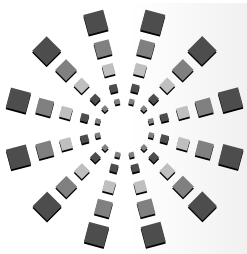

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Ethical and Moral Conflicts in the Nursing Care of Pediatric Patients With Cancer and Their Families

KEY WORDS
Bioethics
Child
Ethical conflict
Family
Moral conflict
Oncology Nursing
Pediatrics

Background: Pediatric oncology nurses encounter ethical and moral dilemmas when providing comprehensive care to pediatric patients with cancer and their families. **Objective:** The aim of this study was to explore ethical and moral conflicts arising in the field of pediatric oncology from the perspective of nursing professionals. **Method:** This qualitative secondary analysis was conducted with 10 nursing professionals from a pediatric cancer hospital through semistructured interviews and analyzed using thematic data analysis. **Results:** Two themes emerged: (1) *living with conflicts intrinsic to the relationships*, which describes multiple sources of conflict in the relationships of nursing professionals with the team, with the family, and with seriously ill children, summarizing trigger-sensitive topics to be addressed for its mediation; (2) *developing moral resilience*, which represents how nurses reframe the conflicts and make use of strategies to avoid being personally harmful. **Conclusions:** The results highlight the challenging work environment of pediatric oncology, recognizing the multiple natures of sensitive topics to nursing professionals during clinical decision making and the incipient strategies in dealing with ethical and moral conflicts. **Implications for Practice:** This study reveals self-reflection and intuitive strategies as protective factors, which could be applied as a step to support nurses encountering ethical and moral conflicts in pediatric oncology daily practice. Furthermore, because of the limited support services for nursing professionals, it is necessary to foresee institutional policies to embrace the development of moral resilience.

There are at least 2 elements in pediatric oncology in which suffering and conflict can arise. These include the manifestation of a life-threatening disease and the fact that this threat is outside the expected course of life because of the patient being a child. Professionals are involved in clinical and ethical decision-making processes, which can be stressful and difficult.[1] Evidence shows that these decisions are associated with high levels of burnout syndrome[1] and moral distress.[2] These consequences, among other causes, are related to the possibility of facing the death of patients during care, subsequently resulting

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in the lack of involvement in a multidisciplinary team-based decision-making process.[2,3]

The care of children with cancer, as well as end-of-life patients, contributes to the development of stress, burnout, and moral distress among health professionals.[4,5] These factors are associated with the emergence of moral dilemmas because they occur when 2 or more clear and applicable moral principles cannot sustain the course of an action, generating ethical questions about what to do, how to act, and on what beliefs and values health professionals should base their clinical practice on. Consequently, these dilemmas are potential generators of ethical conflicts among those involved.[6]

The concepts of morals and ethics are important, and they are related to some extent. The term *ethics* refers to a domain of human knowledge that addresses issues related to making choices between 2 apparently antagonistic paths (right or wrong) according to an external code and social behavior, whereas the morality refers to values based on personal beliefs and character as well as the predominant conduct within groups.[7]

Moral events can involve moral conflicts, tension, uncertainty, dilemma, and limitation; regardless of whether moral events occur in combination with ethical conflicts or they occur as distinct events, they generate moral distress and usually exhibit conceptual similarity.[8,9] Thus, this study explores moral and ethical conflicts together in the context of pediatric oncology nursing.

An integrative review pointed out the importance of knowing the different contexts in which ethical and moral conflicts occur in the international community as well as the need to fill the gaps in the understanding and use of successful conflict resolution strategies.[10] There is a gap regarding the training of nursing professionals in the care of children with cancer in Brazil, as pediatric oncology education is not widespread in nursing curricula.[11,12] This is particularly important considering that several studies have reported that cancer nurses experience ethical dilemmas and moral distress more frequently than nurses in other specialties.[13–15] In pediatric oncology, nurses are at high risk because of the emotional vulnerability and hazards.[16,17] Thus, this study aimed to explore ethical and moral conflicts arising in the field of pediatric oncology from the perspective of nursing professionals.

■ Methods

Type of Study

This was a qualitative, descriptive, and exploratory study conducted in a pediatric cancer hospital in Brazil and was guided by Rushton, Alfred, and Halifax's Framework for Understanding Moral Distress.[18] Qualitative secondary analysis was conducted to explore social phenomena based on data previously collected in semistructured interviews with similar themes.[19] Our primary study had a mixed-methods design that aimed to determine the occurrence of moral distress among oncology nursing professionals. Through the narratives, several situations of ethical and moral conflicts emerged but lacked an in-depth analysis, which was considered for this secondary analysis' study.

Study Participants

The participants were nursing professionals from inpatient and intensive care units (ICUs) of a specialized hospital for children and adolescents with cancer and other hematological or rare diseases. The nursing workforce in Brazil is divided into categories according to their training levels: nurses with a 4-year bachelor's degree and nursing technicians with 2 years of technical education.[20] The inclusion criteria were nursing professionals with experience working in pediatric oncology for at least 6 months. There were 6 nurses and 4 nursing technicians who participated in this study.

Data Collection

Data were collected through interviews for the primary study that took place between June and December 2019 at a pediatric oncology hospital. Before starting the data collection, the study was presented to the coordinators of the units, and the nurses in the units were invited to participate during their shift change on alternate dates and times. The professionals who expressed interest in participating in the study provided their telephone number so that the researcher could contact them to schedule an interview.

The participants chose the location, date, and time for the interview. All participants were interviewed by the author separately at the study hospital in a private room. The interviews were conducted in Portuguese, lasting between 30 and 45 minutes, and were digitally recorded after the participants signed the free and informed consent form. The interviews were then transcribed in their entirety, immediately after their completion. The participants were identified by the letter N (nurses) or NT (nursing technician) followed by Arabic numbers, based on the order of the interviews. For the interviews, a semistructured guide was used, containing questions to elucidate nurses' moral distress, which was the main focus of the primary study, for example, "Tell me about a situation where you experienced moral distress in your practice while caring for children with cancer and their families." "What did you feel?" "What conflicts were involved in these situations?" "What strategies did you use to cope with this situation?"

Ethics Approval

Data collection was initiated after approval by the Research Ethics Committee of the Nursing School of the University of Sao Paulo (no. 2.490.678) and the hospital where the study was conducted (no. 2.571.147). Our study meets the ethical recommendations on research with human beings. All authors had access to deidentified data and deidentified sociodemographic data for each participant.

Data Analysis

Data collection and analysis were continued until the theoretical saturation of the studied phenomenon was obtained.[21] This step was based on thematic analysis that involves searching for themes that can describe the phenomenon investigated. To identify a topic, data analysis with the following phases was performed[22–23]:

(1) familiarization with the data through careful reading and rereading of the data—we reviewed the transcripts of all the interviews, highlighting aspects related to moral and ethical conflicts; (2) initial coding for recognizing units of meaning that could configure codes of analysis—we defined the codes for each interview; (3) identifying themes by grouping codes—we gathered the codes according to their similarities in addressing the research question; and (4) reviewing the themes by verifying the relationship between them and generating a thematic "map" of analysis—we established abstract themes. At this point, we could create themes and subthemes, as shown in the Table: (5) defining and naming the themes by deepening the inferences of the analysis with central definitions for each theme—we reviewed the description of each theme to obtain a concise and clear definition; and (6) production of the report by reviewing the analyses in all previous steps—this phase also included translation and back-translation of the quotes used in the report by a bilingual translator.

All authors of the primary study were involved in the secondary analysis team. To ensure qualitative rigor, we held an audit trail and engaged with data and each analysis step in multiple approaches carried out by different members of the research team; codes and themes were handled separately by 2 members (M.R.S. and L.T.P.S.), who gathered to discuss similarities and differences and illuminate the concepts of the themes and their descriptions. Disagreements were addressed by discussion with other members of the research team (M.M.A., T.A.F., I.N.S., and R.S.) during data analysis meetings.

Results

Ten nursing professionals, that is, 6 nurses (3 working in an inpatient unit and 3 in the ICU) and 4 nursing technicians (2 working in inpatient units and 2 in the ICU) participated in the study. All the participants were women, were aged between 22 and 43 years (median, 37.5 years), and their time working at the institution ranged from 7 months to 11 years (median, 3.5 years).

The analysis yielded 2 themes that described ethical and moral conflicts experienced by oncology nursing professionals while caring for children with cancer and their families: (1) *living with conflicts intrinsic to the relationships*—this theme described multiple sources of conflicts and/or disagreements in the relationships of nursing professionals with the team, with the family, and with seriously ill children. The following subthemes further elaborated on the different dimensions of these conflicts: facing incongruences in the care of seriously ill children, facing powerlessness over family suffering, and facing internal disagreement in teamwork. (2) *Developing moral resilience*—this theme represents how nurses reframed the conflicts and used strategies to avoid being personally harmed, and it revealed ways in which professionals cope with such situations.

Table • Map of the Themes Obtained Through the Thematic Analysis

Research Question	
How do nursing professionals experience ethical and moral conflicts when caring for patients and their families in pediatric oncology?	
THEME	**SUBTHEME**
Living with conflicts intrinsic to the relationships	Facing incongruences in the care of seriously ill child
	Facing powerlessness over family suffering
	Facing internal disagreement in teamwork
Developing moral resilience	

Living With Conflicts Intrinsic to the Relationships

This theme revealed the dimensions of conflicts in the work of the participants with the following subthemes: facing incongruences in the care of seriously ill children, facing powerlessness over family suffering, and facing internal disagreement in teamwork.

FACING INCONGRUENCES IN THE CARE OF SERIOUSLY ILL CHILDREN

The characteristics and particularities that made up the ethical and moral conflicts in the care of children were linked to incongruences related to nurses' ethical and moral judgment regarding the care of a seriously ill child, in contrast with other providers' or families' views. They can also be associated with unresolved feelings in end-of-life care practices and with nurses' beliefs about death and dying of children with cancer.

Nursing professionals experience conflicts regarding the lack of imposition of their assessment, beliefs, and values, according to what they know about the family, in the face of medical decisions. Convincing the family of the medical decision and considering the child's best interest generates guilt and sadness. These responses indicate the harmful environment generated by a prescriptive rather than a tailored and individualized approach in the decision-making process in children's end-of-life care.

> I feel really bad; sometimes, I go home feeling guilty when I see that the doctor asks for something that we know the parents do not agree with, and we often try to convince the family that it is better for their child. They even agree, but this is not easy for me because then I go home and keep thinking. (N2)

There are therapeutic limitations imposed by the disease in which feelings of anguish may emerge amid internal conflicts regarding the child's best interest. Witnessing the families' will for life-sustaining treatment that is no longer appropriate challenges nursing providers who need to activate underdeveloped abilities and resources to open the conversations and mediate the situation with the family, while their moral values regarding the premature finitude of the child are conflicted.

> In oncology, the conflict is because of this: you have to deliver tough care to a child who is dying…and we know that this is happening. At the same time, you have to offer support to the family through cordial clarification even if they do not always agree with it or understand it. (N8)

Death was a substantial factor in the identification of the nature of conflicts, as nursing professionals are very present and involved in the entire process of caring for the child at the end of life and their families. Such conflicts involve profound internal suffering when saying goodbye and experiencing loss and grief, which nurses need to deal with while caring for terminally ill children. Some caring practices have a moral impact as they challenge the set of individual values, such as turning off the child's monitor in the presence of the family.

> We have terminally ill children who come to us at a critical moment in the process, and we have to turn off the monitors; so, it is a very difficult situation for us and for me…It generates discomfort. Sometimes, it becomes a point of conflict with the family; it is tough. (N10)

The care of a child at the end of life is inextricably linked with the system of beliefs and personal values related to the process of health and disease and the finitude of life. Nursing professionals manage care based on their own set of beliefs, which helps them cope with a patient's death. The understanding of death varies based on previous personal and professional experiences and is closely related to each person's worldview. Such beliefs may involve the view of death as an inevitable phase of life, the end of a cycle, or even as a comfort and relief with the end of suffering. Although beliefs exert a protective factor, witnessing the suffering of the child and the family has an impact on the emotional balance of the professionals and challenges the cohesion and management of personal attitudes and values.

> Sometimes dying is a relief…These children fight hard with great suffering […] It is very difficult to see a child, who is very ill, severely ill, dying. The fact itself generates enormous anguish and ends up affecting all our care because everyone is emotionally unwell—the professional, the patient, and the family. (N1)

FACING POWERLESSNESS OVER FAMILY SUFFERING

Nursing plays a prominent role in the care of dying patients and their families, and this has a significant effect on the experience and management of moral conflicts during professional practice. For professionals, experiencing powerlessness in the face of family grief causes enormous anguish, and there are difficulties in managing the care of the child and the family as well as dealing with the feelings and emotions that emerge in these situations.

> When the child dies, we do not know how to cope with it. The family feels lost, with no guidance. I need to think about the family and how to intervene if needed because each one reacts in a certain way […] it is very difficult, and the child's suffering has an impact on you; the suffering of the mother, the father, the family…you will never forget it […]. (N1)

> The child died, and the father simply went to the bedside and stood with her in his arms and screamed that he wanted his daughter back. The mother arrived, and the situation became very, very distressing. There was no one who did not cry; there was no one. Everyone in the unit cried because it was an unbearable situation to manage. (N6)

FACING INTERNAL DISAGREEMENT IN TEAMWORK

Conflicts in the work process were also noted by the participants in their relationships with the team because of internal disagreements. The divergence in the perceptions or related to teamwork between nurses and nursing technicians was highlighted; this divergence impacted the quality of care provided and the nursing professionals' distress and embarrassment. The conflicts were aggravated by individual differences in reasoning and cohesive care planning, affecting interpersonal relationships.

> We must take actions that are not very nice; I don't like making a report about the nursing technician […] I suffer a lot doing it…I had to take an action that I did not want to. It was not a punishment; it was a report for improvement, but it could have been seen as if I wanted to harm the person. (N10)

> I feel that I cannot provide care 100% because it does not have continuity. You leave a lot behind due to staff shortage, and the shift hours are for deciding whether to give medication or a shower…you finish your shift, and the next staff start with a lot of things pending, and the nurse knows about this. (NT4)

In the context of pediatric oncology, the nurses felt an absence and even deprivation of freedom to make decisions or act autonomously. Nurses perceived themselves in an uncomfortable and undervalued situation in a culture that undermines their role. They feel their identity or professional practice is impacted by the lack of autonomy in this area, a situation that is intensified when experienced by the nursing technicians.

> I do not feel I have autonomy and I think it is very bad. I feel powerless; I feel very…I don't know. Angry? Angry, that is the word. I never felt so powerless; I never liked to feel powerless. I work and know what I am doing, and even as a nurse, I still need to keep asking for medical authorization even for something simple; it's very uncomfortable. I have worked in other areas with more freedom in caring. (N8)

> There is a power struggle in the hospital; often the doctor—because he is a doctor—chooses how to do things. If he gives an option, even if I do not agree, he will not give in; he will not let me have a say. (N6)

In summary, the various subthemes in this theme showed 4 convergent scenarios related to conflicts: one belongs to a larger sphere related to the culture and conducts established by the institutions, the other dimension of conflict is established through direct contact with the children and families, the other is limited to the nursing staff and their interpersonal relationships at work, and, finally, the other scenario relates to conflicts due to the difficulty in caring for grieving children and families.

Developing Moral Resilience

The conflicts experienced were noted mainly in the context of the child with cancer at the end of life, which was a natural precursor context of suffering for the professionals. As a counterpoint, the

nurses also perceived a positive impact of working in pediatric oncology on their personal and professional life, such as feeling strengthened when facing constant disagreements and challenges.

> Here, we go through very difficult situations. Oncology is an exhausting universe, but I have full conviction that I am stronger today than at the beginning, when I joined in. I think I have learned a lot. (TN4)

The anguish experienced by professionals due to the ethical and moral conflicts arising during practice is related to the inability (real or perceived) of using or applying their moral agency. To cope with these situations, nurses and nursing technicians resort to innate mechanisms to fulfill obligations and commitments, showing limited skills to solve conflicts with no personal harm. Such mechanisms are related to the fact that nurses play an unavoidable role as conflict mediators, given their duties in the management of personnel, care, and work environment.

> I try to be in harmony with the unit and the team, keep calm as much as possible, help in what I can, have a greater understanding, and be close by…it is not every day we are in a good mood, but we have to talk, establish a dialogue, so that the conflict does not escalate, and build a bridge between everyone. (N1)

Developing moral resilience involves recognizing strategies to cope with conflict, and 3 main strategies used by nursing professionals were identified. First (immediately after experiencing the conflict), the professionals chose to move away from the situation and/or environment for reflection and introspection, trying to understand the emergence and root of the discomfort.

Second, a dialogue was held with those involved for understanding the different perspectives and positions regarding the conflict or with someone else from the trust circle to lighten the situation. This movement helps achieve problem-solving options that promote healthy communication. The third and last strategy is a stage of negotiation wherein considerations are made by both parties to agree upon resolution of the conflict, involving the promotion of best care for the child and family and collegiality among professionals. The identified strategies are summarized in the Figure.

> I try to go out a little, drink some water, breathe, and think about how to solve the problem and why that happened; I try to do this…get around the suffering and try to solve it. (N10)

> I always try to talk to the team. I think I need to be as frank as possible but also carefully solve problems through dialogue and effective communication…I seek to be in harmony even with those who are in conflict and listen to both sides because we have a very competent team here… most professionals here are very knowledgeable. (N8)

The management of conflicts in the workplace by nursing professionals aims to bring together the parties involved through dialogue by emphasizing common interests and minimizing differences that may have generated disagreements. To this end, a negotiation is established in which those involved need to reconcile views and reframe conflict through effective communication.

Figure ■ Strategies to cope with conflicts.

In light of the conflicts experienced by nursing professionals while dealing with children at the end of life and the grieving family, we found that their strategies involved individual practices such as moving away from the situation or seeking introspection or social practices such as communication with other team members. One nursing technician said, "I go home and try to compose myself to come back better the next day." (TN5)

■ Discussion

In this study, the theme *living with conflicts intrinsic to the relationships* showed that ethical and moral disagreements arose when caring for seriously ill children and their families, especially during end-of-life care, and in their interpersonal dynamics. These conflicts can influence the use of self-reflection and other intuitive mechanisms as strategies to cope with conflicting situations, which were described in this study in the theme of *developing moral resilience*.

In this study, conflicts were significantly intertwined with the relationship between nurses, healthcare team, the child, and family. The professionals recognized emotions such as anguish, sadness, and anger arising during disagreements in the child's care, but they did not identify the ethical and/or moral aspects involved in such situations. The types of conflicts found in this study are consistent with those reported in the literature, namely, conflicts in the care provided in end-of-life situations, in the construction of power relations in healthcare, in disagreements with medical professionals, and in restrictions imposed by the institutions.[16] We believe that poor specialized training in the Brazilian context combined with nursing shortage may contribute to the lack of ethical and moral awareness in conflicting situations. The literature shows the potential benefit of a care training model to improve pediatric nurses' professional identity and problem-solving ability for dealing with nurse-patient conflicts.[24]

There is a potential harm in the lack of accuracy in recognizing the nature of these conflicts. Furthermore, it weakens opportunities to refine nurses' moral sensitivity in ethical and moral conflicts as well as in the decision-making process in a child's care. Moral sensitivity is understood as an intuitive recognition of the conditions that can expose the patient to vulnerabilities that can be circumvented with an expanded view of the ethical and moral consequences of decision-making processes.[23,25,26]

Professionals who have improved moral sensitivity can better manage ethical dilemmas than those who do not by broadening caring possibilities and clarifying the pathways for ethical decision-making in situations where autonomy is undermined with contradictions and restrictions of choices in light of the prognosis.[27–29] Therefore, we can infer that the limitations of nursing professionals in identifying ethical and moral conflicts can be overcome by strengthening their moral sensitivity.

Considering the child's end-of-life context, another important aspect noticed in this study was the conflicts in interpersonal relationships in the institution's dynamic and interprofessional practices. Considering nurses' historical and social professional identity, they ground their roles in advocating for children with cancer and their families to attenuate suffering through caring and engage in a process of negotiation between families and other healthcare providers.[15,30,31]

This study showed that frequent adoption of divergent positions among members of the nursing team in Brazilian context causes conflicts related to work dynamics, communication within the team, division of labor, and nursing shortage. Evidence supports that a clear definition of roles, identification and discussion of the importance of teamwork, and the provision of protocols that establish limits, functions, and responsibilities contributed to improved relationships among nursing professionals.[32–35] Furthermore, a good ethical climate and manageable workloads have been shown to reduce moral distress among nurses.[27]

The theme *developing moral resilience* elucidated common strategies that nurses adopt to deal with conflicts in their daily routine. Nursing professionals struggle to recognize ethical and moral issues in conflicting situations and to articulate a suitable or systematic confrontation. The lack of accuracy leads to the use of individual strategies, with an intuitive and empirical background, based on the success or failure of previous experiences in handling conflicting situations.

These strategies must be tailored effectively to manage emotions and disagreements arising from ethical and moral conflicts in caring and to negotiate with the team, family, and child, which demands awareness of the cognitive process related with the roots of the conflict. Nursing professionals refrained from engaging in the process for a suitable conflict resolution, mainly due to the great effort expended to alleviate the suffering of the child and the family.[25,34]

In this context, to develop moral resilience, there is a path to be followed that involves the practice of moral agency. This is defined as the ability to act in the face of ethical obligations and commitments in a limited context.[26–28] This concept is often associated with ethical and moral conflicts, especially in pediatric oncology, as it is related to the suffering and anguish experienced by nurses and how they manage to respond to a given conflicting situation.[11,28,35]

Moral agency and moral resilience presuppose the practice of ethically competent care, which enables decision-making processes with moral integrity, despite the individual differences in conflicting situations during the care of children with cancer and their families.[8,9,29] Furthermore, it legitimizes the cognitive arsenals necessary for professionals to advocate for the child's best interests.[11,27,36,37]

This study highlights the challenging work environment of the nursing team of pediatric oncology, given the multiple possible sources of conflicting situations in addition to emotional distress. This scenario requires sensitive topics to be addressed for conflict mediation and to explore resources for developing moral agency and moral resilience in the face of ethical and moral conflicts. Interventions can include continuing education to enhance nurses' moral sensitivity through communication tools and self-reflective practices that enable them to recognize ethical and moral conflicts and manage emotions and feelings of nurses, children, and families.[6,28,37,38]

Our study was limited to the data collected on moral distress among oncology nurses in this secondary analysis, and an in-depth analysis of ethical and moral conflicts faced by nurses is necessary. Nonetheless, this was overcome with a critical analysis of the literature on the topic. In addition, saturation criteria were defined for the primary study, but the rigorous data analysis process allowed us to deeply comprehend the ethical and moral conflicts.

■ Implications for Practice

This study aimed to contribute to the nursing practice and education by allowing nurses to identify the situations in which ethical and moral conflicts are experienced in pediatric oncology and strategies used to deal with them. We found that self-reflection and intuitive mechanisms were protective factors used in daily practice by the nurses. Ensuring the use of strategies in conflicting situations is important to counteract moral distress and improve moral agency and moral resilience.

Considering the actions and characteristics of Brazilian pediatric oncology services, we identified through interviews limited or nonexistent support services for nursing professionals. In this aspect, it is necessary to adapt institutional policies to embrace professionals' moral distress comprehensively. Furthermore, the results alert us to the harmful environment of pediatric oncology, aggravated by shortage of human resources, exhausting work schedules, and high turnover combined with low salary. Systematic confrontation of conflicts must therefore consider improvements in work processes and the dynamics of care provision by nursing technicians and nurses.

The identified strategies to deal with moral and ethical conflicts in pediatric oncology need to be developed at the individual level and broadened at the organizational level for proper conflict resolution and development of nurses' moral sensitivity and moral resilience. This study highlights the need for future research aimed at developing strategies to enhance nurses' moral resilience in pediatric palliative care, end-of-life care, and pediatric oncology and to preserve the integrity of individuals in conflicts inherent to the practice of caring for seriously ill children.

■ Conclusion

The ethical and moral conflicts experienced by nursing professionals in pediatric oncology are mainly linked to the challenge of providing the best possible and morally acceptable care by nurses and nursing technicians. Conflicts associated with the process of dying or complex care demands and limited prognoses stood out, and it is essential to educate nursing professionals regarding death, dying, and bereavement in pediatrics. Furthermore, coping strategies should be recognized, such as those identified in this study: moving away from the situation/withdrawal, introspection, needing to establish dialogue and communication, and trying to reach a negotiation. Because of the vulnerability of nurses in pediatric oncology, there is an urgent need to increase the bioethical education of nurses and to elucidate the role of increased autonomy for nursing professionals, of frequent and intense antagonism between nurses and nursing technicians, and of interpersonal skills. Self-awareness was recognized as a protective factor. Concurrently, measures to support nursing professionals in managing their careers and working conditions must be part of the measures introduced for helping them cope with ethical and moral conflicts in pediatric oncology institutions.

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