordinary. *Holistic Nursing Practice* 18(2):87-94.
- Grady D (2007) With lasers and daring, doctors race to save a young man's brain. In Kolata G (Ed.) *The best American science writing*. Harper Perennial, New York, USA pp 136-143.
- Grimsmo A & Sørensen BA (2004) *God vakt. Arbeidsmiljø i sykehus*. (A good shift. Working conditions in hospitals). AFI Notat 8/04, Oslo, Norway.
- Groopman J (2007) *How doctors think*. Houghton Mifflin Company, Boston, New York, USA.
- Gulbrandsen P, Førde R & Aasland OG (2002) Hvordan har legen det som portvakt? (What does it feel like to be a gatekeeper?) (English summary). *Tidsskrift for den Norske Legeforening* 122 (19):1874-1879
- Gulddal J & Møller M (1999) Fra filologi til filosofi – introduktion til den moderne hermeneutik (From philology to philosophy – an introduction to modern hermeneutics). In Gulddal J & Møller M (Eds.) *Hermeneutikk – en antologi om forståelse*. (Hermeneutics – an anthology of understanding). Gyldendalske Boghandel, Nordisk Forlag AS, Denmark.
- Gullestad M (1996) *Everyday Life Philosophers*. Universitetsforlaget, Norway.
- Haaverstad R, Hilton C & Hamilton L (2004) Bristol-skandalens effekt på britisk helsetjeneste (Effects of the Bristol-scandal on British health service). *Tidsskrift for Den Norske Legeforening* 124(6):816-818.
- Habiba M, Jackson C, Akkad A, Kenyon S & Dixon-Woods M (2004) Women's accounts of consenting to surgery: is consent a quality problem? *Quality & Safety in Health Care* 13(6):422-427.
- Hafferty FW (2006) Definitions of professionalism. A search for meaning and identity. *Clinical Orthopaedics and Related Research* 449:193-204
- Halbesleben JR & Rathert C (2008) Linking physician burnout and patient outcomes: Exploring the dyadic relationship between physician and patients. *Health Care Management Review* 33(1):29-39.

- Hamric AB & Blackhall LJ (2007) Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine* 35(2):422-429.
- Hansson SO (2007) The ethics of enabling technology. *Cambridge Quarterly of Healthcare Ethics* 16(3):257-267.
- Hasse JT (2000) Perfection and compassion – essentials in cardio-thoracic surgery. *European Journal of Cardio-thoracic Surgery* 18(6):635-641.
- Hawley MP & Jensen L (2007) Making a difference in critical care nursing. *Qualitative Health Research* 17(5):663-674.
- Heidegger M (1996) *Being and time*. A translation of Sein und Zeit. (Translated by Joan Stambaugh) (German original 1953). State University of New York Press, USA.
- Helsedirektoratet (2009) (Norwegian Directorate of health) *Livsforlengende behandling hos alvorlig syke og døende* (Life prolonging treatment of seriously ill and dying patients) <http://shdir.no/> (Retrieved 10.05.09).
- Hendrick HL & Nelson RM (2001) Handling ethical conflicts in the clinical setting. *Seminars in Pediatric Surgery* 10(4):192-197.
- Henriksen K & Hansen EH (2004) The threatened self: general practitioners' self-perception in relation to prescribing medicine. *Social Science & Medicine* 59(1):47-55.
- Hoeyer K (2009) Informed consent: The making of a ubiquitous rule in medical practice. *Organization* 16:267-288.
- Hollingham R (2008) *Blood and guts. A history of surgery*. BBC Books, UK.
- Hughes CL (2003) Integrity and vulnerability. In Fiore RN & Nelson HL (Eds.) *Recognition, responsibility, and rights*. Rowman & Littlefield Publishers Inc., USA, pp119-129.
- Hunter KM (1991) *Doctors' stories. The narrative structure of medical knowledge*. Princetown University Press, Princetown, New Jersey, USA.
- Hurst SA, Perrier A, Pegoraro R, Reiter-Theil S, Forde R, Slowther AM, Garrett-Mayer E & Danis M (2007) Ethical difficulties in clinical practice: experiences of European doctors. *Journal of Medical Ethics* 33(1):51-57.
- Huynh T, Alderson M & Thompson M (2008) Emotional labour underlying caring: an evolutionary concept analysis. *Journal of Advanced Nursing* 64(2):195-208.
- Høye S & Severinsson E (2007) Methodological aspects of rigor in qualitative nursing research on families involved in intensive care units: A literature review. *Nursing and Health Sciences* 9(1):61-68.
- Jacobs F (2005) Reasonable partiality in professional ethics: the moral division of labour. *Ethical Theory and Moral Practice* 8(1-2):141-154.

- Jensen A & Lidell E (2009) The influence of conscience in nursing. *Nursing Ethics* 16(1):31-42.
- Jonas H (1984) *The imperative of responsibility. In search of an ethics for the technological age.* (Translated by Jonas H & Herr D). The University of Chicago Press, Chicago and London, USA and UK.
- Jones JW, McCullough LB & Richman BW (2006) Ethics and professionalism: do we need yet another surgeons' charter? *Journal of Vascular Surgery* 44(4):903-906.
- Jordens CF & Little M (2004) 'In this scenario, I do this, for this reason': narrative, genre and ethical reasoning in the clinic. *Social Science & Medicine* 58(9):1635-1645.
- Kaldjian LC, Forman-Hoffman VL, Jones EW, Wu BJ & Rosenthal GE (2008) Do faculty and resident physicians discuss their medical errors? *Journal of Medical Ethics* 34(10):717-722.
- Kaufman SR (1997) Construction and practice of medical responsibility: Dilemmas and narratives from geriatrics. *Culture, Medicine and Psychiatry* 21(1):1-26.
- Kälvemark S, Höglund AT, Hansson MG, Westerholm P & Arnetz B (2004) Living with conflicts – ethical dilemmas and moral distress in the health care system. *Social Science & Medicine* 58(6):1075-1084.
- Kaplan DM (2008) Introduction: Reading Ricoeur. In Kaplan DM (Ed.) *Reading Ricoeur.* State University of New York Press, USA pp1-12.
- Katz P (1999) *The scalpel's edge. The culture of surgeons.* Allyn & Bacon A Viacom Company, Massachusetts, USA.
- Kleinman A (1988) *The illness narratives: Suffering, healing and the human condition.* Basic Books, Harper Collins, New York, USA.
- Koch T & Harrington A (1998) Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing* 28(4):882-890.
- Kodner IJ (2008) Ethical issues in surgery. Surgeons and clinical ethics. *Surgery* 143(4):460-462.
- Kovner C & Gergen PJ (1998) Nurse staffing levels and adverse events following surgery in U.S. hospitals. *Image- the Journal of Nursing Scholarship* 30(4):325-321.
- Kunnskapsdepartementet (2009) (Norwegian Ministry of Education and Research) *Lærer og sykepleier de viktigste yrkene* (Nursing and teachers the most important professions) Pressemelding publisert (Press release published) 14.04.09. <http://www.regjeringen.no/nb/dep/kd> (Retrieved 12.05.09).
- Kørner H, Søreide JA, Glomsaker T, Søreide K & Fjetland L (2007) Palliativ kirurgi innen kreftomsorg (Palliative surgery in cancer care). *Tidsskrift for den Norske Lægeforening* 127(17):2271-2273.

- Lawler J (1991) *Behind the screens. Nursing, somology, and the problem of the body.* Churchill Livingstone, Melbourne, Australia.
- Le Fanu J (1999) *The rise and fall of modern medicine.* Abacus, London, UK.
- Leino-Kilpi H, Souminen T, Mäkelä M, McDaniel C & Puukka, P (2002). Organizational ethics in Finnish intensive care units: staff perceptions. *Nursing Ethics* 9(2):125-136.
- Levin PD & Sprung CL (2005) Withdrawing and withholding life-sustaining therapies are not the same. *Critical Care* 9(3):230-232.
- Liaschenko J (2002) Thoughts on nursing work. *JONA* 32(2):69-70.
- Lieberman I, Herndon J, Hahn J, Fins JJ & Rezai A (2008) Surgical innovation and ethical dilemmas: A panel discussion. *Cleveland Clinical Journal of Medicine* 75(6 supplement):13-21.
- Limentani AE (1999) The role of ethical principles in health care and the implications of ethical codes. *Journal of Medical Ethics* 25(5):394-398.
- Lindseth A (1992) The role of caring in nursing ethics. In Udén G (Ed.) *Quality development in nursing care. From practice to science.* University Health Service Studies, Linköping, Sweden pp 97-106.
- Lindseth A (2002) Løgstrups etikk i et omsorgsperspektiv. Hva er omsorgens normative fundament, en empatisk evne til nærhet eller fordringen fra den andre? (Løgstrups' ethics in a caring perspective. What is the normative basis of caring, an empathic ability to closeness or the demand of the other?). In: Wolf J & Gjerris M (Eds.) *Spor i sandet. Bidrag til forståelse af K. E. Løgstrups forfatterskap.* (Traces in the sand. Contributions to understanding the authorship of K.E. Løgstrup). Forlaget ANIS, København, Denmark pp 63-80.
- Lindseth A, Marhaug V, Norberg A & Udén G (1994) Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *Journal of Advanced Nursing* 20(2):245-250.
- Lindseth A & Norberg A (2004) A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences* 18(2):145-53.
- Little M, Paul K, Jordens CF & Sayers EJ (2000) Vulnerability in the narratives of patients and their carers: Studies of colorectal cancer. *Health* 4(4):495-510.
- Little M (2002) The fivefold root of an ethics of surgery. *Bioethics* 16(3):183-201.
- Little M, Paul K, Jordens CF & Sayers EJ (2003) Discourse communities and the discourse of experience. *Health* 7(1):73-86.
- Little M & Sayers EM (2004) While there is life... hope and the experience of cancer. *Social Science & Medicine* 59(6):1329-1337.

- Lomborg K & Kirkevold M (2003) Truth and validity in grounded theory – a reconsidered realist interpretation of the criteria: fit, work, relevance and modifiability. *Nursing Philosophy* 4(3):189-200.
- Lütznén K, Cronquist A, Magnusson A & Anderson L (2003) Moral stress: synthesis of a concept. *Nursing Ethics* 10(3):312-322.
- Løgstrup KE (1997) *The ethical demand* (Den etiske fordring) (Danish original 1956, Gyldendal, Copenhagen) (English translation by Jensen TI.). Fortress Press, Philadelphia, USA
- MacIntyre A (2002) *After Virtue – A study in moral theory*. (2nd edition) Harvard University Press, Cambridge, Massachusetts and London, UK and USA.
- Maggs-Rapport F (2001) ‘Best research practice’: in pursuit of methodological rigour. *Journal of Advanced Nursing* 35(3):373-383.
- Magnusson RS (2006) The devil’s choice: re-thinking law, ethics, and symptom relief in palliative care. *The Journal of Law, Medicine and Ethics* 34(3):559-569.
- Marasco SF, Ibrahim JE & Oakley J (2005) Public disclosure of surgeon-specific report cards: current status of the debate. *ANZ Journal of Surgery* 75(11):1000-1004.
- Martinsen K (1996) *Fenomenologi og omsorg. Tre dialoger med etterord av Katie Eriksson* (Phenomenology and care. Three dialogues with an epilogue by Katie Eriksson). Tano Aschehoug, Norway.
- Mauleon AL, Palo-Bengtsson L & Ekmann SL (2005) Anesthesia care of older patients as experienced by nurse anesthetists. *Nursing Ethics* 12(3):264-272.
- May C (1991) Affective neutrality and involvement in nurse-patient relationships: perceptions of appropriate behavior among nurses in acute medical and surgical wards. *Journal of Advanced Nursing* 16(5):552-558.
- McCarthy J (2003) Principlism or narrative ethics: must we choose between them? *Journal of Medical Ethics* 29(2):65-71.
- McCarthy J & Deady R (2008) Moral distress reconsidered. *Nursing Ethics* 15(2):254-262.
- McCullough LB, Jones JW & Brody BA (1998) (Eds.) *Surgical Ethics*. Oxford University Press, New York, Oxford, UK and USA.
- McGrath M (2008) The challenges of caring in a technological environment: critical care nurses’ experiences. *Journal of Clinical Nursing* 17(8):1096-1104.
- McIntyre N & Popper K (1983) The critical attitude in medicine: the need for a new ethics. *British Medical Journal* 287(6409):1919-1923.
- Melia K (2004) *Health care ethics. Lessons from intensive care*. SAGE Publications. London, Thousand Oaks, New Delhi, UK.

- Miljeteig I, Johansson KA & Norheim OF (2008) Ethiske valg ved medisinsk nytteløs behandling (Ethical choices in medically futile treatment) (English summary). *Tidsskrift for den Norske Legeforening* 128(19):2185-2189.
- Milne J & Oberle K (2005) Enhancing rigor in qualitative description. A case study. *Journal of The Wound, Ostomy and Continence Nurses Society* 32(6): 413-420.
- Minick P & Harvey S (2003) The early recognition of patient problems among medical-surgical nurses. *MEDSURG Nursing* (12)5:291-297.
- Mishler EG (1986) *Research interviewing – Context and narrative*. Harvard University Press, Cambridge, Massachusetts and London.
- Mitchell M (2008) Conscious surgery: influence of the environment on patient anxiety. *Journal of Advanced Nursing* 64(3):261-271.
- Moniham R & Smith R (2002) Too much medicine? *British Medical Journal* 324(7342):859-860.
- Morris CR (2007) *The surgeons. Life and death in a top heart center*. W.W. Norton & Company, New York, USA.
- Måseide P (1983) *Medisinsk sosiologi. Noen sosiologiske perspektiv på sykdom og behandling* (Medical sociology. Sociological perspectives on sickness and treatment). Aschehoug, Norway.
- Måseide P (1987) *Interactional aspects of patient care. The social organization of medical adequacy in a hospital ward*. University of Bergen, Department of Sociology (Doctoral thesis).
- Needleman J, Buerhaus P, Mattke S, Steward M & Zelevinsky K (2002) Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine* 346(22):1715-1722.
- Nergård JI (2006) *Den levende erfaring. En studie i samisk kunnskapstradisjon* (The living experience. A study of the knowledge traditions of Sami people). Cappelen Akademisk Forlag, Norway.
- Nicolaisen RF (2003) *Å være underveis. Introduksjon til Heideggers filosofi* (Being in transit. Introduction to the philosophy of Heidegger). Universitetsforlaget A/S, Oslo, Norway.
- Nolte K (2008) “Telling the painful truth” – nurses and physicians in the nineteenth century. *Nursing History Review* 16:115-134.
- Norberg A & Udén G (1995) Gender differences in moral reasoning among physicians, registered nurses and enrolled nurses engaged in geriatric and surgical care. *Nursing Ethics* 2(3):233-242.
- Nordam A, Sørli V & Førde R (2003) Integrity in the care of elderly people, as narrated by female physicians. *Nursing Ethics* 10(4):388-403.

- Nordam A & Sørli V (2005a) Prioritisation and the quality of care for elderly people – Male physicians' narratives. *Vård i Norden* 25(1): 42–47.
- Nordam A, Torjuul K, Sørli V (2005b) Ethical challenges in the care of older people and risk of being burned out among male nurses. *Journal of Clinical Nursing* 14(10):1248-1256.
- Normann HK, Asplund K, Norberg A (1999) Attitudes of Registered Nurses towards patients with severe dementia. *Journal of Clinical Nursing* 8(4):353-359.
- Norsk Sykepleierforbund (Norwegian Nurses Association) (2007) *Yrkesetiske retningslinjer for sykepleiere* (Ethical guidelines for nurses). <http://www.sykepleierforbundet.no/article.php?articleID=10801&categoryID=1435> (Retrieved 25.03.08).
- Northern Nurses' Federation (NNF) (Sykepleiernes Samarbeid i Norden) (2003) *Ethical guidelines for nursing research in the Nordic countries*. <http://ssn-nnf.org/ssn/index.html>. (Retrieved 18.01.08).
- Nortvedt P (1998) Sensitive judgment: an inquiry into the foundations of nursing ethics. *Nursing Ethics* 5(5): 385-392.
- Nuland SB (2000) *The mysteries within. A surgeon reflects on medical myths*. Simon & Scuster, New York, London, Sydney, Singapore.
- Nussbaum MC (1986) *The fragility of Goodness. Luck and ethics in Greek tragedy and philosophy* (revised edition 2001). Cambridge University Press, Cambridge UK.
- Nussbaum MC (2001) *Upheavals of thought. The intelligence of emotions*. Cambridge University Press, Cambridge UK.
- Nydal R & Solberg B (2006) Svaret er ”mer etikk”. Hva er spørsmålet? (The answer is ”more ethics”. What is the question?). I Nydal R & Solberg B (Eds.) *Juks, uredelighet og god forskning* (Deceit, dishonesty and good research). Tapir akademiske forlag, Trondheim, Norway, pp 33-48.
- Oberle K & Hughes D (2001) Doctors' and nurses' perceptions of end-of-life decisions. *Journal of Advanced Nursing* 33(6):707-715.
- Paley J (1997) Husserl, phenomenology and nursing. *Journal of Advanced Nursing* 26(1):187-193.
- Paley J (2005) Phenomenology as rhetoric. *Nursing Inquiry* 12(2):106-116.
- Palmboom GG, Willems CL, Janssen AT & de Haes JC (2007) Doctor's views on disclosing or withholding information low risks of complication. *Journal of Medical Ethics* 33(2):67-70.
- Park J, Woodrow SI, Reznick RK, Beales J & MacRae HM (2007) Patient care is a collective responsibility: Perceptions of professional responsibility in surgery. *Surgery* 142(1):111-118.

- Paulsen PM & Brattebø G (2006) Medisinstudentar og legar sine haldningar til medisinske feil og pasientskade (Attitudes to medical errors and patient injury among doctors and medical students) (English summary). *Tidsskrift for den Norske Legeforening* 126(16):2129-2132.
- Pawlik TM (2006) Withholding and withdrawing life-sustaining treatment: a surgeon's perspective. *Journal of the American College of Surgeons* 202(6):990-994.
- Pedersen R, Hofman B & Mangset M (2007) Pasientautonomi og informert samtykke i klinisk arbeid (Patient autonomy and informed consent in clinical practice) (English summary). *Tidsskrift for den Norske Legeforening* 127(12):1644-1647.
- Pepine CJ (2003) Creating and adopting an ACC ethical code of conduct. *Journal of the American College of Cardiology* 42(11):2028-2029.
- Peter E, Macfarlane AV & O'Brien-Pallas LL (2004) Analysis of the moral habitability of the nursing work environment. *Journal of Advanced Nursing* 47(4):356-364.
- Peterson M & Potter RL (2004) A proposal for a code of ethics for nurse practitioners. *Journal of the American Academy of Nurse Practitioners* 16(3):116-124.
- Prentice R (2007) Drilling surgeons: The social lessons of embodied surgical learning. *Science, Technology & Human Values* 32 (5):534-553.
- Puntillo KA, Benner P, Drought T, Drew B, Stotts N, Stannard D, Rushton C, Scanlon C & White C (2001) End-of-life issues in intensive care units: A national random survey of nurses' knowledge and believes. *American Journal of Critical Care* 4(10):216-229.
- Puntillo KA & McAdam JL (2006) Communication between physicians and nurses as a target for improving end-of-life care in the intensive care unit: Challenges and opportunities for moving forward. *Critical Care Medicine* 34(11, Suppl):332-340.
- Ricoeur P (1976) *Interpretation Theory. Discourse and the surplus of meaning*. Texas University Press, Texas, USA.
- Ricoeur P (1981) *Hermeneutics and the human sciences*. Essays on language, action and interpretation. (Edited and translated by John B Thompson). Cambridge University Press, USA.
- Ricoeur P (1992) *Oneself as another* (French original 1990, Editions du Seuil). (English translation by K Blamey). University of Chicago Press, Chicago and London.
- Riessmann CK (1993) *Narrative analysis. Qualitative research methods*. Sage Publications, London, UK.
- Rognstad MK, Nortvedt P & Aasland O (2004) Helping Motives in Late Modern Society: values and attitudes among nursing students. *Nursing Ethics* 11(3):227-239.

- Rodney P & Street A (2004) The moral climate of nursing practice: Inquiry and action. In Storch JL, Rodney P & Starzomski R (Eds.) *Toward a moral horizon. Nursing ethics for leadership and practice*. Pearson Education Inc., Canada pp 209- 231.
- Rosenberg AG (2006) Surgical evolution: development of minimally invasive surgery. *Operative Techniques in Orthopaedics* 84-86.
- Rosenthal MM, Mulcahy L & Lloyd-Bostock S (Eds.) (1999) *Medical Mishaps. Pieces of the puzzle*. Open University Press, Buckingham- Philadelphia, USA.
- Saarni AI, Halila R, Palmu P & Vänskä J (2008) Ethically problematic treatment decisions in different medical specialities. *Journal of Medical Ethics* 34(4):262-267.
- Samuels A (2005) The duty to warn the patient. *British Journal of Neurosurgery* 19(2):117-119.
- Sandelowski M (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* 8(3):27-37.
- Sandelowski M (1993) Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science* 16(2):1-8.
- Schei E (2007) *Hva er medisin? (What is medicine?)* Universitetsforlaget, Oslo, Norway.
- Scheingraber S, Brien B, Machens A & Hirner A (2004) Change remains – paradigm shifts in modern surgery. *Medicine, Health Care and Philosophy* 7(2):195-200.
- Schluter J, Winch S, Holzhauser K & Henderson A (2008) Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nursing Ethics* 15(3):304-321.
- Schwarze ML (2007) The process of informed consent. Neither the time nor the place for disclosure of surgeon-specific outcomes. *Annals of Surgery* 245(4):514-515.
- Sellman D (2007) Trusting patients, trusting nurses. *Nursing Philosophy* 8(1):28-36.
- Severinsson E (2003) Moral stress and burnout: Qualitative content analysis. *Nursing and Health Sciences* 5(1):59-66.
- Shattell M (2002) 'Eventually it'll be over': the dialectic between confinement and freedom in the world of the hospitalized patient. In Thomas SP & Pollio HR (Eds). *Listening to Patients. A Phenomenological Approach to Nursing Research and Practice*. SpringerPublishing Company, New York, USA pp 214–236.
- Silén M, Svanteson M & Ahlström (2008) Nurses' conceptions of decision making concerning life-sustaining treatment. *Nursing Ethics* 15(2):160-173.
- Skjervheim H (1976) Fenomenologi og psykologi (Phenomenology and psychology). In Skjervheim H. *Deltakar og tiskodar og andre essays (Participant and spectator and other essays)*. Tanum-Nordli, Norway pp171-191. .
- Slote M (2001) *Morals from motives*. Oxford University Press, New York, USA

- Sokolowski R (2000) *Introduction to phenomenology*. Cambridge University Press, USA.
- Solbakk JH (2004) Therapeutic doubt and moral dialogue. *Journal of Medical Philosophy* 1(29):93-118.
- Stolt CM (2000) "Utan virkelig medkänsla kan man aldrig bli en bra läkare". (Without compassion you can never become a good physician). *Läkartidningen* 97(17):2104-2105.
- Storch JL & Kenny N (2007) Shared moral works of nurses and physicians. *Nursing Ethics* 14(49):478-491.
- Straume K (2001) Er barmhjertighetens tid forbi? (The end of beneficence?) *Tidsskrift for den Norske Legerforening* 121(4):495-497.
- Suhonen R, Välimäki M, Dassen T, Gasull M, Lemonidou C, Scott PA, Kaljonen A, Arndt M & Leino-Kilpi H (2003) Patients' autonomy in surgical care: a comparison of nurses' perceptions in five European countries. *International Nursing Review* 50(2):85-94.
- Suhonen R, Nenonen H, Laukka A & Välimäki M (2005) Patients' informational needs and information received do not correspond in hospitals. *Journal of Clinical Nursing* 14(10):1167-1176.
- Sullivan M (2003) The new subjective medicine: taking the patient's point of view on health care and health. *Social Science & Medicine* 56(7):1595-1604.
- Sundar T (2000) Fremtiden i robotens hender (Future in the hands of robots) *Tidsskrift for den Norske Legerforening* 120(1):136-137.
- Sundar T (2003) Geriatrik hjertekirurgi – alder ingen hindring? (Geriatric heart surgery – age is no obstacle?) *Tidsskrift for den Norske Legerforening* 123(12):1706-1709.
- Sundin-Huard D & Fahy K (1999) Moral distress, advocacy and burnout: Theorizing the relationship. *International Journal of Nursing Practice* 5(1): 8-13.
- Syse H (2005) *Veier til et godt liv: filosofiske tanker om hverdagslivets etikk*. (Roads to a good life: philosophical reflections on the ethics of everyday life) Aschehoug, Oslo, Norway.
- Söderberg A & Norberg A (1993) Intensive care: situations of ethical difficulty. *Journal of Advanced Nursing* 18(12):2008-2014.
- Söderberg A, Norberg A & Gilje F (1996). Meeting tragedy: interviews about situations of ethical difficulty in intensive care. *Intensive and Critical Care Nursing* 12(4):207-217.
- Söderberg A (1999) *The practical wisdom of enrolled nurses, registered nurses and physicians in situations of ethical difficulty in intensive care*. Umeå University Medical Dissertations, New Series No. 603. The Department of Nursing, Umeå University, Sweden.

- Sørli T, Busund R, Sexton HC & Sørli D (2005) Pasienttilfredshet etter opphold på kirurgisk avdeling (Patient satisfaction after hospitalisation for surgery) (English summary). *Tidsskrift for den Norske Legeforening* 125(6):756-759.
- Sørli V, Lindseth A, Udén G & Norberg A (2000) Women physicians' narratives about being in ethically difficult care situations in paediatrics. *Nursing Ethics* 7(1):47-62.
- Sørli V, Førde R, Lindseth A & Norberg A (2001a) Male physicians' narratives about being in ethically difficult care situations in paediatrics. *Social Science & Medicine* 53(5):657-667.
- Sørli V (2001b) *Being in ethically difficult care situations. Narrative interviews with registered nurses and physicians within internal medicine, oncology and pediatrics.* Umeå University Medical dissertations. New series No.727. The Department of Nursing, Umeå University, Sweden.
- Sørli V, Jansson L & Norberg A (2003a) The meaning of being in ethically difficult care situations in pediatric care as narrated by female registered nurses. *Scandinavian Journal of Caring Sciences* 17(3):285-292.
- Sørli V, Lindseth A, Førde R & Norberg A (2003b) The meaning of being in ethically difficult care situations in paediatrics as narrated by male registered nurses. *Journal of Pediatric Nursing* 18(5):350-357.
- Sørli V, Kihlgren AL & Kihlgren M (2004) Meeting ethical challenges in acute care work as narrated by enrolled nurses. *Nursing Ethics* 11(2):179-188.
- Sørli V, Kihlgren A & Kihlgren M (2005) Meeting ethical challenges in acute nursing care as narrated by registered nurses. *Nursing Ethics* 12(2):134-142.
- Sørli V, Torjuul K, Ross A & Kihlgren M (2006) Satisfied patients are also vulnerable patients – narratives from an acute care ward. *Journal of Clinical Nursing* 15(10):1240-1246.
- Takman C & Severinsson E (2005) Comparing Norwegian nurses' and physicians' perceptions of the needs of significant others in intensive care units. *Journal of Clinical Nursing* 14(5):621-631.
- Talseth AG, Gilje F & Norberg A (2001) Being met - a passageway to hope for relatives of patients at risk of committing suicide: a phenomenological hermeneutic study. *Archives of Psychiatric Nursing* 15(6):249-56.
- Thornton T (2006) Judgment and the role of the metaphysics of values in medical ethics. *Journal of Medical Ethics* 32(6):365-370.
- Tjora A (2008) (Ed.) *Den moderne pasienten.* (The modern patient). Gyldendal Akademisk, Norway.
- Tranøy KE (1998) *Det åpne sinn. Moral og etikk mot et nytt årtusen.* (An open mind. Morality and ethics towards a new millennium). Universitetsforlaget, Oslo, Norway.

- Treviño LK, Weaver GR & Reynolds (2006) Behavioral ethics in organization: a review. *Journal of Management* 32 (6):951-990.
- Tuckett AG (2004) Truth-telling in clinical practice and the arguments for and against: a review of the literature. *Nursing Ethics* 11(5):500-513.
- Tuckett AG (2005) Part II. Rigour in qualitative research: complexities and solutions. *NurseResearcher* 13(1):29-42.
- Udén G, Norberg A, Lindseth A & Marhaug V (1992) Ethical reasoning in nurses' and physicians' stories about care episodes. *Journal of Advanced Nursing* 17(9):1028-1034.
- Udén G, Norberg A & Norberg S (1995) The stories of physicians, registered nurses and enrolled nurses about ethically difficult care episodes in surgical care. *Scandinavian Journal of Caring Sciences* 9(4):245-253.
- van Dijck J (2001) Bodies without borders: the endoscopic gaze. *International Journal of Cultural Studies* 4:219- 237.
- Varcoe C, Doane G, Pauly B, Rodny P, Storch JL, Mahoney K, McPherson G, Brown H & Starzomski R (2004) Ethical issues in nursing: working the in-betweens. *Journal of Advanced Nursing* 45(3):316-325.
- Veerapen RJ (2007) Informed consent: physician inexperience is a material risk for patients. *Journal of Law, Medicine & Ethics* 35(3):478-485.
- Verpeet E, Castele BD, Arend AV & Gastmans CA (2005) Nurses' views on ethical codes: a focus group study. *Journal of Advanced Nursing* 51(2):188-195.
- Vetlesen AO (1994) *Perception, empathy and judgment*. Pennsylvania State University Press, Pennsylvania: USA.
- Vetlesen AO (2007) *Hva er etikk? (What is ethics?)*. Universitetsforlaget, Norway.
- Volker DL (2003) Is there a unique nursing ethic? *Nursing Science Quarterly* 16(3):207-211.
- Walker AC (2002) Safety and comfort work of nurses glimpsed through patient narratives. *International Journal of Nursing Practice* 8(1):42-48.
- Walker MU (1993) Keeping moral space open. New images ethics consulting. *Hastings Center Report* 1(23):33-41.
- Walker MU (1998) *Moral understandings. A feminist study in ethics*. Routledge, New York and London, UK and USA.
- Walker MU (2003) *Moral contexts*. Rowman & Littlefield Publishers Inc., USA.
- Warnock GL (2008) Reflecting on principles of professionalism. *Canadian Journal of Surgery* 51(2):84-85.

- Weaver K, Morse J & Mitcham C (2008) Ethical sensitivity in professional practice: concept analysis. *Journal of Advanced Nursing* 62(5):607-618.
- Webster G & Baylis F (2000) Moral residue. In Rubin SB & Zoloth L (Eds.) *Margin of error: the ethics of mistakes in the practice of medicine*. University Publishing Group, Hagerstown, Maryland, USA, pp 217-232.
- Westphal M (2008) Ricoeur's hermeneutical phenomenology of religion. In Kaplan DM (Ed.) *Reading Ricoeur*, State University of New York Press, USA pp109-127.
- White SM (2004) Consent for anaesthesia. *Journal of Medical Ethics* 30(3):286-290.
- Whitehead L (2004) Enchanting the quality of hermeneutic research: decision trail. *Journal of Advanced Nursing* 45(5):512-518.
- Williams SJ (1997) Modern medicine and the "uncertain body": from corporeality to hyperreality? *Social Science & Medicine* 45(7):1041-1049.
- Wirtz V, Cribb A & Barber N (2006) Patient-doctor decision-making about treatment within the consultation – A critical analysis of models. *Social Science & Medicine* 62(1):116-124.
- Witt L & Ploeg J (2006) Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing* 55(2):215-229.
- World Medical Association (2000) *The declaration of Helsinki. Ethical principles for medical research involving human subjects*. Revised edition. <http://www.wma.net/e/policy/b3.htm> (retrieved 18.01.08).
- Yegdich T (2000) In the name of Husserl: nursing in pursuit of the things-in-themselves. *Nursing Inquiry* 7(1):29-40.
- Ödman PJ (2007) *Tolkning, förståelse, vetande. Hermeneutik i teori och praktik* (2 opplag). (Interpretation, understanding and knowledge. Hermeneutics in theory and practice). Norstedts Akademiska Förlag, Finland.
- Aasland OG (2001): The physician role in transition: is Hippocrates sick? *Social Science & Medicine* 52(2):171-173.
- Aasland OG (2006) Legerollen – fra pjestall til skammel. (The physician' role – from pedestal to footstool). *Tidsskrift for den Norske Legeforening* 126(1):61-62.
- Aasland OG, Røvik JO & Wiers-Jenssen J (2008) Legers motiver for valg av spesialitet under og etter studiet. (Motives for choice of specialty during and after medical school). *Tidsskrift for den Norske Legeforening* 128(16):1833-1887.
- Åström G, Furaker C & Norberg A (1995) Nurses' skills in managing ethically difficult care situations: interpretation of nurses' narratives. *Journal of Advanced Nursing* 21(6):1073-1080.

13 Acknowledgements

First I would like to thank the surgeons and nurses who took the time to participate in the study and shared their experiences of ethical ends and difficulties in practice with me.

I am especially grateful to Professor *Venke Marhaug Sørli* at The Centre of Practical Knowledge, The School of Professional Studies, Bodø University College, my supervisor, for inviting me into the research project and for outstanding guidance and support throughout the research process and in completing this thesis. I am indebted to you for sharing your huge knowledge of ethics and extensive research experience with me. I am also grateful for your encouragement and critical comments on my work. I will always remember your unlimited enthusiasm, humour and hospitality. You will always have a friend in Trondheim.

I am also grateful to Professor *Ingunn Elstad* at the Department of Health and Care Sciences, Faculty of Health Sciences, University of Tromsø, my co-author and co-supervisor for excellent guidance and support, and your critical and constructive comments on my work.

Thanks to doctoral student *Ann Nordam* for your contribution as a co-author of two papers. It has been a pleasure to work together with you.

I am grateful for the financial support given by Sør-Trøndelag University College, Faculty of Nursing, Norway. I would also like to thank the staff, colleagues and students at the Faculty of Nursing for your support, patience and encouragements throughout this study.

I am grateful to Stewart Clark, Norwegian University of Science and Technology, Trondheim for his thorough linguistic revision.

14 Papers I-IV

Paper I

Torjuul Kirsti, Nordam Ann, Sørli Venke (2005)

Ethical challenges in surgery as narrated by practicing surgeons

BMC Medical Ethics 6:2

Paper II

Torjuul Kirsti, Nordam Ann, Sørli Venke (2005)

Action ethical dilemmas in surgery: an interview study of practicing surgeons

BMC Medical Ethics 6:7

Paper III

Torjuul Kirsti & Sørli Venke (2006)

Nursing is different than medicine: ethical difficulties in the process of care in surgical units

Journal of Advanced Nursing 56 (4):404-413

Paper IV

Torjuul Kirsti, Elstad Ingunn & Sørli Venke (2007)

Compassion and responsibility in surgical care

Nursing Ethics 14(4):522-534

OVERSIKT OVER TIDLIGERE DOKTORGRADSAVHANDLINGER VED PHD-GRADEN I HELSEVITENSKAP DER HOVEDVEILEDER OG/ELLER BIVEILEDER HAR VÆRT ELLER ER ANSATT VED INSTITUTT FOR KLINISK MEDISIN/INSTITUTT FOR HELSE OG OMSORGSFAG, DET HELSEVITENSKAPELIGE FAKULTET, UNIVERSITETET I TROMSØ.

Sissel Lisa Storli – (2007) Living with experiences and memories from being in intensive care. A lifeworld perspective.

Hovedveileder: Professor Kenneth Asplund

Biveileder: Professor Anders Lindseth

Åshild Fause – (2007) Forpleiningen tilfredsstillende. Prisen ligesaa.

Hovedveileder: Førstemanuensis Ingunn Elstad

Gunn Kristin Øberg – (2008) Fysioterapi til for tidlig fødte barn. Om sensitivitet, samhandling og bevegelse.

Hovedveileder: Professor Eline Thornquist

Cathrine Arntzen – (2008) ”Jeg får ikke hendene til å gjøre det de skal gjøre”

Å leve med apraksi etter hjerneslag.

Hovedveileder: Førstemanuensis Ingunn Elstad

Aud-Mari Sohini Fjelltnun (2009) Waiting for nursing home placement:

A study of the life situation of frail elderly and their carers.

Hovedveileder: Førstemanuensis Ketil Normann

Biveileder: Førstemanuensis Nils Henriksen

Liv Wergeland Sørbye – (2009) Frail homebound elderly: basic nursing challenges of home care. A comparative study across 11 sites in Europe

Hovedveileder: Professor Astrid Norberg

Biveileder: Professor Torunn Hamran

Gudrun Nilsen (2009) Smerter under Nordlyset. Den vanlige lidelsen. Det uvanlige livet.

Hovedveileder: Professor Ingunn Elstad

Elin Damsgård (2010) Activity related pain in patients with musculoskeletal disorders. An explorative study.

Biveileder: Professor Torunn Hamran



Trykk: Tromsprodukt - 40 00 72 00

ISBN 978-82-7589-258-2