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Nurs Ethics 2008; 15; 745

DOI: 10.1177/0969733008095385

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A CROSS-CULTURAL COMPARISON OF NURSES' ETHICAL CONCERNS

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Key words: cross-cultural comparison; ethical dilemmas; nursing ethics; quality of nursing; workplace distress

The aim of this study was to compare Swedish and Chinese nurses' experiences of ethical dilemmas and workplace distress in order to deepen understanding of the challenges neuroscience nurses encounter in different cultures. Qualitative interviews from two previously performed empirical studies in Sweden and China were the basis of this comparative study. Four common content areas were identified in both studies: ethical dilemmas, workplace distress, quality of nursing and managing distress. The themes formulated within each content area were compared and synthesized into novel constellations by means of aggregated concept analysis. Despite wide differences in the two health care systems, the nurse participants had similar experiences with regard to work stress and a demanding work situation. They were struggling with similar ethical dilemmas, which concerned seriously ill patients and the possibilities of providing good care. This indicates the importance of providing nurses with the tools to influence their own work situation and thereby reducing their work-related stress.

Introduction

Health and medical services in Sweden are organized as a uniform, nationwide programme that gives each person the right of access to care based on personal medical needs.¹ The health care system is publicly financed and services are to a high degree publicly provided.^{1,2} However, during approximately the last 20 years the Swedish health care system has undergone fundamental change. Its structure has become more orientated towards provider–purchaser models. In addition, several major organizational health care reforms were carried out during the 1990s, resulting in bed reductions in geriatric and psychiatric care.² Likewise, the health care system in China has undergone radical change since the 1980s owing to a move towards a market economy, leading to significant economic restructuring.³ Ownership of health care facilities has been decentralized⁴ and private practices have become more common.⁵ General access to health care has been restricted during this process and

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the majority of the Chinese people do not have medical insurance coverage. Simultaneously, there has been a transition in the types of illness occurring in China, and the leading cause of death is now chronic disease.⁴

These rapid changes may directly or indirectly influence nurses' working situations in China and Sweden. Increased workplace distress due to a shortage of nursing staff has been described in previous Swedish studies.^{6,7} This scarcity of resources has been the basis for the growth of ethical problems.⁸ Decision making with regard to life-sustaining treatment is another area that gives rise to ethical dilemmas in Sweden.⁹ By way of comparison, the major sources of stress for Chinese nurses are work overload and inadequate staffing, interpersonal relations, and dealing with hospital administration.¹⁰ The current modernization of Chinese society has also been noted to contribute to increased workplace distress in the health care market.¹¹ Pang vividly describes the resulting ethical dilemmas that nurses encounter daily in China.⁴

Our research group has conducted three separate studies¹²⁻¹⁴ on workplace stress and the ethical problems that nurses encounter in Sweden and China. Exploring nursing phenomena among populations with great cultural differences may help to identify and further explore general patterns occurring across cultures. However, only a few cross-cultural comparisons have been performed on nurse-related ethical issues and they have mainly focused on nurses' ethical reasoning^{15,16} or ethical role responsibilities.¹⁷ We have not identified any cross-cultural study that explores the differences in the ethical dilemmas that nurses may encounter in daily practice. Thus our aim was to compare Swedish and Chinese nurses' experiences of ethical dilemmas and workplace distress to deepen our understanding of the common and unique challenges nurses encounter in different cultures, focusing on the demanding field of neuroscience nursing.

Method

The analytical approach used was a form of aggregated concept analysis,¹⁸ in which researchers collect and use findings from other studies. This analysis was performed to attain greater understanding and transferability of the nursing experiences investigated in the present study. The two empirical studies in this comparative analysis^{12,13} used the same research design. They involved recruitment of similar nursing populations in China and Sweden and the same procedures for interviewing and analysing the qualitative data obtained. Schutz's¹⁹ distinction between first- and second-order constructs was applied. First-order constructs were represented by the nurses' experiences during their daily work in each country as described in the previous studies.^{12,13} Second-order constructs were realized in the present study through comparison and synthesis of these empirical results, leading to a higher level of abstraction of the nursing phenomena under study.

Participants

The physicians in charge and the head nurses at the two hospitals concerned gave permission for performance of the two previous studies^{12,13} after being informed of their purpose. Nurse participation was based on informed consent. The data collection in China was restricted to a period of two days and all nurses working day shifts

Table 1 Background data of participating Swedish ($n = 21$) and Chinese nurses ($n = 20$)

Background variable	Swedish nurses ¹³	Chinese nurses ¹²
<i>Age (years)</i>		
Mean (SD)	37 (12.0)	33 (6.8)
Range	24–62	25–47
<i>Civil status: no. (%)</i>		
Married/cohabiting	15 (71)	16 (80)
Living alone	6 (29)	4 (20)
<i>Family members: no. (%)^a</i>		
2 or less	14 (74)	6 (30)
3 or more	5 (26)	14 (70)
<i>Satisfaction with personal finances: no. (%)^a</i>		
Yes	16 (84)	15 (75)
No	3 (16)	5 (25)
<i>Receiving help at home: no. (%)^a</i>		
Partner	9 (47)	12 (60)
Relative(s)/other(s)	3 (16)	8 (40)
<i>Professional nursing education: no. (%)^a</i>		
Diploma	17 (89)	13 (65)
Specialist training	2 (11)	7 (35)
<i>Academic nursing education: no. (%)^a</i>		
Bachelors degree	5 (26)	1 (5)
<i>Years worked in neuroscience nursing</i>		
Mean (SD)	7.7 (9.2)	13.6 (7.6)
Range	0.5–31	3–30
<i>Years worked in nursing</i>		
Mean (SD)	7.7 (10.4)	14.1 (7.3)
Range	1–41	6–30

^aMissing data from two Swedish nurses.

during that time were approached. Twenty of 22 eligible nurses agreed to participate. Likewise in Sweden, all 20 nurses working day shifts in two neurological departments were asked to take part, all but one of whom agreed. Thus a total of 41 nurses made up the final research population, 20 being drawn from two neurological wards at a hospital in China and 21 from two equivalent wards at a university hospital in Sweden. In the written and oral information distributed preceding data collection, it was clearly stated that participation was voluntary and that confidentiality was assured. More details about the sampling procedure are described in the previous studies.^{12,13} Table 1 presents background characteristics of the participating nurses.

Data collection and analysis of first-order constructs

The interviews were carried out in both countries by two of the Swedish researchers (GA and BW) using a conversational format. In China, two Chinese nurses (HZ and LT) were interpreters and the interviews were conducted in English. The interview

guides were the same in both countries with the exception of the language used (Swedish and English, respectively) and consisted of the following questions:

- 1) What upsets you at work?
- 2) When do you feel displeasure at work?
- 3) What situations at work make you sad after a working day?
- 4) Do you experience ethical issues/dilemmas in your work? If yes, can you give an example of a situation in which such an issue/dilemma appeared?
- 5) If yes to question 4, how did you try to cope with it?
- 6) How do you perceive the quality of nursing care in your unit?
- 7) Do you experience a discrepancy between the actual quality of nursing care at your unit and the desirable quality?
- 8) If yes to question 7, how do you try to cope with this discrepancy?
- 9) What in the working environment is an obstacle to resolving ethical issues/dilemmas in your work?

Additional follow-up questions were asked, their scope and number depending on how precisely and fully the person had answered the general questions. The interviews were tape-recorded and typed verbatim, with pauses and expressions of emotion included because these elements were considered important for understanding the content. The typed texts were then analysed using qualitative latent content analysis.^{20,21} The theoretical assumption underlying qualitative content analysis is based on communication theory. This analysis concerns the content and relationship levels of communication. The words (content) also contain in them relationship aspects such as attitudes or intentions. To uncover these aspects is the aim of the interpretative process of latent content analysis. The analytical procedure and the subsequent findings are described more thoroughly in the previous studies.^{12,13}

The second-order constructs – aggregated concept analysis

The analysis commenced with a reading of the findings of the two previous studies^{12,13} to obtain a sense of the whole. Thereafter, the themes identified within each content area of the empirical studies were compared. This process resulted in the identification of both similar and differing themes among the Swedish and Chinese nurses (Table 2). Where substantial similarities were found, a general theme was extracted that would encompass and reflect the essence of the themes from both countries. Where the themes in a content area differed substantially from each other, a unique theme was formulated for the detected differences (Table 2). This synthesis of the findings of the two previous studies^{12,13} increased the level of abstraction, which, according to Estabrooks,¹⁸ leads to a more general understanding of the nursing phenomenon investigated.

Results of the aggregated and comparative analyses

The results are presented in the form of aggregated or common themes, incorporating similar empirical findings from both countries. The unique themes derived from

Table 2 Example of aggregated concept analysis in the content area of ethical dilemmas

Content area	Themes from Swedish nurses' experiences ¹³	Themes from Chinese nurses' experiences ¹²	Common new themes, shared by nurses in both countries	New unique themes, not shared by nurses in both countries
Ethical dilemmas	Conflicting views on right treatment and decision	Conflicting views on optimal treatment and nursing	Conflicting views on the right course of treatment	
	Difficulties in providing for patients' and families' needs, rights, and desires	Misalignment of nursing responsibilities, competence and available resources	Limited power to fulfil the nurses' duty of providing the best care	
	Troublesome decision making on initiation or withdrawal of treatment			Life-sustaining treatment causing moral conflict (Swedish nurses)
		Treatment choice meeting with financial constraints		Patient's financial situation decides treatment level (Chinese nurses)

the narratives of the Swedish and the Chinese nurses are also presented. See Table 3 for information on which content areas contain the common or unique themes.

Aggregated themes combining experiences from both cultures

Conflicting views on the right course of treatment

The nurses in Sweden said that nurses and physicians sometimes held different opinions concerning the right treatment for patients. For example, the physicians decided on further treatment while the nurses thought that the treatment should be terminated. Subsequent frustration and resentment arose because of the conflict of opinion. The nurses and the patients' next of kin could also have conflicting views about the correct course of treatment.

Likewise there were conflicts between nurses, physicians and next of kin in China regarding the right treatment decision for patients. When the nurses voiced a different opinion the physicians did not acknowledge the nurses' professional competence and knowledge about patients' situation, putting them in the difficult position of having to carry out orders they did not consider appropriate and useful. This disrespect also applied to relatives because they often distrusted nurses' professional skills

Table 3 Aggregated and unique themes emerging from Chinese and Swedish nurses' experiences

Content area	Aggregated themes combining experiences from both cultures	Unique themes from Swedish nurses	Unique themes from Chinese nurses
Ethical dilemmas	Conflicting views on the right course of treatment Limited power to fulfil the duty of providing the best care	Life-sustaining treatment causing moral conflict	Patient's financial situation decides treatment level
Workplace distress	High demands and lack of influence Lack of respect and interprofessional communication Nursing seriously ill patients causes high emotional strain		
Quality of nursing	Lack of resources are a hindrance to high quality General satisfaction with the quality of nursing		Recurrent evaluation and improvement of nursing
Managing distress	Collegial communication facilitates nursing Recovery through separation of work and leisure	Controlling stress by reflecting and adjusting	Managing by striving for higher competence Avoiding open conflict to minimize stress

and did not consent to nurses administering the proposed treatment, even when prescribed by a physician. The nurses always attempted to protect patients and would not disclose any patient's health status to a relative against the patient's wishes.

Hence nurses in the two countries were struggling with similar ethical dilemmas resulting from conflicting views regarding appropriate treatment and care. This influenced their working situation and their ability to provide care according to their own ethical opinions. This was more obvious in China because relatives' opinions and decisions about care are also connected to their capacity to finance the care. An important difference with regard to the nature of the existing conflicts was that the Chinese nurses wished to provide substantially more care and treatment for seriously ill and dying patients, while the aggressiveness of treatment in terminal care often caused conflict in Sweden.

Limited power to fulfil the duty of providing the best care

An ethical issue for the nurses in Sweden was the difficulty of upholding the privacy and integrity of patients owing to the lack of single rooms on the wards. The

nurses had ambivalent feelings regarding next of kin's involvement in the care, desiring more family participation in the decision making, but not to the extent that the care was provided on the family's terms.

Having too many patients and not enough time limited the Chinese nurses' ability to provide proper care. In addition, they did not always have the knowledge needed to handle clinical problems or to operate new equipment. Another example of the mismatch between responsibility and capability was in patient education situations when the nurses felt a lack of the necessary competence to support patients adequately.

The nurses in both countries thought that they had too little control over the caring context, which created ethical dilemmas and negatively influenced job performance. The Swedish nurses pointed out patient integrity as the most important area, while the Chinese nurses talked more about their own limited knowledge and capacity.

High demands and lack of influence

The Swedish nurses thought there were insufficient nursing staff in proportion to patients' care needs, which increased the workload and led to professional dissatisfaction and distress, as well as personal exhaustion. They were also dissatisfied with their salary, a new work schedule and frequent reorganizations, none of which they could influence. This unfavourable work situation was experienced as being shaped by political decisions and demands for cost cutting. The Chinese nurses also experienced workplace distress when caring for seriously ill patients, in addition to having a demanding workload. They often had to manage on their own, prioritizing tasks and doing their best despite a sense of powerlessness because usually they could not influence medical care decisions. This made them angry and frustrated, particularly when they received unfair criticism in difficult cases. A shortage of resources and the demanding workload made it difficult to meet the standards of good care and at the same time comply with all the rules and regulations.

Lack of respect and interprofessional communication

A feeling of not being respected or listened to as professionals was common among the nurses in Sweden. This lack of respect and communication was thought to be a result of the hierarchical medical system. In addition there was a lack of understanding between nurses and assistant nurses regarding their respective professional roles and responsibilities, which could sometimes result in conflict. This professional conflict among medical staff upset the nurses. Co-operation with municipal health care managers concerning patients' aftercare was likewise characterized as inadequate because the nurses did not feel their opinions were valued or that they could influence decisions concerning patients' aftercare.

In China the nurses' experiences were very similar, the main complaint being a lack of respect for them as professionals on the part of physicians, which created frustration and discontent. They described many situations in which patients or relatives did not understand and respect their professional knowledge, leading to conflict that interfered with care. The Chinese nurses still tried hard to follow directions and kept the best interests of the patients at heart even though seldom receiving appropriate appreciation. These tough working conditions were believed to be a direct consequence of nurses' low social standing in China.

Nursing seriously ill patients causes emotional strain

The care of young and seriously ill patients was a significant factor that affected the Swedish nurses. They found it very demanding mentally to take care of these patients.

The same pattern was revealed in China, where nurses said they felt sad and helpless, especially when there was a young patient with a terminal disease. They also explained that it was very hard when access to care and treatment was limited, even for seriously ill patients, because of insufficient health insurance. Another source of mental strain was the fear of making mistakes, especially failing to stay focused in urgent situations with critically ill patients.

Lack of resources a hindrance to high quality

The quality of nursing was thought by the Swedish nurses to be dependent on the workload and the number of staff working. Sometimes the nurses felt they did not have time to talk properly to the patients and indeed could not always give them basic care. Changing working conditions (such as new work schedules that would result in poorer continuity in caring) and a future reorganization of the clinic were other factors cited by these nurses as causing the quality of nursing care to deteriorate.

Similarly, the Chinese nurses were of the opinion that the shortage of nurses diminished the quality of care provided. Lack of time and resources meant that patients sometimes had to wait a long time before their bell calls were answered and seldom had the chance to talk to the nurses about their feelings. Another challenge was a lack of knowledge and training when it came to operating new equipment, which meant that other nurses had to provide help, thus reducing the time available for patients. Improved hospital management was considered a prerequisite for higher nursing quality because the Chinese management system was experienced as too bureaucratic and hierarchical.

General satisfaction with the quality of nursing

The general nursing quality was still judged as being high by a large majority of the Swedish nurses. Factors that contributed to this high quality were well-qualified nurses with specialized knowledge about neurological diseases and a holistic view of patients, as well as interprofessional teamwork. The nurses received praise from patients and families. Individualized care, information and the involvement of patients and relatives in care planning meetings was an important part of delivering high quality nursing care.

The Chinese nurses emphasized the importance of being flexible in order to provide nursing care in accordance with patients' needs, and of treating patients with empathy. However, more nurses were needed to achieve a higher quality of care. Another way of raising quality was considered to be by means of yearly examinations and continuing education for nurses. The Chinese nurses were also self-critical and expressed the need for a change of attitude towards patients, who needed to be seen as whole persons and not just as bodies.

The nurses' description of good quality in nursing care included the same parameters in both countries. However, the Chinese nurses were more self-critical and thought that there was a need for an increase in their skills and knowledge levels in

addition to the employment of more nurses. The nurses in Sweden also pointed out that the systematic involvement of patients and relatives in care is a prerequisite for high quality nursing.

Collegial communication facilitates nursing

It was of great value for Swedish nurses to have the opportunity to talk to colleagues about ethically difficult situations. The conversations usually took place during coffee breaks or when reporting to the next shift. A more formal meeting was also organized when there was a situation that involved the whole staff: nurses, physicians and, when necessary, the medical social worker. The subject for discussion was often decisions about life-sustaining treatment.

In China the nurses were striving for better communication and improved co-operation. Communication and the exchange of nursing knowledge at regular case meetings was seen as a way of spreading expert nursing practices throughout the hospital, which would benefit patients in all departments. In addition, the importance of a good working relationship between nurses and physicians was stressed. The physicians could be called upon to explain the benefits of treatment to patients and relatives. However, relationships with the physicians were problematic and nurses told of situations where they felt it their responsibility to initiate communication with physicians in order to prevent misunderstanding.

Recovery through separation of work and leisure

Allowing problems and concerns for patients to remain at work was a way to manage work distress for the Swedish nurses. Even if they regarded it as important not to let the work influence their private life, it was nevertheless hard to let go of certain issues related to patients. At these times the nurses talked to family or friends to achieve some release from this kind of work-related stress. They emphasized that their spare time was important for seeking new strength and that it should include time for relaxation.

The Chinese nurses also said that they coped with work stress by relaxing and doing things they liked in their free time. If they needed to talk about their experiences, friends and family encouraged them to do so and gave their support. Pondering on the events of the day was also important.

Unique themes found in Sweden

Life-sustaining treatment causing moral conflict

The Swedish nurses said that ethical dilemmas often concerned initiating or withdrawing a certain life-sustaining treatment, especially as the physicians did not often include the nurses in the decision-making process. The issue was whether the patient would benefit from the treatment or be caused pain or prolonged suffering. Their lack of influence on treatment decisions and physicians' vacillation between active treatment and no treatment at all were emotionally difficult to bear.

Controlling stress by reflecting and adjusting

The nurses accepted a treatment or care decision made by a physician or social welfare officer, but they did not always agree with it. They expressed their opinion even when they knew that it would not change the decision, feeling it important to make their own view clear as a means of accepting the decision.

The Swedish nurses also said that they used reflection and past experiences to help manage a difficult situation, sometimes looking at it from another person's point of view in order to shed new light on it. They always did their best and at the same time did not see themselves as irreplaceable, trusting others to take care of unfinished nursing tasks. When the situation involved decision making with regard to life-sustaining treatment it could be helpful to have a holistic view of patients in order to understand the physician's decision and to uphold the patient's dignity.

Unique themes found in China*Patients' financial situation decides treatment level*

The nurses in China found themselves in a serious ethical predicament when patients or relatives could not afford vitally needed treatment. In such situations they felt helpless and frustrated because they knew they could have helped patients. Against this background the Chinese nurses expressed the opinion that the present health care system was unfair, privileging patients with the financial means to pay for their treatment and care (Table 3).

Recurrent evaluation and improvement of nursing

In China the quality of care was continually measured and evaluated in terms of patient recovery, lack of complications and patients' and relatives' satisfaction with the care received. Nursing actions emanated from the diagnosis and the nursing plan. The nurses therefore carefully checked the condition of all patients' every morning and, if problems were detected, nursing interventions were carried out. Treating pressure sores was a priority that required constant observation. The head nurses' and physicians' acceptance of the care was a good measure of the nursing quality achieved. In addition, the nurses' lack of knowledge and training was perceived as directly influencing the quality of care provided.

Managing by striving for higher competence

The Chinese nurses emphasized that greater competence was important and they were continually striving to update and improve their nursing skills through further education. As nursing is a profession in its own right, there was also a growing awareness of the importance of not solely relying on physicians' opinions on matters related to nursing and of being more patient focused in order to raise the quality of nursing and improve the future work situation.

Avoiding open conflicts to minimize stress

The Chinese nurses said that they avoided job conflict by being acquiescent. They considered it important to retain a positive and calm attitude towards patients at all

times despite being upset, in order to attempt to reduce stress in the working environment. Acquiescence was also often used as a coping strategy when nurses had to follow physicians' orders despite having different opinions or when giving in to relatives' suggestions to avert a dispute.

Discussion

The aim of the present study was to compare Swedish and Chinese nurses' experiences of workplace distress and ethical dilemmas in a neurological setting to deepen our understanding of the challenges neuroscience nurses encounter in different cultures. In spite of wide differences in the two health care systems,^{1,2,4} both the Swedish and Chinese nurses had very similar experiences. However, some differences were also found.

Caring for seriously ill patients, especially young adults, was a factor that strongly affected the nurses' working situation in both countries and resulted in emotional strain. This is in line with the findings of previous studies.²²⁻²⁵ In addition, Xianyu and Lambert²⁶ argue that nurses in China have traditionally not received sufficient education on how to deal with death or dying and do not know how to express their emotions when they encounter and care for dying patients.

In both China and Sweden, the nurses did not always agree with the treatment prescribed by the physicians and therefore faced ethical dilemmas. This influenced their working situation and their ability to provide care in accordance with their own ethical views. This result has also been described in reports of previous studies.^{8,27} Redman and Fry²⁸ point out that nurses comprise an especially vulnerable group with regard to these kinds of ethical dilemmas, in that they have great care responsibilities but limited power to make decisions about the care. Regarding the nature of existing conflicts between nurses and physicians in the case of the present study, one difference identified was that the Chinese nurses wished to provide substantially more care and treatment for seriously ill and dying patients. In Sweden the aggressiveness of treatment in end-of-life care was instead often the cause of conflict. This perceived overuse of life-sustaining treatments for patients with a poor prognosis has also been reported in previous studies.^{29,30} In Sweden the treatment given depends on the medical needs of patients,¹ while in China it depends in part on patients' financial means and the chances of the treatment being successful.⁴ Thus, the Chinese nurses spoke of finding themselves in a serious ethical predicament when patients or relatives could not afford the requisite treatment. In such situations, the nurses felt helpless and frustrated because they knew that these patients could have been helped. This has also been found in nurses working in western countries.²⁸ MacDonald²⁷ highlights in her review the ethical problems experienced by nurses that are related to institutional or health policy constraints.

Another marked difference is that the Swedish nurses emphasized patient integrity as a potential source of ethical dilemmas, whereas the Chinese nurses did not discuss this issue at all. This probably reflects a cultural difference because an individual patient's privacy is not considered to be very important in China.⁴ In Sweden, the concept of integrity is brought up frequently in health care legislation, and this subject is often discussed.^{31,32} Pang *et al.*¹⁷ found that values highly prized by American nurses were related to individual rights, much more so than in Japanese and Chinese nurses.

It is clear that nurses in both China and Sweden were very disappointed about not receiving proper respect for their nursing knowledge. This lack of respect and the accompanying disregard of their professional competence influenced their ability to contribute optimally to patient treatment, which ultimately resulted in an ethical dilemma if patients did not receive what the nurses regarded as the best care. The frustration experienced by the Swedish nurses about not being allowed to participate in medical decision making has previously been noted by other researchers.^{33,34} However, in China the nurses did not seem ready even to consider that they might contribute substantially to the decision-making process. It is difficult to know whether this difference in nursing behaviour depends on cultural or educational differences, but the nursing profession is not widely respected and acknowledged in China.⁴ Norberg *et al.*¹⁶ have similarly found that Chinese nurses had a more docile response to physicians' orders and prescriptions, this possibly being a reflection of cultural differences. Norberg *et al.*¹⁶ and Li and Lambert²⁵ discuss the importance of maintaining harmony in Chinese culture, which means that human conflict should be solved by a more reconciliatory approach than is normally used in western countries. Begåt *et al.*¹⁵ also discuss the same issue in Japanese culture. Such cross-cultural differences could be important factors influencing nurses' experiences of their working situation and of ethical dilemmas.

The two populations of nurses studied were unanimous in their opinion that more nurses are needed to relieve workplace distress and were frustrated about the insufficiency of nursing staff in relation to patient care needs. In China there was a tendency to blame individuals when nurses were not able to finish their work completely, although in Sweden there was an awareness that political and economic factors influence nursing staff levels. The nurses in both China and Sweden were struggling with work overload, giving rise to workplace distress. This is in line with the findings from a study by Lambert *et al.*²³ showing that workplace stressors appear to be the same in several countries. The highest ranked nursing stressors in that study were workload and dealing with death and dying. In a review by McVicar³⁵ six sources of workplace distress for nurses were identified: workload, relationships with other clinical staff, leadership and management issues, emotional demands of caring, shift working, and lack of reward. These stressors were also common in the present study. MacDonald²⁷ notes that the workplace culture in hospitals has a profound impact on nurses' moral agency. She argues that the practice setting influences the type of ethical issue encountered and the way in which nurses respond. However, in the present study the nurses worked in different practice settings in two countries located far apart from each other, but experienced to a great extent the same kind of workplace distress and ethical problems. This indicates that the role of a specific practice setting could be of limited importance with regard to these issues, but this is an area for future research.

Most of the nurses stressed the value of being able to talk to and communicate with colleagues about difficult work situations. Seeking formal and informal support from colleagues was a common strategy, which is similar to the results of another study performed in Sweden.³⁶ In China, case meetings provided nurses with a forum to discuss and exchange knowledge, while this exchange of information was more informal in Sweden. Källemark *et al.*⁸ found in a Swedish study that discussion about ethical issues most often occurred during coffee breaks. The Swedish nurses

in that study may therefore have felt more comfortable about turning to their own colleagues when needing help and support instead of having these kinds of issues discussed with external supervisors. The preference for informal discussion may also reflect Swedish nurses' perception that there is a lack of organized support in the workplace.³⁶

Another difference in professional attitudes was that the Swedish nurses often spoke of engaging in critical and reflective thinking. They were more deliberate in using their past experiences to help them manage a difficult situation, sometimes looking at it from another person's point of view to shed new light on it. This discrepancy may depend on educational differences because China has a rather short history of academic nursing education.³⁷ It is interesting that the Chinese nurses were more critical of their own competence and skills than were the Swedish nurses, emphasizing the importance of increased competence and continually striving to update and improve their nursing skills through further education. This aspiration may in part be explained by the intrinsic value that Chinese culture attributes to education in general, and higher education in particular.³⁷

Both the Swedish and the Chinese nurses believed that increased co-operation and communication were ways to manage stress. Especially in China, the nurses spoke of avoiding job conflict by being acquiescent. They regarded it as important to maintain a positive and calm attitude towards patients at all times, regardless of whether they were upset, thus contributing to the reduction of work environment stress. Acquiescence was also often used as a coping strategy when the nurses had to follow physicians' orders even if they themselves had a different opinion, or when they had to give in to relatives' suggestions in order to prevent a dispute. Harmony is highly prized in Chinese culture, strongly influencing all aspects of life, even though western values are now present in the Chinese health care system.³⁸ Li and Lambert²⁵ argue that the educational preparation given to Chinese nurses with regard to effective coping is inadequate and this could influence Chinese nurses' ability to manage stress. Unique to the Chinese nurses in this study was their faith in the idea that increased competence would be a way for them to manage their distress. However, one similar coping strategy was used among nurses in both China and Sweden: when away from the work environment, to stop thinking about work; instead to relax and enjoy being with friends and family. This is emotion-focused coping, which has been previously identified in Chinese nurses.^{10,25} However, the present study was limited in scope because only one interview question was concerned with coping with ethical issues.

With regard to the methods used in this aggregated concept analysis, Estabrooks *et al.*¹⁸ point out three important criteria for the selection of individual qualitative studies whose findings are suitable for aggregation: (1) select studies that focus on similar populations and themes; (2) select studies that use a similar research approach; and (3) the themes reported by original researchers must be clearly rooted in the data. In the present study, all three of these criteria were fulfilled, although the two studies on which it is based were performed in only one neurological work setting in each country, but this cross-cultural comparative study is a starting point for further studies in this area. When conducting cross-cultural research, researchers must always remember that they study other people's culturally different experiences from their own vantage point.^{39,40} In our study it was an advantage that researchers representing both cultures were involved.

Conclusion

The results show that neuroscience nurses have demanding jobs in both Sweden and China. The nurses in both these countries were struggling with largely similar ethical dilemmas, even though the causes of the dilemmas could differ. In both countries, the ethical dilemmas concerned seriously ill patients and the possibilities of providing good care. The nurses also had similar experiences of workplace distress, saying that they were not professionally respected. The ways in which they handled stress at work were different, but both groups of nurses used similar strategies to relax after work. Thus, this study indicates that the ethical conflicts described by nurses in various countries are global in nature. Both organizational and interdisciplinary relationships seem to have an impact on the ethical dilemmas encountered in practical nursing. Interventions to improve nurses' work conditions and change the ethical climate at organizational level must therefore be two of the most prioritized areas in ongoing discussions about health care improvement.

Acknowledgements

The authors gratefully acknowledge the financial support of the School of Health Sciences, Jönköping University, Sweden. We would like to thank research assistant Camilla Johansson for participating in the analysis, also Haiyan Zhang (HZ) and Long Ting (LT) for translating the interview guide into Chinese, acting as interpreters for the interviews and validating the analysis results. In addition, we wish to express our gratitude to Su Yan for her work with translation and validation and to all the nurses who generously participated and willingly shared their experiences in the interviews.

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