INTERNATIONAL PEDIATRIC NURSING

Column Editor: Bonnie Holaday, DNS, RN, FAAN

The Meaning of Being in Ethically Difficult Care Situations in Pediatrics as Narrated by Male Registered Nurses

Venke Sørlie, RNT, MSc
Anders Lindseth, MA
Reidun Førde, MD, PhD
Astrid Norberg, RN, PhD

During the last decades in particular, pediatric care has changed due to the possibilities provided by the fast development of new technology. Sick children in the northern part of Europe now receive more outpatient treatment than earlier children admitted to hospitals and have more serious problems.

Norwegian qualitative interview studies among nine female and 17 male physicians in pediatrics have shown that caring for seriously ill children and the possibilities offered by the technologies available in hospitals create ethical demands that were difficult to meet, and thus put tremendous pressure on health care workers (Sørlie, Lindseth, Udén, & Norberg, 2000; Sørlie, Lindseth, Førde, Lindseth, & Norberg, 2000). A common problem in pediatric wards was that the time spent with patients was taken up mostly by technical tasks, and there was seldom any focus on the quality of contact with patients, parents, and colleagues; thus, an open dialogue between physicians was needed (Sørlie et al., 2000). Ethical problems occurred when life and death decisions had to be taken, sometimes in the absence of sufficient information about the situation (Sørlie et al., 2000), and also when the decision-making process seemed to be prolonged and therefore leading to overtreatment of the child (Sørlie et al., 2000).

Pediatrics in the United States is one of the specialist areas from which male registered nurses (RNs) are almost absent (Glasper & Campbell, 1994). Studies have shown that male RNs in the United States tend to work in areas such as psychiatry, urology, administration, and anesthesiology (Johnston, 1987). In Norway, 13 male RNs were interviewed twice, with a 10-year interval between the interviews, about their reasons for choosing to become nurses, and their experiences and positions within the profession. Eight interviewees had worked as nurses within psychiatric care and 10 had current senior positions (Sørlie, Talseth, & Norberg, 1997).

This study is a part of a comprehensive investigation of the meaning of being in ethically difficult situations in pediatric care as narrated by female and male physicians (Sørlie et al., 2000) and RNs.

Studies concerning ethical problems experienced by RNs and physicians in different fields in health care have been performed in, for example, oncology and internal medicine (Udén, Norberg, Lindseth, & Marhaug, 1992; Lindseth, Marhaug, Norberg, & Udén, 1994), surgical care (Udén, Norberg, & Norberg, 1995), gerontologic care (Norberg, Udén, & André, 1998), intensive care (Söderberg & Norberg, 1993), and in 10 medical specialties in Denmark (Holm, 1997).
Studies have shown that professionals of different gender narrate care situations in different ways (Ford & Lowery, 1986). Studies have shown that there are also differences between professions (Söderberg & Norberg, 1993) and that differences between professions overshadow gender differences (Corley & Seling, 1992; Udén et al., 1992; Norberg & Udén, 1995).

Registered nurses as well as physicians experience many complex ethical problems in their work with children, however, few empiric studies have been undertaken that disclose how professionals think about their experience of being in ethically difficult care situations in pediatrics (Sørlie et al., 2000). As mentioned earlier, there are few male RNs working in pediatrics. This indicates the importance of hearing male voices in a predominantly female working environment.

This study elucidates the meaning of male RNs’ lived experience of being in ethically difficult care situations in pediatric care.

**METHODS**

**Participants**

All male RNs (n = 5) working in various wards within pediatric clinics in two university hospitals in Norway participated in the study. They were aged from 26 to 34 years (median, 32 y), had worked in the pediatric clinics from 1 to 7 years, and in health care from 1 to 11 years.

All the male RNs at both clinics were told about the study at various meetings and were asked to participate by narrating their experiences of situations that had been ethically difficult for them. They were working full time and were on duty when they were interviewed. For reasons of confidentiality, the male RNs’ individual characteristics are not included.

The study was approved by the Ethics Committee of the 5th Health Region of Norway (§41/1991, 31.10.91). The RNs gave their informed consent to participation.

**Interviews**

Tape-recorded narrative interviews were conducted. The interviewees were asked to narrate one or more ethically difficult care situations that they had experienced in their work in the pediatric clinics. Their narratives expressed their experience, and the aim was to understand the meaning of this experience. Only when the interviewer wanted the RN to develop his story or had problems understanding the narration did she ask questions (eg, What did you do, think, or feel then?) (Mishler, 1986, pp. 53–59). The interviewees related more than one narrative each, providing a total of 36 narratives. The interviews lasted from 35 to 60 minutes (mean, 50 min) and were later transcribed verbatim.

**Interpretation**

A method of interpretation inspired by Ricoeur’s phenomenologic hermeneutics (1976, 1982), and developed at the University of Tromsø and Umeå University was used. This method has previously been used by Talseth, Lindseth, Jacobsson, and Norberg (1999) and Söderberg, Gilje, and Norberg (1997, 1999). The interpretation proceeds through phases that constitute a dialectic movement between the whole and the parts of the text and between understanding and explanation. A naive reading is the first surface interpretation of the text as a whole, which provides the direction for further analyses. A structural analysis includes various examinations of the parts of the text to validate or refute the initial understanding obtained in the naive reading. The structural analysis explains in greater detail what has been understood already. An interpreted whole is a critical in-depth interpretation based on the authors’ pre-understanding, the results of the naive reading, and the structural analysis, performed in the light of conceptual frameworks, for the purpose of gaining a deeper understanding of what the text indicates.

A naive reading was made of all the transcribed interviews as a whole, to obtain a first impression of the meaning of the interviewees’ lived experience of being in ethically difficult care situations in their clinical work. This first repeated reading was made as open-mindedly as possible without any analysis of the text. The aim of the first impression of the meaning was to guide the structural analysis.

Then a structural analysis was performed. The interviews were divided into meaning units (ie, one sentence, parts of sentences, or several sentences with a related meaning content). The meaning units were then condensed and subthemes and themes were identified.

Finally, a critical reading was made, that is, the authors’ pre-understanding, the naive reading, and the structural analysis were taken into account and the text was read as a whole and understood in relation to ethical theory and to previous results from investigations into ethical reasoning in nursing care. This interpretation led to the formulation of a comprehensive understanding.
RESULTS AND DISCUSSION

Naive Reading

First and foremost the narratives were focused on the child and the situation of the parents, and secondly on relations between professionals. Helping the child is to do good, that is, lighting the spark of life, providing comfort to the child and to the child’s parents, and consoling and cuddling the child. For these male nurses these were the most important tasks in caring. These aspects of caring were called “the other,” “the other side,” “the other thing,” “the good,” and “soft values and attitudes.”

Saving life by means of advanced technology is necessary and difficult, and might exceed the limits of sound practices. Sometimes it causes the child meaningless pain and suffering. It is a heavy burden for male RNs to remain in these situations because they risk becoming emotionally stunted. They suffer owing to a lack of open communication about their thoughts and feelings both related to seeing and thereby helping the child, and to participating in medical treatment and the difficulty of uniting these two dimensions.

Structural analysis

The 36 narratives concerned care of children with various medical problems (Table 1). An overview of themes that emerged from structure analyses is shown in Table 2.

Saving Life

Not seeing the child

Focusing on diagnosis and treatment. Diagnostics and treatment create a distance to the child. The child is not allowed to die until a diagnosis has been established.

The second example, which immediately comes to my mind, was a very sick child, the skin was peeling, and after a while it developed multiple organic malfunctions. One of the chief physicians said that ‘we cannot stop the treatment, and after all I am the one who is responsible for the treatment and we do not have any diagnosis.’ In the end it was very provoking sort of to look at this poor, little human being and that nobody took responsibility and it is arrogant that we cannot have an open dialogue about it.

The result is that the diagnosis becomes the overwhelming aim of examination.

The child’s breathing was very labored, sort of in a mechanical way. The doctor was still sitting doing the ultrasound, he was a specialist in this field and surely saw what was happening, but did not do anything to intervene, really to help the child. But what happened was that the child suffered spasms and cardiac arrest.

The medical examination in itself takes all the attention.

The child died. We sat down afterwards and talked about what had happened. Then the doctor was sort of preoccupied with explaining what had happened medically, diagnosing massive heart failure.

Focusing on tests and procedures. The child’s suffering becomes secondary to procedures and routines.

Actually there are lot of small episodes every day which I do question. Several times I have discussed with colleagues whether it is necessary to do all this testing, and all the punctures and all the trachea suctioning as often as we do. We could for example coordinate everything at regular intervals. Maybe the best result and what would be the best for the child would be to let it have more peace and quiet.

With good routines, you can actually have plenty of time to attend to ‘the other side’ rather than all the technical stuff.

In communication with parents the child’s well-being becomes secondary to test results.

I experience it as an ethical problem that we nurses prepare for and expect the parents to ask about blood oxygen levels and other laboratory results. It is much more important that we talk about the child, about how the child is doing. It is much more important to give information about the child’s personality and appearance than to show the parents EEG results and the results from blood tests.

Helping the Child

Seeing the child

The interviewees experience that helping the child is more important than saving life although diagnoses and medical knowledge are necessary.

I have been trained as an intensive care nurse and have worked in an intensive care unit which is highly technical—there is a lot of technology—a lot of such stuff. I felt that I could not offer other values, I felt a bit empty, I had shortcomings and had to gain more knowledge of other values, so-called ‘soft values’ and knowledge about children. That is the reason I chose pediatrics. I felt that I would need a lot of it there. Could learn a lot about it, then I would attain a level of knowledge, or a foundation for arguing for my beliefs. Isn’t it true? There are more soft values and soft attitudes, which are taken into consideration in pediatric wards than in intensive care units. That is

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>Number of RNs</th>
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<tbody>
<tr>
<td>Premature child</td>
<td>4</td>
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<tr>
<td>Child with brain damage</td>
<td>4</td>
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<tr>
<td>Child with serious conditions</td>
<td>4</td>
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<tr>
<td>Child with serious heart failure</td>
<td>3</td>
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<tr>
<td>Child with chromosome aberration</td>
<td>1</td>
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the way it is. In an intensive care unit the main issue is maintaining life and the survival of the patient. That is the primary thing.

Interviewees experience that it is wrong to let a child die without trying to help. At least it is possible to comfort the child by touching it with warm hands.

After a while I understood that it was not going to have a good outcome... I felt it was problematic that I didn’t try to communicate with the doctor afterwards about: What is happening now?... That I saw the child was dying... I still think about that situation, I really do. Thinking about what I could have done as a nurse.

Another alternative is to terminate treatment and relieve pain, so a child can be with its parents for the last days of life.

Lighting the spark of life. Mastering technology and knowing routines are the necessary means but not aims in themselves in relation to young sick children.

Routines are dangerous in themselves - if you have to finish all the technical tasks before you can cuddle the child. But you can cuddle the child while you make observations and do technical tasks. I think that is important. It is very important. That strengthens the patient's spark of life.

Maintaining the spark of life. Mastering technology and knowing routines becomes dangerous if RNs do not recognize the really important task of comforting the child. Through contact/closeness to the RNs, the child acquires a sense of safety and security.

Patients who are very ill, and we often have such patients, might not see an end to it, are exhausted from pain and illness, it is not necessarily pain, but protracted disease. I think it is important to maintain the patient’s spark of life. I see it as quite essential, because you have to Without the right technique you do not have the capacity to carry out the ‘other things.’ You can’t do it, because you get so frustrated about everything that is ticking, blinking, and bleeping etc. You become so preoccupied with it, you have to master it and feel secure to be able to give ‘the other.’

Even if the children are lying with a lot of wires attached, the parents can be allowed to apply body lotion to the child’s feet, hands, and face (when they are coming here)... Of course this also means a lot to the parents, it means a lot to be allowed to touch their child, cuddle it, etc. Being allowed to give the child a hug even surrounded by all the machinery. That is possible. The way I see it, the funny thing is that what matters for the children, might matter for the adults.

The parents should have more time with the children... Others feel that they do a better job if the parents are not present, and the children cry a lot then. It is exhausting. But it is exhausting for the staff and not for others. I think it is important for the children to release their feelings, not to have to have pent up feelings. That is why they are crying and that is actually positive, isn’t it?

Seeing parents. Taking care of parents is an important task.

In a way, I think it is very easy to see what the parents feel. They begin to search for words and become insecure and they are often close to tears. If you start talking about what hope there is for the child and begin to talk about the future, etc., they easily break down and cry and then in a way they say what they feel.

There is a need for more male nurses in pediatrics... that would be positive. As a rule, there is one mother and one father. I think that I have something to contribute to both mothers and fathers, but perhaps especially to the fathers. We can have a slightly different dialogue and talk in a slightly different way... I feel that I fill a void... it is difficult caring for patients who cannot express themselves verbally... it is an enormous challenge both to treat those small ones and help them and the relatives who are also a great challenge.

Helping parents is seeing and understanding that they experience a heavy burden, being pulled between hope and hopelessness.

We cannot let the parents lose hope. It might turn out well... that is a difficult situation to maintain. It is also very stressful for both us and the parents. ... There is such a prolonged psychological strain when you get a little hope and then the next day you lose it. Some days pass and you get new hope and then you lose it every time the child’s condition gets worse, it fluctuates, you get some hope, it is destroyed, and you get new hope, and it is destroyed. Over the months gaining hope, yes what shall I say, gaining hope which is broken, but at the same time you clutch at straws, all the time for a long time... You cannot as a parent, even if you see that it is going downhill, you can never give up hope. You somehow don’t have the right to lose hope, and your conscience troubles you because you have ambivalent feelings—you want the child to live, at the same time you wish that the child could be allowed to
Die. Isn’t that true? For the parents there are often ambivalent feelings of hope and hopelessness. Hoping the child will live at the same time wishing it would die. I believe that the idea of wishing your own child’s death is a very difficult feeling.

**Difficult caring tasks**

*Hoping and feeling hopelessness.* Interviewees experience hope, although there is a reverse side and they also experience difficulties in relation to hope. They feel they have to hope despite everything.

Even if the child has severe brain damage, I think it experiences pain. That is one of the most difficult situations for me as a nurse. Being with a patient over a long period of time, you see that this doesn’t look so good, but you hope and you have to. There is hope, but you never know for certain whether the child is going to make it. As time passes you become absolutely convinced that the baby is going to die. But then it might be 2 months before that happens.

The more premature the baby is the less likely it is that it will survive. Maybe one out of 10 survives, is it right then to torment the other nine? I find that very difficult. So many children die, and some children are brain damaged. They half manage and might live for a long time, maybe 7-8 months before they die. They always need respirator treatment.

**Meeting challenges.** Recognizing, meeting, and helping children are important challenges that are difficult to rise to.

To terminate treatment somehow touches on the problem of active euthanasia because turning off a respirator is in a way an active thing to do. I believe it is one of the most difficult situations to be in. I struggle with my own feelings. The most difficult thing about the most premature babies is that you are so close to the limit between life and death. They often have a lot of side effects and there is the issue of inflicting pain and all those difficult things. There are so many who don’t do well. Like—how much pain can you take? How many can you inflict pain on, in order to save a few?

Interviewees emphasize the task of caring by not engaging very much in medical decisions.

Concerning the question of terminating treatment and questions like that, I must say that I do not interfere in these issues. In a way, I can express my opinion, but at the same time I know that it is not my responsibility to make the decision.

The issue of terminating treatment and such issues, when the patients are very sick, then I often feel that the doctors continue the treatment when there is often no doubt that they ought to terminate it. Maybe I am a bit cowardly in not saying when I think it ought to be terminated.

**The real task of caring**

*Combining tasks.* Interviewees wonder if it is really possible to combine medical treatment and nursing care in a good way.

At the outset I think that we sometimes overtreat sick, small premature babies. I have experienced different attitudes concerning treatment, continuing treatment, terminating treatment, and offering pain relief. And it is sort of enormous how much pain we inflict on the baby. He had a miserable prognosis. The baby had all the clinical signs indicating that it is not going to work out and the situation continued for 3 months. Afterwards, what was difficult for me to think about was: What did we subject this poor, little human being to, for those 3 months? It had on earth, punctures and drugs, like huge doses of antibiotics?

*Unifying tasks.* It is possible to unify treating and caring by recognizing the other side of treatment. This other side of treatment is the real task of caring. It is meeting the patients, which means meeting the vulnerable life expressions of the sick patients. It is important to bring comfort to a child expressing pain by using your warm hands. The other side is a prerequisite for saving life.

In an intensive care unit the primary task is to maintain life and ensure the survival of the patient. It is absolutely the primary issue. When I phrase it like this, I do not mean that the patient, whether it is a child or not, can survive exclusively by technical means. I believe that we must do something good, at the same time as we have to do things that hurt the baby. We have to do some good to compensate for all the bad and painful things. The baby must experience something good. We cannot touch them only when we perform procedures. We have to cuddle them otherwise they will simply not survive. I don’t think that children can survive by technical means alone, we are often faced with extremely sick children and a lot of technical equipment which we as nurses are dealing with and then it is difficult to find the time to this other thing too. When you have time, you can’t just grab a cup of coffee, you have to spend it with the child as well, stroking it a little. Even though small children do not understand what is being said, they can listen to the tone of your voice. If they do not understand the words they understand the tone of voice. I believe that. Also the way you touch them, in a secure manner or in an insecure way, moving them around, or do you touch the child in a firm way with warm hands, etc. The communication is very important for establishing a sense of security. Show consideration in all these matters.

In my experience, when you are technically skilled, you see that the technical side is an extremely boring job. What really matters is taking care of the other side. Then you go home with the feeling of having done a good job. Focusing on the other side makes me feel satisfied with my job. I know that I have done a better job, if I leave a patient for whom I have done a good job and who seems satisfied.
Cooperation in care situations

Lacking consolation. Fulfilling medical tasks leads to a lack of time for open dialogues with colleagues and meeting own feelings of grief.

A child died. I was off duty but was called to take care of the parents. It was awfully tough and exhausting. It was a situation that continued to bother me. I had nowhere to turn. It was terribly hard and exhausting, made me cry for several weeks. I had nobody to talk to. I actually went home and tried to call friends and acquaintances. Nobody was at home. It was Sunday and nobody was in. You are not supposed to discuss situations like these with your friends. In these situations you must be offered time with colleagues to talk things through, if not exactly then and there, at least very soon after I can get some support and consolation from them. I struggled with this for several weeks.

Lacking open dialogue. Interviewees miss an open dialogue in the care team.

We don’t have enough time for each other. We divide up and share the tasks, but we should spend more time together, talking about difficult things and taking care of each other.

Interviewees experience a lack of closeness and they miss an open dialogue in which physicians admit that they also experience many situations as unclear and difficult.

I told the doctor: Why can’t we be so honest with each other, say that we can tell when things are difficult. What is provoking is that we refrain from saying anything and a nonchalant attitude develops concerning bringing up ethical problems... I actually miss it, because I do believe that we have the chance in terms of time, during a day... If we could make the doctor sit down and discuss things with us, it is a declaration of trust in us nurses working with the patient 24 hours a day, if a doctor were to sit with a nurse and say: “I also find things difficult.”

Interviewees expressed a fear of becoming too distanced, becoming emotionally stunted, too clever in a way, too concerned with technical tasks, and thus giving insufficient attention to their own feelings and finally becoming burned out.

There is a danger of being too polished. In the sense that you become less and less open. The distance can be too great especially between us [professionals]... If I am not critical enough, I am afraid of becoming stunted, that I will stop reacting, that you become so clever that you cut off your own feelings. That is what I am afraid of... I wish I could preserve the sensitivity and level of reflection I had when I started to work here. It is also important to be sensitive to the patients, the parents, and to my own feelings. I am afraid that I will become burned out, acting as part of a routine...
caring perspective was expressed as being a basic value, which means that caring was the patients' prerequisite for survival, "the child cannot survive exclusively by technical means... We have to coddle them otherwise they will simply not survive." Helping is being close, consoling, and enfolding the other in good and warm hands.

The demand of helping the other may be neglected because obstacles are placed between the child and the helper. Too much focus on treatment, diagnosis, and routines may take precedence over the other, and this was seen as constituting a hindrance to perceiving the appeal from the other to be helped. One male RN had problems for a long time after the event because he did not intervene to help a dying child. "I still think about that situation, I really do. Thinking about what I could have done as a nurse." Why this represented a problem may be that it is about answering or ignoring an appeal from the other or not. To respond to the appeal is to take the other seriously. To perceive the other is to perceive the expression of vulnerability and suffering. Caring, thus, may be a demand put up by the suffering child that must be met.

The male RNs' focus on ethical demands in a caring perspective regarding child and parents can be seen in the light of the ethics of Lögstrup (1997). His ethics concept has been applied within different fields in which treatment and caring for other people are central (eg, nursing and pedagogy) (Christoffersen, 1999 pp. 9–10).

According to Lögstrup (1997), human life always means expressing oneself with the expectation of being met by others. "Regardless of how varied the communication between persons may be, it always involves the risk of one person daring to lay him or herself open to the other in the hope of a response. This is the essence of communication and it is the fundamental phenomenon of ethical life" (p. 17). Using a metaphoric expression, Lögstrup (1997) says that a person in his or her relationship with another person is always "placing something of his own life into the hands of the other person" (p. 16). The other person may keep what we put in his or her hands, or the person may let it fall. In trust we expose ourselves to other persons and therefore we are fundamentally vulnerable as human beings. It is a fact that we have to surrender something of our lives to others. "Therefore, our existence demands of us that we protect the life of the person who has placed his or her trust in us" (p. 17). This ethical demand, however, is unspoken. It "is not vocal but is and remains silent" (p. 22), although it is "implicit in every encounter between persons" (p. 22). So we ourselves have to recognize the vulnerability of the other person who places him/herself in our hands. Such a recognition requires sensitivity, and recognition that we will never be able to meet the demand in such a way that it will end. If we were able to live in perfect trust and unshakable hope, the demand would be completely met. Phenomena such as trust, hope, mercy, charity, openness of speech, frankness, and sympathy Lögstrup (1995) calls "life-manifestations" (p. 89), and he maintains that they represent the ethically good, the answer to the ethical demand, and the foundation of ethics. They are not, however, under our control. We are not in a position to arrange our lives in such a way that the ethical demand comes to an end and ethics thereby become superfluous.

In life we are mutually exposed to each other. Nevertheless, we like to believe "that the rest of us are not part of another person's world" (Lögstrup, 1997, p. 16). But this idea is "completely wrong because we do indeed constitute one another's world and destiny" (p. 16). We wish to think that we are fully independent as human beings, but in some situations in life we cannot protect ourselves from experiencing that we are vulnerable and dependent. Illness is such a situation. It makes it possible to experience very strongly that we are demanded as helpers to meet and care for the vulnerable life expressions of patients, relatives, and also colleagues. John Donne said, "No man is an island entire of himself."

Male nurses emphasized the importance of taking care of the child and the parents. On the one hand, they see the challenges in recognizing, meeting, and helping them, but on the other they emphasize how hard it is to meet these challenges. To be aware of what the "doing good" is, may mean to see what is absent in the particular situation. It is in the absence of the manifestations of life that you become aware of them (eg, the failed trust, mercy, and openness of speech force you to become aware) (Lögstrup, 1982, p. 10).

Seen from the perspective of Lögstrup's (1982, 1995, 1997) ethics, what matters is the person's ability to put the other in the center and take her or him seriously and not whether the person is male or female, physician, or nurse.

Male RNs expressed how demanding it is to believe in the hope of saving the lives of children, although they really do not believe in it. They questioned whether one should really save the life if the chance of it becoming a positive outcome is only one in 10.
Other studies also have shown that professionals miss the existence of open dialogue among the care team (Sørlie et al., 2000a, 2000b).

People do not usually think through that speaking openly is ethical, or that they normally meet the other in openness. Manifestations of life are silent, that is, it is only when they are not there that you become aware of their importance as dimensions of existence. Trust, openness of speech, and mercy belong to what it means to be a human being. If we were only to meet each other with a lack of openness, hatred, lack of mercy, and mistrust, our life would collapse and we would not be able to live (Lögstrup, 1997, p. 17).

Over time the development of distance and lack of openness may lead to the risk of becoming emotionally stunted. It is to neglect and not answer the appeal from the other, it may mean closing oneself to the ethical demand, which may lead to burn out.

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