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Moral resilience through harmonised connectedness in intensive care nursing: a grounded theory study

ABSTRACT

OBJECTIVES

To examine intensive care nurses' main concerns in respect of ethical practice, and to investigate how nurses continue to practise in an ethical way despite challenges in order to offer a conceptualisation of moral resilience.

RESEARCH METHODOLOGY / DESIGN

This qualitative study followed Glaser and Strauss' version of grounded theory. The study was reviewed, and approved, by research ethics committees in Switzerland and in England.

MAIN OUTCOME MEASURES

Data consisted of field notes and in-depth interviews with 16 nurses working in intensive care in Switzerland and memos developed during the analysis. Data analysis followed the constant comparative method. This study took place between 2014 and 2017.

FINDINGS

This study identified new understanding in how intensive care nurses manage their concerns and challenges regarding moral practice. The main category for moral resilience is harmonising connectedness, which represents intensive care nurses' main concern with regard to their moral life, and at the same time, represents the pattern of behaviour in their social interactions and what they yearn for.

CONCLUSIONS

This study offers new insight into intensive care nurses' moral practice, moral resilience and strategies nurses use to achieve moral wellbeing.

Key words:

Moral resilience, classic grounded theory, nursing moral practice, intensive care nursing

IMPLICATION FOR CLINICAL PRACTICE

- *Harmonising connectedness* represents the core of moral resilience

- *Harmonising connectedness* emerged as intensive care nurses' main concern in relation to moral practice and it sets the condition for experiencing moral wellbeing.
- Improving nurses' moral wellbeing should become a priority among education, management and research. This paper offers evidence to guide the promotion of moral resilience and thus of harmonising connectedness.

Main paper

INTRODUCTION

Nursing is an ethical practice and its aim is for the good of patients (Gastmans et al. , 1998). However, nurses' moral practice is not problem-free (Epstein and Delgado, 2010) due to the particular position nurses have within the health care system, institutions and care teams in which they work. An inability to practise care-giving according to one's own moral and ethical principles, beliefs and values can lead to moral distress (Corley, 2002, Hamric, 2012, Jameton, 1984). Moral distress leads to negative consequences for both nurses and patients. However, a European study found the majority of patients would recommend the hospital where they were treated because they appreciate the quality of nursing care that they received (Aiken et al. , 2012). Accordingly, it can be said that the majority of nurses continue to work ethically despite moral challenges. It could be suggested that this may be due to the moral resilience that nurses develop during their work.

Background

Nursing encompasses both practical and moral practice. The field of nursing ethics is now well established with a dedicated international journal in its 26th year (<https://journals.sagepub.com/home/nej>). The field engages with a wide range of philosophical (normative ethics) and empirical (non-normative) approaches. Normative ethics prescribes theories (for example, those which focus on duties, on consequences or on virtues) and principles (for example, respect for autonomy and justice). Non-normative or empirical ethics includes a range of qualitative and quantitative methods. This study draws primarily on insights from virtue ethics and on a qualitative approach to analyse the moral life in nursing practice.

Edwards (2001) asserted that the technical activities of nursing, interpretations, and morality are crucial for nursing practice and represent its 'internal goods'. These internal goods involve virtues such as empathy, honesty, integrity, courage, sense of justice and care (Edwards, 2001). These virtues find their expression in the practice of nursing and are necessary in order to achieve its ultimate goals. Bishop and Scudder (2001) believed these virtues to be necessary in order to be a good nurse, which is defined as one that is concerned for their patients. This concern is integrally related to efficient,

effective and attentive care that fosters patient wellbeing. Armstrong (2007) stated that standards of excellence can only be reached through the exercise of kindness, patience, courage, compassion, justice and respectfulness.

In real life, these goods of excellence sometimes clash with the goods of effectiveness usually pursued by organisations. An example of 'goods incongruence' between institution and nurses is the importance of cost containment strategies and resource reduction set by employers, which can lead directly to an increased workload for nurses and an implicit rationing of nursing care (Aiken et al. , 2013, Schubert et al. , 2013, Sellman, 2011). The conditions of nursing practice, its ethical dimension and the different fields of tension in which nurses have to work, makes avoiding tensions unrealistic.

Moral resilience

There is no single agreed definition of moral resilience. According to Titus (2006) and Oser and Reichenbach (2005), moral resilience represents the source of inhibition for immoral actions and is necessary in order to resist negative external and internal pressures when taking a moral decision.

The two definitions given by Oser and Reichenbach (2005) and Titus (2006) identify proactive characteristics that are important when trying to avoid moral distress. Unfortunately, moral distress is sometimes caused by external constraints that cannot be influenced by the moral agent (the nurse), a shortage of nurses and uncooperative behaviour by patients or family members. Hence, it is possible to say that these two definitions fail to address situations where moral distress arises in circumstances that are beyond the nurse's control. What further emerges from the perspectives offered by Titus (2006), Oser and Reichenbach (2005) is that they are more concerned with the behaviour of an individual taking decisions that affect him or herself, rather than with the behaviour of individuals taking decisions with others and for others.

Lützén and Ewalds-Kvist (2013) define moral resilience as: "a distinctive sense that life is meaningful under every condition" (p. 320). Lützén and Ewalds-Kvist (2013) grounded their definition on Frankl's work, *Man's search for meaning* (2006), in which he describes his experience in a concentration camp. Having goals beyond the traumatic event can be considered as components of resilience. Frankl's work can represent a valid example of resilience and although its connection with moral resilience is less obvious; the idea that there can be protective factors as well as coping strategies in respect to moral distress holds some merit. However, it is questionable if the same protective factors and coping strategies apply in cases of moral distress.

Monteverde (2016) defined moral resilience operationally: "as an outcome based on a change in PMD [*Perceived Moral Distress through the administration of moral distress thermometer*] in a given axis of time" (p. 107). Monteverde (2016) expected moral resilience as a favourable and desirable outcome.

He suggested that providing students and healthcare workers, with a sound knowledge of ethics could ameliorate their moral agency and in best case prevent them from developing moral distress. However, defining moral resilience as an outcome that can be influenced by improving nurses' moral agency through education also presents some challenges. In fact, there are situations that are beyond nurses' control and desire, such as uncooperative patients or family members. In these cases, it is questionable if moral distress can be prevented or if the aim should rather be that of reduce the experience of moral distress.

Finally, Traynor (2017) addresses psychological resilience and he points out that the risk of applying an individualistic perspective to resilience. He argues that charging the individual with too much responsibility, especially in situations where the suffering is provoked by others detrimental. Thus, this individualistic perspective lacks consideration of external, environmental variables, which can be source of suffering.

Given the conditions of nursing practice, its ethical dimension and the different fields of tension in which nurses have to work, it appears evident that concentrating efforts solely on trying to avoid tensions and conflicts is unrealistic.

Thus far, the definitions of moral resilience display some limitations. When these limitations are considered alongside the unique nature of nursing, it must be argued that there is still a need to foster and deepen understanding of the concept of moral resilience among nurses.

METHODS

Aims and objectives

This study was part of the first author's PhD study and aimed to investigate how nurses working in intensive care continue to practise in an ethical way within an environment of pressures, tensions and conflict caused by their particular position within health care teams and services.

The objectives of this study are:

- To examine the main concerns among intensive care nurses in respect of ethical practice.
- To conceptualise the term 'moral resilience'.

Design

Glaser and Strauss' (1967) version of grounded theory guided the design of this study. Grounded theory is recommended to investigate and explain practices and processes when theory is not available or when models are available but were developed and tested on samples and populations

other than those of interest (Creswell, 2007). According to Artinian et al. (2009), in grounded theory researchers are willing to trust that the ways the subjects (in this case nurses) choose to solve their concern (in this case moral concerns) will emerge. The results emerging from this approach are grounded in the data from participants who have experienced the process (Glaser and Strauss, 1967). In classic grounded theory the researcher is invited to immerse her/him self into the data with no preconceptions, this should avoid data being forced into preconceived categories and thus the resulting findings emerge from and are grounded in the data.

The result of Grounded Theory research is a substantive theory, where the substantive theory illustrates and explains the core category of a declared substantive area, its sub-categories and the relationship between them.

Ethical considerations

The study was positively reviewed by three Ethics Committees; a UK University (EUC ref: UEC/2015/004/FHMS), the Cantonal Ethics Committee and the Hospital Research Committee of the Southern Switzerland Hospital Organisation (no reference number was assigned as this study is no subject to the research participants' protection act). Every participant provided informed consent and measures were in place to protect confidentiality. Interviews took place outside the hospital, protecting the confidentiality of the participants with an explanation as to possible exceptions to confidentiality. Interviews transcripts used an alphabetic letter to identify each participant. All data and the signed informed consent forms are kept securely, adhering to all requirements of research ethics.

Sample/Participants

This study took place in Southern Switzerland and it involved all five intensive care units within the territory. The aims of the study were presented by the first author at several intensive care units' staff meetings and potential participants were given an information sheet and a consent form and invited to volunteer. The study was presented by the first author who had no relationship with the intensive care wards and did not know any of the nurses. The presentation of the study lasted 5 minutes during which the first author introduced herself and presented broadly the aim and the scope of the research. A total of 25 nurses contacted the researcher. A total of 16 nurses were interviewed in depth between August 2015 and March 2016. After the fifteenth interview data reached a level of saturation and no new findings emerged. The remaining nine nurses who were not interviewed received an e-mail from the author thanking them and explaining why they would not be required for interview. All nine nurses replied to the e-mail expressing their understanding.

The first four nurses were selected through convenience sampling, on the basis of their accessibility

(Morse, 2007). Theoretical sampling was carried out thereafter, as suggested by Glaser and Strauss (1967), guided by theoretical sensitivity as the core category and its related variables emerged. Theoretical sampling was achieved through adapting the interview questions as subsequent participants were interviewed according to the emerging categories from preliminary analysis.

The sample who participated in this study consisted of fourteen nurses who had attended a residency program in intensive care and two who had interrupted their additional training but were still working in an intensive care unit at the time of the interviews. Eleven participants were women and five were men. Their work experience in intensive care varied between 2 and 30 years.

Data and data collection

The data for this study consisted of interviews and field notes taken during the interviews and during the informal conversation which took place before and after the interviews with participants. The interviews were carried out face-to-face as this mode has the advantage of observing non-verbal communication. The interviews were carried out solely by the first author and lasted between 60 and 90 minutes. Participants were unknown to the researcher before the interviews. The researcher had previous experience in conducting in-depth interviews and experience in intensive care nursing. Having experience in intensive care nursing meant the author kept a study journal to note any prejudices, as suggested by Glaser (1998), enabling them to be explicit and at the same time putting them aside.

The interviews were carried out at the University where the first author worked as a lecturer. The interviews were audio recorded and transcribed verbatim and analysed alongside the field notes. The participants were asked if they wished to check the transcribed interview for comments or corrections and none took up the offer.

The first interviews included very general questions such as 'What are your main concerns during your daily work?'; 'Can you describe how you feel in these situations?'; 'How did you deal with those situations?'; 'How did you cope with these feelings?'.

An important part of the data was represented by memos which the researcher wrote while coding. As the analysis developed, the memos became richer and represented a separate source of data.

Data analysis

Data analysis followed the methodology suggested by Glaser and Strauss (1967), and was carried out simultaneously with data gathering, and determined the theoretical sampling (Figure 1).

Substantive coding was the first step in the data analysis. After having finished the coding of eight interviews and field notes, the analysis focused on comparing incident to incident and code to code in order to arrive at the emergence of categories. A further four interviews were undertaken and the

coding followed the selective coding procedure. During this phase of the study, the memos became more abstract and included not only simple descriptions of categories but possible explanations that emerged from the data. The categories were compared with each other; some categories were merged with others and some relationships between categories were discovered. A further four interviews were carried out followed by selective coding on these transcriptions as well as on the field notes. The last two interviews did not add anything new to the categories as the incidents referred to were interchangeable. At this point, it was clear that data saturation had been reached. A total of 537 codes saturated a total of 34 categories. From this point onwards, the analysis moved to theoretical coding. The aim of this stage of the process was to identify a suitable hypothesis that enabled all the categories to emerge from the data, indicating a relationship between them and thus an explanation for them to exist.

Even though Glaser (1978) did not recommend the use of any software during the study process, the author decided to use ATLAS.ti as this would improve management of data.

FINDINGS

Constant comparative analysis guided this study and it resulted in three categories emerging: *awareness and self-awareness, respect and appreciation and moral life*. The relationship between these three categories was grasped by the core category: *harmonising connectedness* (Figure 2).

Self-awareness and Awareness

Awareness and self-awareness have a role in moral resilience. Awareness and self-awareness find their expression in the continuous process of evaluating what is going on in their daily practice.

In some situation I feel as if my face gets all red, I start sweating [...] but I have learned that I have to breathe deeply, down to below my belly button. This helps me to get my concentration back and I can start thinking again about what is really going on. (Nurse F)

Nurses are always in contact with themselves through self-awareness, which keeps them attentive to their feelings and physical reactions in certain situations. Some of the nurses said that they realise when something is not going as it should and that their connectedness with others is under threat when they become aware of some physical symptoms.

As more as the interviews took place and the category of awareness and self-awareness was explored it became clear that self-confidence is a property of awareness. Self-confidence encourages nurses to listen to their feelings and symptoms. The analysis showed that inner dialogue creates a bridge between self-confidence and self-awareness.

Respect and appreciation two guiding values

Awareness also allows nurses to detect the degree of reciprocity and consistency of respect and appreciation, which represent the two values regulating the daily interactions nurses have within their professional realm.

At the end of the day, I always have that sense of respect for my colleagues; it is not about hierarchy, it's about different competencies, roles and responsibilities. (Nurse A)

When asked, all nurses were able to name their guiding values, and all of the answers put respect and appreciation at the top of the list. From the first interview onwards, the value of respect was seen as very important:

As the code of respect emerged during the interviews, more of its properties became clear and visible. The value of respect should be understood as an overall value, which determines nurses' attitude toward others and themselves.

For me, harmony means that there is respect. I can't agree with all the decisions and everything that is done, and the other persons do not always agree with my decisions and with what I believe is right, but what is important for me is that the other person is heard, it is important to respect the other person, whether this person is a physician or a health care assistant. (Nurse R)

The previous quotation corroborates what already emerged from the interviews, that respect is pivotal for the process of moral resilience. The quotation is defining for the understanding of respect in nurses' moral life and wellbeing.

Respect and appreciation set the condition for moral resilience to happen. The findings show that appreciation represents the antecedent and the consequence of true respect for nurses. Respect is the basis for genuinely harmonising the connectedness nurses have with patients, colleagues and their employer.

Nurses' moral life and moral wellbeing

Nurses' main aims are to achieve and enjoy moral wellbeing. These acknowledgements set the basis for the theory of moral resilience. The point of intersection between private and professional life is represented by nurses' moral life. Nurses' moral life represents the continuum between private and professional life, leading nurses to appreciate the experience of connectedness with others. When asked about the nature of their job, all of the nurses highlighted the moral dimension of nursing.

In reply to the question, 'What constitutes your work?' one nurse answered:

We have a very delicate job, yes because you have to use your intellect. There are so many things you have to pay attention to such as for example the electronic devices [...] Then there is the moral work, you have to pay attention to all these parts of your work, because if you make a mistake or

if you forgot something it stays on your conscience [...] This is the heaviest part because you cannot just switch off. (Nurse H)

The interviews clearly showed that for nurses there is a private life and a professional life, and the interaction between them is made possible by the awareness of moral life. From the first interview, moral life turned out to be the point of intersection between nurses' work and private life, where their roles merged and they perceived their experience as human beings.

That evening I was at peace with my patient, because he was dying in a very quiet way. He was serene, I followed the protocol and I was there, I was touching him, I was caressing him before he died, and I felt fine there. I went home and was happy about what happened; I was able to let my patient have a good death. (Nurse L)

Nurses' moral wellbeing depends on their private and professional moral life because these cannot be separated in the lived experience.

The above reported quotation shows how a positive moral experience can have very pleasant consequences for nurses, even when the situation is emotionally stressful and sad.

It includes three very important points of nurses' moral life: a) the deep sense of the harmonised connectedness that nurses feel with patients and the surrounding world enable favourable conditions for a positive lived experience; b) private and professional moral wellbeing constantly influence each other and the overall wellbeing; and c) professional and private roles merge in morally loaded situations.

The whole theory is built around the core category of harmonising connectedness as it represents the intensive care nurses' main concern in respect to their moral practice and at the same time represents the pattern of behaviour in their social interactions and what nurses yearn for. Moral resilience should be understood as an on-going process in which intensive care nurses engage daily because of the challenges to the nurses' moral life.

Indeed, harmonising connectedness happens within nurses' moral life, which is represented by the intersection between their professional and private life.

Harmonising connectedness

Harmonising connectedness emerged through theoretical coding, therefore it has a high degree of abstraction. Harmonised connectedness represents the nurses' main concern in respect to moral practice and at the same time it represents the pattern of behaviour in their social interactions and what nurses yearn for. The term harmony was introduced by one participant who asserted:

In order to face difficult situations, I need harmony, that is to say that I need a calm environment around me and that everybody is more or less happy. (Nurse P)

Nurses need to feel at peace with the surrounding world and with themselves, throughout the interviews this emerged to be their main concern. In achieving this they experience moral wellbeing. This dimension is shown by their wish to be harmoniously together with partners while maintaining their own personal moral integrity. This acknowledgement is pivotal for the theory of moral resilience because it represents its overall aim. The gerund 'harmonising' has been chosen because it indicates the continuous form of the verb as an on-going activity. The word 'harmonising' refers to the nurses' need for feeling and reciprocity within their connectedness with others and themselves.

Given the dense net of relationships in which nurses are rooted, harmony emerged to refer to the regulation of these relationships where respect and appreciation represent the two guiding values. Connectedness does not necessitate a real relationship between parts; in fact, nurses experience connectedness with their institution, for example, which is not a person. Furthermore, it does not only refer to the regulation of relationships, but it also refers to the integrity of the nurses and to the connection that nurses maintain between them as professionals, and as people between their competences and their role and between their private and professional life. Connectedness is constantly evaluated by nurses through awareness and self-awareness. The word 'harmonising' refers to the nurses' need for feeling and reciprocity within their connectedness with others and themselves. For instance, it is not the intensity or closeness of the connectedness that play an important role but rather the equality of the guiding moral values and the reciprocity of the emotional and energetic investment in the experience. Hence, what emerged is that nurses strive to achieve harmony and maintain connectedness.

DISCUSSION

Harmony has been discussed mainly in Asian nursing literature, where it represents an important value for society (Horton et al. , 2007). Harmony represents the most important virtue in Confucianism where it is indispensable for a peaceful life among individuals (Yao, 2000). A parallel can be drawn between this conception of harmony and the one that emerged from the data within this study. According to the intensive care nurses, harmony in connectedness with others satisfies the need for peace with the surrounding world and with themselves, as it regulates reciprocity.

One of the main sub-categories emerged as awareness, with self-awareness a major part of it. Self-awareness and awareness in general set the indispensable conditions for harmonised connectedness to occur. Awareness is essential to establish connectedness between nurses and their partners. This finding has been supported by Varcoe et al. (2004) who described nursing as 'working in-betweens'. By saying this, they do not only refer to professionals who operate in the healthcare system but also refer to different values that guide them. In order to be able to recognise these values, as well as their

position in the healthcare system, awareness is pivotal for nurses (Varcoe et al. 2004). From the data, it became clear that awareness changes over time due to experience and personal knowledge.

In the literature, awareness of moral issues has been defined as moral sensitivity (Lützn et al. , 2006). They claim the concept of self-awareness to be pivotal for ethical sensitivity because it allows nurses to recognise their role and responsibilities in a given situation. For intensive care nurses, awareness and self-awareness transpired to be a constant component in nurses' moral life, and thus in the theory of moral resilience, providing new knowledge in this respect, as from the data it emerged that reflection is carried out through inner dialogue and both are properties of moral resilience.

The main instrument that nurses use for ethical reasoning and achieving and maintaining a harmonised connectedness with themselves and their surrounding world was recognised to be inner dialogue, which in turn is closely related to awareness and self-awareness; this last finding is supported by the literature (Alderson-Day and Fernyhough, 2015). The finding that inner dialogue is important when managing moral issues is supported by Laabs (2011). Hence, this discussion leads to the assumption that awareness, self-awareness and thus moral sensitivity, which is facilitated by inner dialogue, are pivotal for nurses' moral resilience.

The characteristics of 'harmonised connectedness' include equality in guiding values and reciprocity of emotional and energetic effort. Harmonised connectedness represents a state of grace that nurses aim to reach and maintain. This is demonstrated by the continuous process of evaluating others' positions, expectations and guiding values in an attempt to reach harmony in terms of reciprocity through moral resilience. This state of grace is experienced as moral wellbeing.

There are two further conditions that need to be satisfied to achieve harmonised connectedness: respect and appreciation. In this study, it emerged that nurses wish to be both the subject and the object of respect, which is very important to them and is supported by the literature (Gallagher, 2007). Appreciation was seen as closely related to respect, representing an antecedent and an outcome. Appreciation and respect represent a subcategory of harmonising connectedness as both are necessary for moral resilience to exist and permeate the majority of the other categories that constitute the theory of moral resilience.

Appreciation is also discussed in the literature. According to Kantek et al. (2015), appreciation represents the most effective motivational factor for nurses, and according to Abualrub and Al-Zaru (2008), it has a buffering effect on nurses' perceived stress. These findings support those of this study where respect and appreciation allow nurses to carry out emotionally distressing activities while still experiencing moral wellbeing.

Rigour

Glaser and Strauss (1967) asserted that the criteria for rigour in grounded theory are: fit, workability, relevance and modifiability. Later Glaser (1992) added two further criteria for evaluating grounded theory: parsimony and scope.

The criterion 'fit' refers to the ability of the core category to relate to as many other categories as possible and is the dimension of primary concern (Glaser and Strauss, 1967). Examples of narratives are used, though this was not requested by the method and despite every effort made by the authors to present readers with the possibility of partially immersing themselves in the data, the grounded theory does not lend itself to this exercise of reproducibility (Glaser, 1992).

The criterion workability refers to the meaningfulness of the categories that developed from the data and how they are organised into hypotheses that possibly explain the behaviours under study. Every effort was made to highlight the relevance of harmonising connectedness in relation to intensive care nurses' moral practice.

The criterion of modifiability is very difficult to evaluate as at the moment there is no further data that can challenge this theory.

Parsimony refers to the simplicity of the conceptualisation and to the concepts that explain the totality of the variation in minimal ways. This process was carried out during the analysis, when codes were merged and grouped into categories that show a higher level of abstraction.

Finally, according to Glaser and Strauss (1967), scope indicates that the core category relates to the data and that the core category is accountable for what is really happening. In the authors' view, harmonising connectedness is accountable for the nurses' main concern and at the same time represents the main pattern of the behaviours of the participants in this study.

Limitations

A limitation of grounded theory is that even if concepts are grounded in the data, they are not proven but only suggested, while the theory resulting from the analysis is an integrated set of hypotheses (Glaser, 1978).

One further limitation of this study is that the language used in the interviews was Italian while the paper written is in English. Tirozzi (2011) suggests that in classic grounded theory, the process of translation requires the translator to understand the text deeply. The researcher was fluent in Italian and English and although true nuances are often only known in the mother tongue, an impoverishment may still remain within the participant quotes in spite of every effort in translation.

RECOMMENDATIONS

Given the importance of values in the theory of harmonising connectedness, nursing students should

be invited to reflect on their personal values, be introduced to nursing values and more broadly gain insight into unique nursing ethics perspectives. Making values explicit could possibly help students in finding a harmonised connectedness between their personal values and their professional values. Self-awareness and awareness are pivotal in the theory of harmonising connectedness, therefore they should be considered and fostered during nursing education. This can be done through the discussion of real-life situations that represent an ethical challenge (Woods, 2005) and with the help of medical humanities literature where the use of films and narratives as starting points for shared reflections offer opportunities for enhancing moral sensitivity (Shapiro et al. , 2009).

Nurses in their daily practice should be provided with opportunity of continuing education in nursing ethics as well as the chance to participate in ethical case discussions, possibly with the advice of an clinical ethicists. Discussing ethical cases can help nurses in understanding other professionals points of view, enhancing awareness and self-awareness and increasing peer-support (Peter and Liaschenko, 2004).

Further data could be gathered in contexts other than intensive care and other than in southern Switzerland and could be extended to other healthcare professionals in order to gather enough data for a formal theory.

CONCLUSION

This paper offers an insight into what matters to intensive care. Given the tight social net in which intensive care nurses are rooted, harmonising connectedness is pivotal for ethical practice. Harmonising connectedness is an on-going process in which nurses are constantly engaged and which in turn is constantly challenged because of different interests and perspectives of other professionals, patients, or of the institution. The conditions *sine qua non*, which have to be satisfied in order to achieve harmonised connectedness, are reciprocal respect and appreciation and awareness and self-awareness. If these conditions are satisfied, then intensive care achieve harmonising connectedness, which leads to the condition of moral wellbeing. Moral wellbeing emerged as a state of grace in which nurses are able to do well and feel well while acting according to their moral values.

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