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ORIGINAL ARTICLE

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RESPONDER: A qualitative study of ethical issues faced by critical care nurses during the COVID-19 pandemic

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Abstract

Aims: To identify and understand ethical challenges arising during COVID-19 in intensive care and nurses' perceptions of how they made "good" decisions and provided "good" care when faced with ethical challenges and use of moral resilience.

Background: Little is known about the ethical challenges that nurses faced during the COVID-19 pandemic and ways they responded.

Design: Qualitative, descriptive free-text surveys and semi-structured interviews, underpinned by appreciative inquiry.

Methods: Nurses working in intensive care in one academic quaternary care centre and three community hospitals in Midwest United States were invited to participate. In total, 49 participants completed free-text surveys, and seven participants completed interviews. Data were analysed using content analysis.

Results: Five themes captured ethical challenges: implementation of the visitation policy; patients dying alone; surrogate decision-making; diminished safety and quality of care; and imbalance and injustice between professionals. Four themes captured nurses' responses: personal strength and values, problem-solving, teamwork and peer support and resources.

Conclusions: Ethical challenges were not novel but were amplified due to repeated occurrence and duration. Some nurses' demonstrated capacities for moral resilience, but none described drawing on all four capacities.

Implications for Nursing Management: Nurse managers would benefit from greater ethics training to support their nursing teams.

KEYWORDS
bioethics, COVID-19, ethics, intensive care, moral resilience, nursing ethics

1 | BACKGROUND

Nurses have been at the forefront of responses to the SARS-CoV-2 (COVID-19) pandemic. Nurses adapted to the ever-changing environmental circumstances, cared for patients with a novel respiratory disease for which there was little clinical guidance and dealt with an overwhelming number of high acuity patients. In the United States, between 1 August 2020 and 13 February 2022, 4,449,166 individuals were hospitalized due to COVID-19, and intensive care unit (ICU) admissions ranged from 14.8% to 37.5% (AHA, 2022; COVID-NET Network, 2022). Nurses provided medically complex care, including proning and extracorporeal membrane oxygenation, and were witness to ongoing suffering and death during a time when they were challenged by staffing shortages that compromised safe, high-quality care.

The pandemic generated ethical questions that were previously less frequently encountered in the United States such as fair distribution of scarce resources, maintaining safety of health care workers when personnel and protective equipment were limited, and expanding hospital capacity (Truog et al., 2020). Less is known about the particular ethical challenges encountered by ICU nurses during the pandemic and the way in which they aimed to overcome them. Researchers captured the negative impact of the pandemic on nurses, for example, additional stress and anxiety that resembled post-traumatic stress disorder (Couper et al., 2022; Saragih et al., 2021) and moral distress (Silverman et al., 2021). Moral distress is the psychological distress that occurs when nurses encounter morally challenging situations and can arise when nurses feel unprepared to address ethically complex situations (Morley et al., 2020).

In recent systematic reviews, authors discussed interventions developed in response to moral distress. Interventions included reflective debriefs, mindfulness exercises, yoga, ethics education and programmes to build moral resilience (Imbulana et al., 2021; Morley et al., 2021). Moral resilience is "an individual's ability to sustain or restore [their] integrity in response to moral complexity, confusion, anguish or setbacks" (p. 581, Young & Rushton, 2017). Building capacity for moral resilience is thought to enable individuals to pause, listen, develop awareness of ethical issues, engage in ethical analysis and engage in strategies to support one's own well-being (Rushton, 2018). Exercising moral resilience may enable an individual to overcome ethical challenges productively and mediate the negative effects of moral distress (Spilg et al., 2022). Moral resilience is constructed of multiple capacities but when constructing the Rushton Moral Resilience Scale to empirically capture moral resilience, Heinze et al. (2021) focused on four domains: personal integrity, relational integrity, moral efficacy and response to moral adversity. Since these are considered to be measurable, these core domains will be the focus of our analysis.

The aims of this study were to identify and understand: ethical challenges nurses encountered during COVID-19 in the ICU; nurses' perceptions of how they made "good" decisions and provided 'good' care when faced with ethical challenges; and whether nurses drew upon moral resilience to overcome ethical challenges encountered. For the purpose of this study, ethical challenges were defined as situations that (a) gave nurses cause for professional concern or (b) made it difficult to decide the right action to take. We did not define a "good decision" or "good care" to enable participants to bring their own understanding of terms when responding. Exploring perceptions of perceived good decisions enabled us to learn about possible moral resilience strategies that supported decision-making and action and whether moral resilience was a quality that participants drew upon in response to ethical challenges encountered.

2 | METHODS

The RESPONDER (Responding to Ethical Issues during the COVID-19 Pandemic and Operationalizing Nurses Insights to Develop Ethical Resilience) study used a qualitative design of narrative survey responses and one-time semi-structured interviews, analysed using summative content analysis. The project was underpinned by the theoretical perspective of appreciative inquiry that takes a strength-based approach to consider how we might improve contexts and processes (Trajkovski et al., 2013). Rather than focusing on deficits, appreciative inquiry assumes that good clinical practice exists. The RESPONDER study was developed by international nursing scholars (including the first author) to explore the impact of the pandemic on ICU nurses. Individuals within the collaboration gave permission for investigators to conduct local research when funding for international collaboration was not granted. Reporting adheres to the consolidated criteria for reporting qualitative studies (COREQ) guidelines (Tong et al., 2007).

2.1 | Ethical considerations

The health system institutional review board gave approval to conduct the study (#21-284).

2.2 | Setting and sample

Research was conducted at a large academic quaternary care medical centre and three community hospitals in the Midwest United States. Purposive sampling was used to recruit nurses from all adult intensive care units to understand the impact on COVID-cohort units and non-cohort units. Inclusion criteria were nurses who worked in ICU during the recruitment period. In total, 798 nurses met inclusion criteria. The survey link was distributed via email using Research Electronic Data Capture (REDCap) database system, a secure, password protected, Health Insurance Portability and Accountability Act compliant web-based program designed for building and managing web-based projects.

2.3 | Data collection

Qualitative, descriptive free-text surveys were divided into two parts. Part 1 contained six questions to capture short narratives about

nurses' experiences with ethical challenges during COVID-19 and how they responded. Informed by appreciative inquiry, when participants indicated that they had encountered an ethical challenge, they were prompted to provide more detail about what happened, how they made "good" decisions and provided "good" care. Participants could indicate willingness to be contacted to potentially participate in one-time semi-structured interviews to explore the same question in more depth. Survey questions and an interview guide can be found in supporting information, Appendices S1 and S2. Participant demographic data were also collected as part of the survey.

Data were collected between April and October, 2021. The survey participant information sheet was linked at the top of the survey, and participants were informed that completion would be considered consent to participate.

Respondents who indicated willingness to be contacted to participate in an interview provided their email address and were sent the interview participant information sheet. Participants could select face-to-face (using face masks and following social distancing guidance) or virtual using Microsoft Teams. Of the 21 respondents who agreed to be contacted for an interview, five were completed virtually, two in person and 14 did not respond to two email follow ups with requests to finalize a date and time. Interviews were conducted by GM, DC and RF, all of whom had prior training and experience in qualitative research interviewing. Participants were assigned to interviewers to minimize interactions between participants and interviewers who had previously established working relationships. All participants were provided an opportunity to request a different interviewer. Participants were informed that participation was voluntary and they could withdraw their survey contribution without giving a reason for up to 4 weeks following completion. No participants requested their data be withdrawn. Confidentiality was maintained and data were de-identified.

2.4 | Data analysis

Data were analysed using content analysis, a systematic coding and categorization approach to analyse text and identify patterns in words used to develop larger themes (Vaismoradi et al., 2013). Drawing on summative content analysis as described by Hsieh and Shannon (2005), keywords associated with each theme were counted in survey responses. Identifying patterns in word usage enabled us to prioritize and group themes.

The analysis approach was appropriate since data were free text, descriptive responses of varying depth and length from a few sentences to paragraph narratives. Three authors coded the data in REDCap according to the steps described in Table 1. Given how little was known about the ethical challenges experienced by nurses during the COVID-19 pandemic, an inductive data analysis was used. Survey data were coded to generate initial themes. Interviews were analysed to determine whether descriptions of themes needed to be amended or new themes created. One investigator coded in NVivo 11, and two investigators used a colour coding system.

TABLE 1 Data analysis process

Content analysis steps	Application
1. Familiarization with the data.	Reading and re-reading the qualitative survey data and making notes of initial ideas.
2. Generating initial codes.	Making a note of initial ideas and codes in REDCap. Investigators met regularly to review the generation of labels of codes and discussed different interpretations of the data.
3. Identification of key words/ phrases.	Survey data reviewed for frequency of particular keywords and phrases. One investigator conducted searches of words to identify the number of times each word/phrase associated with codes were used. Research team members met to discuss themes to be deprioritized, deleted or combined. Word and phrases were refined and another search of words was conducted.
4. Searching for themes.	Codes identified in the survey data were used to code the interviews and new codes/themes were identified and discussed by the research team. Interpretations were discussed and challenged by investigators to enhance credibility.
5. Generating new codes.	New codes were added that did not fit initial codes. When all codes were identified, all narratives were re-coded to ensure no new codes.
6. Summarizing and refining.	Codes reviewed, summarized and a hierarchy of codes developed based upon frequency and significance.

2.5 | Trustworthiness

To enhance trustworthiness, the research team met weekly to review data interpretations and discuss appropriate terms for coding and theme development. Investigators were not clinical caregivers assigned to deliver patient care; however, they supported teams during the pandemic. As members of the community living through the pandemic, analysing data could be influenced by knowledge of leadership responses in the organization, media and scientific updates. The team practiced reflexivity to minimize the effect of personal experiences on data analysis and interpretation. The team captured reflexive notes in REDCap and shared these reflections and possible biases at research meetings for broader discussion (Rolfe, 2006).

3 | RESULTS

Of the target population of 798 ICU nurses who were invited via email to participate, 49 completed part one of the survey, and 29 completed the demographic and work characteristics section (59.2%).The

majority of participant responders were female ($n = 24$, 82.8%) and worked at a community hospital ($n = 17$, 63.0%). Other characteristics are in Table 2. Of seven participants who completed interviews, five (71.4%) worked at a community hospital; other characteristics are in Table 2.

3.1 | Ethical challenges

3.1.1 | Implementation of the visitation policy

Fourteen nurse participants described challenges associated with implementing the visitation policy, related to both general enforcement and the provision of equitable exceptions. A nurse manager from one community hospital described attempts to make exceptions for compassionate reasons, such as end-of-life scenarios or acute changes in clinical status. This attempt at meeting situational needs was perceived as a "flavor of the day" by another colleague. Participants stated that visitation exception decisions frequently became the responsibility of nurse managers. Some clinical nurses described feeling frustrated that nurse managers took control of visitation decisions (P7, Table 3); however, two nurse managers described their perceptions that clinical nurses preferred that they took responsibility since there was too much ethical complexity, and they "don't really know the right answer."

> [They] asked me what the flavor of the day was in regards to visitation. That was the first time this [healthcare provider] had ever approached me that way, and I was very kind of shocked at first, so I didn't lay down the law like I probably should've … but I was just like "Well there's no 'flavor of the day'. I take every situation, just dig myself into that specific situation. That's the only thing I can do in order to attempt to keep this fair, if we're going to make exceptions to guidelines that we currently have." So sometimes it was one person. Sometimes it was four people that we allowed … I have told our leadership team … one of the biggest challenges for me throughout this entire thing is "my staff are still not willing to make those decisions in regards to visitation. They don't want to be the bad person. They want to support the patient. They want the patient to have somebody to be able to do that for them, and they might not be able to. They want somebody holding that patient's hand, but they also don't want to put themselves at risk. They don't want to put other visitors at risk. They don't really know. We don't really know the right answer. We just try to come up with the best answer that we can with the information that we have, but I find that it's still on me on a daily basis, when those decisions are made." (P3 – interview)

Five participants described their perception that enabling visitation was irresponsible and put the nursing team and public at greater risk of transmission. Participant 39, an experienced clinical nurse, expressed the view that allowing visitation for patients with COVID-19 did not represent the "greatest good":

> The visitation issue is not a specific situation, it's every COVID + patient we have had since the visiting policy was changed; I do not have a say in this decision in my role; I think it is irresponsible to allow contagious COVID patients on high flow oxygen to have visitors who are not fitted for n95 masks, it might be good for that one patient, but it is not good for the visitor and their other contacts. It is not the greatest good for the most people. (P39)

TABLE 2 Participant demographics and work characteristics

Factors[a]	Surveys ($n = 29$)[b]	Interviews ($n = 7$)
Gender, female; *n* (%)	24 (82.8)	7 (100.0)
Highest nursing degree; *n* (%)		
RN/BSN	21 (72.4)	4 (57.1)
MSN/APRN/CNP	6 (20.7)	2 (28.6)
Tenure, years; mean ± standard deviation		
Nursing	12.5 ± 11.1	10.7 ± 9.9
In current unit	8.2 ± 9.0	5.6 ± 1.7
In current health care system	11.5 ± 10.0	9.0 ± 4.2
Primary shift; *n* (%)		
Days	13 (44.8)	6 (85.7)
Nights	9 (31.0)	0 (0.0)
Alternating	7 (24.1)	1 (14.3)
Campus; *n* (%)		
Quaternary care site	10 (37.0)	2 (28.6)
Community site	17 (63.0)	5 (71.4)
Current setting; *n* (%)		
Inpatient	26 (92.9)	7 (100.0)
Outpatient	1 (3.6)	0 (0.0)
Both	1 (3.6)	0 (0.0)
Intensive care unit type		
Medical	15 (51.7)	4 (57.1)
Surgical	2 (6.9)	0 (0.0)
Medical-surgical	7 (24.1)	2 (28.6)
Cardiovascular/coronary	5 (17.2)	1 (14.3)

[a]Missing data by factor: Highest nursing degree: survey $n = 2$; interview $n = 1$; Campus: survey $n = 2$; Current setting: survey $n = 1$.
[b]49 participants completed section one of the survey; 29 provided demographic data.

TABLE 3 Verbatim quotations to support themes

Themes and subthemes	Verbatim quotations to support theme
Implementation of the visitation policy	"Staff is being exposed more and more to COVID positive patients and their visitors … I was the bedside nurse. A patient was positive COVID and their family member was as well. I expressed my concern for my safety, the unit safety and other staff member safety being exposed to the visitor coming to see the patient. Nurse Manager asked me if I was comfortable with the visitor coming in. I said no. The nurse manager ignored my concern and allowed the visitor to come in. This happened to me twice." (P7)
	"I have told our Leadership Team throughout this entire pandemic, I think that was one of the biggest challenges for me throughout this entire thing is 'My staff are still not willing to make those decisions in regards to visitation. They do not want to be the bad person. They want to support the patient. They want the patient to have somebody to be able to do that for them, and they might not be able to. They want somebody holding that patient's hand, but they also do not want to put themselves at risk. They do not want to put other visitors at risk. They do not really know. We do not really know the right answer. We just try to come up with the best answer that we can with the information that we have, but I find that it's still on me on a daily basis, when those decisions are made'." (P2 – interview)
Patients dying alone	"Having patients pass without their loved ones. That still makes me cry thinking of that memory and having to discuss that aspect." (P25)
	"Patients dying in the hospital without any visitors allowed during their last weeks of life early in the pandemic. Absolutely soul crushing." (P33)
	"So I cannot even count how many people. Whose hands I hold, and they I knew that they would rather have their family. You know, I'm holding, you know, an iPad or whatever it was." (P4 – interview)
	"I've had patients who I've watched slowly wither away and die alone." (P34)
Surrogate decision-making	"They tell you the things that are important to them and the people who are important to them and you kind of get stuck in this kind of limbo where you become the patient's emotional support as well as their nursing support so it turns into this thing where you are the only person that goes in that patient's room for 12 hours …. At the same time you have another patient that's in the same exact boat, if not sicker and maybe a third because we have no staff, because everybody left, because everything sucks … And then you take over again in two weeks and they are intubated and they are paralyzed and they are proned and they are getting everything that we can possibly do to keep them oxygenating. And you get to like the 4th or 5th prone and you know that they are not going to recover from this … and it's the family keep saying, 'yeah, keep going'." (P6 – interview)
	"End of life situations in which patient's wishes are unknown or family decisions do not align with patient's wishes." (P39)
	"Lack of family access to be advocates/POA …. When patients cannot speak for themselves or make decisions and family does not have access, they have not been able to see the patient's condition or make adequate decisions on their care." (P10)
	"Ethics not being involved or helping in a situation in which the patient is suffering and their personal wishes are ignored while intubated because the family feels differently." (P36)
Diminished safety and quality of care	"Staffing issues leading to patient safety concerns have been relevant during the last year. It has been challenging for us to be short staffed and try to care for all the patients. Many medication errors and patient safety event have occurred during the last year." (P3)
	"Early in the pandemic, we were making changes to our protocol to limit/prevent exposure to staff – but these changes were at the cost of patient safety." (P46)
	"I feel as though management (unit management and higher) showed that they do NOT care about how safe or unsafe we feel, they do not care about us reaching our limits, and put very little effort into ensuring that our patients were safe, and we were in a good place mentally. We were treated like numbers, and expected to be 'yes' men, and never complain or strive for change. We were expected to take on 2-3 patients at a time that would have been 1:1 prior to COVID." (P14)
	"It was as these resources are stretched, how do you possibly provide the high-quality care that we are trained and know we want to do and want to give? All of those. When you have two-proned, COVID, vented patients and now you are getting a third patient, how do you possibly do all the quality care that you want to for those three patients?" (P1 – interview)
Imbalance and injustice between professionals	"Dealing with physicians who refused to enter COVID rooms or personally communicate with the patients. It then fell on nursing … Most other services and providers did not enter rooms accept in code situations, so the team dynamic was not really enhanced." (P33)
	"I had to work with physicians who were vaccinated first and refused to provide patient care …. I watched a 48 year old man die alone. I asked the Resident on our floor to come pronounce him. He told me that he will not go in the room to pronounce because physicians cannot just go into these rooms and be exposed because 'we need to limit exposures'. He pronounced him from an office on the other side of the unit without looking at him or his monitor." (P34)

(Continues)

TABLE 3 (Continued)

Themes and subthemes	Verbatim quotations to support theme
Personal strength and values	*Good decisions*:
	"I just try to do the best I can for each patient. I try to respect their wishes and see if I can continue to offer the quality of life they desire." (P37)
	"How I was raised. My values." (P4)
	"Personal ethics." (P8)
	Good care:
	"Treating every patient as if they were my family member. Going above and beyond even when it feels like I have little left to give." (P19)
	"Thinking about the care I would want for myself or my family." (P39)
Problem solving	*Good decisions*:
	"Being aware of personal bias" (P26)
	"Time to identify, critically evaluate and choose or accept possible problem solutions" (P30)
	"Experience and critical thinking." (P5)
	"Thinking through the situation and figuring what the appropriate outcome would be" (P16)
	"I try to identify the key stake holders and try to make the best decision with the information that is given to me …" (P2)
Teamwork and peer support	*Good decisions*:
	"The support and collaboration of my co-workers" (P15)
	"Discussing with coworkers and doctors that I respect." (P43)
	Good care:
	"I work with an amazing team in ICU. We all helped each other tremendously. Occasionally, we would get helping hands from other floors and that helped too." (P20)
	"Relying on help from co-workers & managers. Working as a team." (P35)
	"Good staffing and support from nursing assistants." (P38)
Resources	*Good decisions*:
	"Knowing all my resources." (P29)
	"Usually talk it over with the NM. Try to be consistent and stick with established guidelines. If I am following the guidelines then I feel like I am less likely to 'play favorites'." (P40)
	Good care:
	"Having adequate staffing, resource and competent people." (P44)
	"I have no choice but to follow hospital policy. That way it takes me out of the decision making, which would have just caused guilt to an already dire situation." (P20)
	"Good management, resources, personal support from co-workers and family." (P43)

3.1.2 | Patients dying alone

By contrast, eight participants described the negative impact of restricted visitation being that many patients died alone or without family physically present. Some participants described using virtual technology to facilitate goodbyes (also P4, Table 3).

> It's always about having no family members at bedside. Patient's die without family, or die on FaceTime. (P20)

An experienced clinical nurse from a community ICU described taking on additional personal risk to be with a patient as they died but then being chastised by the nurse manager. They describe how a few months later their colleagues received awards of recognition for being with patients as they died. The experience described by participant 6 seemed to negatively impact their perception of the healthcare organization as they described the organization as two-faced.

> … we agreed no one should die alone. However, I was chastised for holding the hand of my patient (being present for 30 min). Within 30 min of the death, I was assigned my 3rd COVID patient and was later chastised for sitting at my patient's bedside, being told, "You had another patient." I questioned my belief about patient's dying alone and how our [department] agreement was dismissed. In sum, it seemed as though "It were a 2-faced image the [hospital] was presenting to the public." Months later, co-workers were receiving "Hero" awards for sitting w/their dying patients. (P6)

3.1.3 | Surrogate decision-making

Nine participants described their perception that surrogates were making decisions that did not reflect the patient's wishes. Participant 1, a clinical nurse working in a community ICU, described feeling that she was "torturing" the patient because family were motivated to see their loved one again.

> Multiple times this year there were situations when family chose to prolong care for patients because they wanted to see their loved one again, and due to the visitation guidelines could not do so. These choices frequently went against a patient's established living will and led to patients suffering on life support that they never wanted … Emotionally as the patients nurse this was frustrating and made me feel like I was abusing or torturing the patient …. Reflecting on these kinds of situation now still cause me distress and make me question if my actions as a nurse were really to help the patient and aligned with the concept of "do no harm" because my conscious tells me that I did hurt these patients. (P1)

In the United States, family are legally recognized as surrogate decision-makers and are obligated to make decisions that reflect the patient's wishes (using either substituted judgement or best interest's standards). Participants 1 and 8 (below) do not explicitly use the term "moral distress" but do describe scenarios in which they experienced moral-constraint distress because they perceived the life-sustaining treatments provided were contrary to the patient's wishes and contributing to the patient's suffering because they were constrained by the surrogates decisions (Fourie, 2015; Morley et al., 2020).

> Patient was a do not resuscitate/do not intubate maxed out on BiPAP [bilevel positive airway pressure support] and developed respiratory arrest. I, the nurse, and the intensivist thoroughly explained the situation to the family and encouraged transition to comfort care, yet the family refused. The patient suffered for another day and a half before she died. I was furious at the family and heartbroken for the patient, she deserved a more dignified death than she received. (P8)

3.1.4 | Diminished safety and quality of care

Eight participants described their perception that resource scarcity impacted safety and quality of care which was most frequently attributed to understaffing. Participant 4, a nurse with 4 years' experience in a community ICU, describes managing three patients and feeling unable to monitor them as frequently as required.

> I think that some of the hardest things we went through ethically was like understaffing, because we're taking care of patients who are at baseline the sickest patients we've probably ever seen, and we're taking care of two or three of those patients. … … I feel like I'm only able to give sometimes, not even half of myself to these people, and I think that … we expressed to management, like how understaffed we were. Other ethical issues we faced were … like rigging equipment … when have you ever heard about having IV tubing outside of a room or a vent outside of the room? We found these to be actually really dangerous situations. (P4 – interview)

Participant 4 described their perception that these challenges exacerbated burnout.

> I felt as if I needed to choose which patient was more important to care for instead of being able to care for. The more frequent moral and ethical decisions to be made while working accelerates burnout tremendously. (P4 – survey)

3.1.5 | Imbalance and injustice between professionals

Five participants described injustice between professionals because physicians were not going into patient rooms and assessing patients, stating that they had to limit their exposure, and yet ICU nurses were frequently in patient rooms. Participant 38, a nurse with 4 years' experience in the coronary ICU, stated:

> Doctors would not want to go into COVID positive rooms and see their patients. … my responsibility is to provide care to my patients. … We had multiple attending's that would not go into patient rooms to assess patients, give updates to patients and families. Things/care was sometimes missed. Nursing spoke to management and unfortunately nothing changed. (P38)

An experienced nurse manager describes her perception that this only occurred at the start of the pandemic and suggests that physicians justified this on the basis of scarcity. Participant 2 describes how the nursing team were overburdened with additional tasks because they were the only ones going into patient rooms.

> The expectation that the providers only went into the room one time per shift definitely impacted the nurses' thoughts on the support that they had. They avoided it [having to go into rooms] at first. Like there aren't as many providers as there are nurses. We have to keep everybody safe. Not only were my nurses doing that,

> they were taking out garbage. They were changing the sharps containers. Everything was being put on them because they were the ones providing the most care at the bedside. (P2 – interview)

3.2 | Responses to ethical challenges

In the following section, illustrative quotations are provided to clarify themes. Additional quotations are found in Table 3.

3.2.1 | "Good" decisions and "good" care

Participants described their responses to ethical challenges by describing how they made "good" decisions and provided "good" care.

3.2.2 | Personal strength and values

Nine participants described drawing upon their own strength and ethical values to make "good" decisions, and eight participants indicated that this enabled them to provide "good" care. Participant 14, a nurse with 5 years' experience in a community ICU, described making decisions that were in the "best interest" of patients, making personal sacrifices to prioritize patient care, and relying upon their own strengths—work ethic and faith—to provide care as if the patient were family.

> I always think in the best interest of the patient. I never turned down an assignment, and always got through my night as best as I could. I spoke out about unsafe situations, and tried to help where I could. My patients are my biggest priority, I skip lunches and breaks to ensure they are safe, my work is done, and they are treated with as much care and respect as I would care for my loved one. (P14)

Six of the nine participants described drawing upon their own personal values to make good decisions on behalf of patients.

> My personal religious beliefs. (P43)

> My ethical and spiritual views that keep me accountable to myself. (P38)

3.2.3 | Problem solving

Nine participants described metacognitive methods to making good decisions and overcoming ethical challenges, for example, critical analysis, introspection, recognizing personal biases, assessing and identifying possible solutions. Participant 1, a nurse with 5 years' experience in a community ICU, describes their process:

> When I am making a decision at work that concerns patient care, my first priority is to always ensure patient safety. This requires me to critically think (what is the problem), plan the next few steps (how can I fix the problem), assess and decide how to utilize resources (what resources do I need and do I actually have those resources, if not what can I do to substitute them), and then acting on my conclusion. (P1)

3.2.4 | Teamwork and peer support

Seven participants described the ways in which peer support and teamwork enabled them to make good decisions.

> Discussing situations with colleagues/management. (P10)

Several participants also indicated seeking input from the interdisciplinary team to make decisions.

> Support of my coworkers and sharing ideas with the interdisciplinary team. (P3)

Fifteen participants provided examples of cohesive teamwork (peer support) that supported nurses' ability to provide good care and overcome COVID-19 challenges.

> I believe my coworkers help more than anything. Without teamwork we would be lost. Hence why understaffing was such an issue. It was hard to have teamwork when each of us were overwhelmed with our patient load. (P14)

3.2.5 | Resources

To make good decisions, 10 participants described drawing upon resources such as policies and consult services to supplement their own problem-solving skills. A nurse manager with 10 years' experience describes consulting the Ethics Consultation Service even when others might be reluctant to and engaging in reflection.

> I'm probably a little bit more confident than others in those situations navigating resources. Like I did not have a problem saying, "We need palliative care on this case," or you know, "The family has a strong religious background. We need spiritual care," or you know we are at this point where I would talk to the physicians

and the advance practice providers. If I could not get them to say "We need to at least have a conversation," if I could not get them to that point, I did not have a problem consulting ethics [the Ethics Consultation Service]. I would like to say that across the board, people are comfortable with that. I do not know that they are. I mean we know that sometimes those resources aren't used as soon as they should, but those were the

TABLE 4 Four facets of moral resilience

Facet of moral resilience	Participant examples
Personal Integrity: moral wholeness that is maintained when an individual is able to maintain their ethical norms, values and commitments when facing adversity.	"How I was raised. My values." (P4) "I spoke out about unsafe situations." (P14) "Right now with COVID and the Delta variant, it's frustrating when you have a patient that's COVID-positive and they do not believe that they are COVID, or they pass away and their family says, 'What did they die from?' and they still do not believe it's COVID. … I'm frustrated that they did not take the steps they could to protect themselves, but I have never been in a position where I'm like 'I'm not gonna take care of them.' … I take my oath very seriously …. But it's never crossed my mind that I'm not gonna take care of them." (P1 – interview) "I always think in the best interest of the patient. I never turned down an assignment, and always got through my night as best as I could. I spoke out about unsafe situations, and tried to help where I could. My patients are my biggest priority, I skip lunches and breaks to ensure they are safe, my work is done, and they are treated with as much care and respect as I would care for my loved one." (P14)
Moral Efficacy: belief and confidence in one's capabilities to effect change in response to ethical challenges even when faced with resistance.	"Being aware of personal bias, consulting ethics if needed, collaborative and respectful conversations, creating an environment where it is okay to speak up." (P26) "We try to spend a little bit of time decompressing, so like yeah, on your drive home you kind of zone out and you try to think about the good things that are happening. There was a couple of patients that did really well and you hold on to those couple of patients and you are like listen I know this thing work out for this patient. You kind of like rationalize it in your mind." (P2 – interview) "We do not really know the right answer. We just try to come up with the best answer that we can with the information that we have, but I find that it's still on me on a daily basis, when those decisions are made. I even hear the Residents and the physicians, 'I have to ask the Nurse Manager', and I'm just like 'I promise you guys can do this. You have all of the information that you need to make these decisions'." (P3 – interview)
Relational Integrity: the ability to enact and promote the patient's values while maintaining a sense of one's own beliefs.	"I just try to do the best I can for each patient. I try to respect their wishes and see if I can continue to offer the quality of life they desire." (P37) "I just try to do the best I can for each patient. I try to respect their wishes and see if I can continue to offer the quality of life they desire." (P37)
Response to Moral Adversity: constructed of "buoyancy" which is the ability to be courageous when faced with ethical challenges; and "self-regulation" which is the ability to recognize one's emotions and behaviours and manage one's response, such as managing strong emotional reactions.	"I think it's important, especially during COVID or working in the ICU, I mean you are gonna have challenging days, weeks, months, and at this point of year, so it is so easy to focus on the negative, but maybe I did have a negative situation like that where this patient had been suffering for two weeks. What did I do to advocate for them? Am I able to answer to myself that, 'Yes, I did everything'? If it's no, then I have to do better tomorrow. And then it's also focusing, for me as a Manager, it was 'What three things did I do well for my team today? What three things did I learn that I need to do for my team?' and then it was, 'What three things did I do well in general for myself, outside of the leader role?' and then 'What do I need? Am I tired? Am I burned out, or do I just need to recharge for a minute?'" (P1 – interview) "Take it day by day, 'cause you do not know what's gonna happen. You might be fine, and you might not', … 'When we get there, we'll get there, but until then, do not try to worry so much'." (P4 – interview)

> routes that I took, and then it was really a matter of me debriefing with myself at the end of the day, because "What can I not control?" and if there's a situation I was uncomfortable with, "Did I do everything I could?" (P1 – interview)

Participant 6, a community ICU nurse with 14 years' experience, describes "obedience" to policies to supplement their problem-solving:

> My experience and logical-mindedness and compassion and "obedience" to policy/agreements/protocol. (P6)

To provide good care, 12 participants stated the importance and need for resources such as equipment, supplies and supportive management. Participants 36, a nurse with 4 years' experience in a community ICU, and one other participant highlighted the inequity between night shift and day shift in regard to access to resources.

> Adequate supplies for cleaning; Safe staffing ratios; Adequate screening with visitors; Additional physician providers for rounding at beginning of day; Additional respiratory staff, especially on nightshift. (P36)

As described in Table 4, we found that some participants narratives mapped onto the four domains of moral resilience (see Table 4), but none of the participants described drawing upon all four. Significantly, we identified only one verbatim quotation that appeared to map onto the notion of relational integrity.

4 | DISCUSSION

This study explored the ethical challenges that nurses working in ICUs encountered during the COVID-19 pandemic. Four of the themes that we identified aligned with challenges reported in recent nursing studies: the ethical complexities related to restricted visitation (McMillan et al., 2021), compromised quality of care, staffing constraints (Maben et al., 2022), patients dying alone (Strang et al., 2020) and perceived injustices between professional role expectations of nurses, physicians and advanced practice providers (Jia et al., 2021).

One novel theme that had not been previously described as an ethical challenge experienced by nurses during the COVID-19 pandemic was surrogate decision-making. Though it has been previously established that surrogate decision-makers often incorrectly predict patient's wishes in various clinical scenarios (Shalowitz et al., 2006), there is limited research that captured nurses' perceptions of this issue during the pandemic. Spalding and Edelstein (2022) found that during the pandemic, uncertainty regarding illness trajectory exacerbated uncertainty about patient wishes amongst surrogate decision-makers. Since nurses in this study described perceptions that patient wishes were unknown or that surrogates decisions did not reflect patient wishes, it may be important to understand that visitation restrictions and surrogates' motivation to see loved ones are powerful motivators of decision making that may reappear in another pandemic. When nurses perceive that surrogates fail to understand the severity of patients' clinical status, they may need to initiate critical conversations that should be interdisciplinary when possible, including using ethics support services. More research is needed to learn the best methods of integrating visual information into decision making when discussions cannot occur in person.

An appreciative inquiry theoretical foundation allowed us to understand how participants overcame ethical challenges by making "good" decisions and providing "good" care. Though very few empirical studies have focused on how nurses made decisions or responded to the ethical challenges they encountered during the pandemic (Aydogdu, 2022), there are research findings available regarding nurses' approaches to ethical decision-making in non-pandemic times (Dierckx de Casterlé et al., 2008; Goethals et al., 2010). Both Dierckx de Casterlé et al. (2008) and Goethals et al. (2010) reported that nurses tended to draw upon preconventional reasoning that tended towards conformity, peer expectations and obedience, and many nurses lacked reflectivity and understanding of patient preferences and values. Similarly, we found that nurses infrequently described appealing to patient's values. Instead, they described drawing upon their own personal strengths and values when making perceived good decisions. As Johnstone and Hutchinson (2015) highlighted, when nurses appeal to their own values this can be problematic since it risks decisions being driven by nurses own values, biases and beliefs rather than by patients. Despite significant barriers to providing quality care, nurses described situations in which they perceived that their personal strengths and values enabled them to provide good care and they verbalized a commitment to treating patients as family members.

Goethals et al. (2010) described how some expert nurses were able to break away from conformist decision-making and behaviours, combining critical thinking and identification of patient needs to identify a pathway forward. Our findings also indicated that a subset of nurses were able to exercise critical thinking skills to make perceived good decisions. Perceived good (high quality) care and good decisions reflected some nurses' ability to overcome moral adversity and address ethical challenges. Nurses would benefit from pre- and post-licensure ethics education that teaches them how to effectively respond to ethical challenges during crisis (and non-crisis) times and would overcome noted variabilities and deficiencies in nurses' ethics education (Hoskins et al., 2018; Robichaux et al., 2022).

By gathering nurses' responses to the ethical challenges encountered, we aimed to understand if nurses drew upon, or exhibited moral resilience. As described by Rushton (2018), moral resilience is constructed of multiple capacities but there are four core, measurable domains that were the focus of our analysis (Heinze et al., 2021). Previous studies have utilized the Rushton Moral Resilience Scale to measure moral resilience and have not reported the results as they relate to the individual domains of moral resilience (Spilg et al., 2022). Since

only one nurse narrative in our study reflected the domain of relational integrity, further research is needed to understand whether nurses are able to exercise particular domains of moral resilience more readily than others. Struggling to exercise relational integrity may be interrelated with nurses' inability to identify patients' values and difficulties with disentangling their own values from patients' values. Finally, it is important to note that we ought not to regard nurses' inability to draw upon ethical reasoning skills and moral resilience as an individual failing but rather this reflects the lack of focus and attention on ethics education in nursing training.

4.1 | Limitations

The total population of ICU nurses was large, and those who participated represented a small sample. Low response rate may be due in part to time limitations and the emotional burden of recalling challenging experiences related to the pandemic. We recruited from one large health care system in the Midwest and while the sample size was reasonable for an exploratory, descriptive study, transferability of the findings may be limited. Overall, some narratives lacked depth, highlighting a limitation of using a survey method. We engaged in

TABLE 5 Implications and recommendations for nurse managers and leaders

Theme	Implications and recommendation for nurse managers and leaders
Ethical challenges in the ICU	
Implementation of the visitation policy	• Nurse managers would benefit from more concrete guidance about how to employ compassionate exceptions equitably. • Health care organizations should gather data to monitor compassionate exceptions to review for bias, especially racial bias.
Patients dying alone	• Some participants described using virtual means to facilitate goodbyes but it is not clear how widely available this technology was. While it is the personal preference of patients and loved ones whether they are comfortable using technology during such an intimate moment, there should be equitable access to this technology.
Surrogate decision-making	• Additional training and education regarding the required standards for surrogate decision-making (substituted judgement and best interests) should be provided to the entire health care team to promote decision-making that reflects patient values.
Diminished safety and quality of care	• Normalizing the impact on safety and quality of care during times of contingency and crisis within organizations should be encouraged so that nurses and other health care workers do not carry guilt about care left undone. • Continuous review of redundant and workflow inefficiencies to preserve the essential safety and quality care characteristics of care valued by patients, families and organization.
Imbalance and injustice between professionals	• While many clinical ICU nurses are primarily responsible for providing direct patient, unnecessary imbalances between health care professionals should be addressed. • If there is guidance in place to reduce interactions with patients who are COVID positive, this guidance should be clear and transparent to mitigate feelings of injustice between professionals.
Strategies and responses to ethical challenges	
Personal strength and values	• While it is admirable that participants were driven by their work ethic and willing to make sacrifices to prioritize patient care, such behaviours risk exhaustion and burnout. Nurses should be reminded to take breaks and leaders be transparent about the fact that some necessary care will be missed because of insufficient staffing and high acuity. • Some participants talked about making decisions for patients based upon their own personal values which indicates there is a need for more robust ethics education.
Problem solving	• Many participants described drawing upon their problem-solving skills, nurse managers and leaders should continue to recognize and cultivate nurses with strong analytical, problem-solving skills.
Teamwork and peer support	• Strong teamwork and peer support were frequently mentioned as crucial for overcoming ethical challenges, nurse managers and leaders should continue to enhance teamwork and recognize and reward strong teams.
Resources	• Nurse managers and leaders should leverage the resources available to them such as palliative medicine and clinical ethics support services to assist with surrogate decision-making. • Many participants described the importance of available policies and evidence-based guidance to reduce the burden of decision-making and to provide good care. It is important for leaders to make these visible and readily accessible for ease of use. • All nurses, nurse managers and leaders need access to supportive resources to help them deal with the stressors of the pandemic.
Moral resilience	• If cultivating moral resilience continues to demonstrate utility as a way to overcome ethical challenges and mitigate the negative effects of moral distress, then it needs to be taught to clinical nurse and nurse managers.

reflexivity during data collection and analysis; however, the relationship of authors to social structures within the institution represents a limitation.

5 | CONCLUSION

We captured ethical challenges encountered by nurses in an ICU setting. Although the challenges were not completely new, they were amplified due to their repeated occurrence and duration. Some nurses' demonstrated capacities for moral resilience, but none described drawing on all four capacities. Nurses described an ability to overcome and address some ethical challenges encountered through teamwork, problem-solving, using resources and drawing on inner strength and values. However, nurses also struggled to disentangle patients' values from their own and use ethical reasoning to inform their decision-making. If cultivating moral resilience continues to demonstrate utility as a way to overcome ethical challenges and mitigate the negative effects of moral distress, it will need to be taught to nurses. One approach might be integrating moral resilience into ethics education and teaching nurses ethical analysis for more robust decision-making.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

We have made a number of specific recommendations for nurse managers and leaders (see Table 5). Our findings suggest that nurse managers would also benefit from more ethics education, guidance and support so that when faced with complex decisions, such as applying compassionate exceptions equitably, they would feel more equipped to communicate their reasoning to others.

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CONFLICT OF INTEREST

All authors declared no conflicts of interest. This single site research was internally funded.

ETHICS STATEMENT

This study was approved by the Cleveland Clinic Institutional Review Board (IRB number 21-284).

AUTHOR CONTRIBUTIONS

GM and NMA wrote the research protocol. GM, DC, RF and MZ analysed the data. All authors contributed to preparing and finalizing the manuscript.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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