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Institute of Family Medicine and Public Health, Faculty of Medicine, University of Tartu, Estonia

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To all nurses

What is essential is invisible to the eye, it is only with the heart that one can see rightly.

Antoine de Saint-Exupéry, The Little Prince

CONTENTS

LIST OF ORIGINAL PUBLICATIONS

The thesis is based on the following original publications:

1. **Usberg [Mõts], Gerli**; Uibu, Ere; Urban, Reet; Kangasniemi, Mari. Ethical conflicts in nursing: An interview study. *Nursing Ethics*. 2021; 28(2): 230–241. doi:10.1177/0969733020945751

2. **Usberg [Mõts], Gerli**; Clari, Marco; Conti, Alessio; Põld, Mariliis, Kalda, Ruth; Kangasniemi, Mari. (2024). Changes in nurses' work: A comparative study during the waves of COVID-19 pandemic. *International Journal of Nursing Practice,* 30(4): e13250, doi: 10.1111/ijn.13250

3. **Usberg [Mõts], Gerli;** Clari, Marco; Conti, Alessio; Põld, Mariliis; Kalda Ruth; Kangasniemi, Mari. (2024). COVID-19 and ethical issues: Comparisons between two European countries. *Nursing Ethics.* 2024; 31(8): 1674–1887. doi: 10.1177/09697330241255936.

The contribution of Gerli Mõts (GM) to the original publications is as follows:
1. Paper: GM prepared and planned the study, prepared the interview guide and documents for the ethical committee, carried out communication with the committee, performed the interviews and the data analyses, prepared the literature review, drafted the manuscript, and carried out the submission process and communication with the journals.

2. and 3. Papers: GM prepared and planned the study in Estonia, carried out the translation, adaptation, and testing of the questionnaire, collected data, collaborated in data analyses, prepared the literature review and original drafts, and carried out submissions and communication with the journals.

ABBREVIATIONS

ANA	American Nurse Association
CI	Confidence Interval
COVID-19	Corona Virus Disease of 2019
CSC	Crisis Standards of Care
DNR	Do Not Resuscitate, e.g. decision for healthcare providers to not resuscitate the patient
ED	Emergency Department
EQF6	European Qualifications Framework level 6
ICN	International Council of Nurses
ICU	Intensive Care Unit
MD	Moral Distress
OECD	Organisation for Economic Co-operation and Development
PPE	Personal Protective Equipment
UDHR	The Universal Declaration of Human Rights

1. INTRODUCTION

Ethical issues are an inevitable part of nursing care. Patients have the right to receive safe, high-quality and ethical care at all times. Nursing care, as an autonomous value-based practice, is primarily based on the individual needs of the patients (Fowler, 2024; Thompson et al., 2006). However, nurses work in a rapidly developing and efficiency-oriented environment (Kieft et al., 2014) and collaborate with various parties, whose perspectives towards care situations may be controversial (Gaudine & Thorne, 2012; Kälvemark et al., 2004; Thompson et al., 2006). Therefore, nurses cannot always provide care for patients consistent with the core values of nursing (Rassin, 2008; Shahriari et al., 2013) and face ethical issues (Gaudine & Thorne, 2012; Redman 2000; Wlodarczyk D, 2011).

While ethical principles of nursing are consistent and have persisted and expressed in ethical codes for nurses for decades across most cultures (American Nurse Association, 2015; International Council of Nurses, 2021), their practical application and interpretation are shaped by the specific sociocultural context (Kangasniemi et al., 2015; Ludwick & Silva, 2000; Rainer et al., 2018; Wros et al., 2004). Consequently, ethical issues are context-sensitive phenomena, depending on nurses working in clinical, organisational and societal contexts (Kangasniemi et al., 2015; Ludwick & Silva, 2000; Wros et al., 2004), which are in constant change (Jameton, 1984; Lützén, 1997; Thompson et al., 2006). According to Jameton (1984) widespread social changes increase health needs, force advancements in healthcare, evolve understanding of health and illness and influence the expectations of patients and healthcare professionals. Emphasis on patients' rights has been growing, but at the same time, the shortage of nurses has increased, as has the importance of cost-effectiveness. Crises, which significantly disrupt the functioning of healthcare, such as the latest most extensive global health crisis, the COVID-19 pandemic, exacerbate existing ethical issues and introduce new ones (World Health Organisation, 2020) such as nurses' fear for their own and their loved one's safety (Hsin & Macer, 2004). Such situations inevitably cause shortcomings in care provision and therefore also ethical issues for nurses. Changes in the societal and clinical context raise questions for nurses on how to provide ethical care (Jameton, 1984; Thompson et al., 2006).

Ethical issues, especially ethical conflicts can be a considerable threat in nursing. Problems that cause ethical issues for nurses, such as, lack of patient autonomy or indifference towards patients' needs and preferences, affect the care quality and safety and place heavy emotional and mental burdens on nurses (Ulrich et al., 2010). This can lead to moral distress, anxiety, compassion fatigue and depression and can decrease job motivation, attentiveness and commitment to patients (Thorne, 2010; Ulrich et al., 2010). Exhausted and burned-out nurses are less able to provide attentive, empathetic and patient-centred care to patients. This is an additional danger to care quality and safety and promotes new ethical issues (Gustafsson & Hemberg, 2022; McAndrew et al., 2018). Consequently, nurses may leave their jobs or profession (Gaudine & Thorne, 2012; Gustafsson

& Hemberg, 2022), which is a serious threat to the shortage of nurses, including in Estonia (Kiivet et al., 2013).

To maintain safe, human-centred, and high-quality care, it's crucial to continuously and multidimensionally study ethical issues in nursing. The expected outcomes of this study are relevant for clinical practice, healthcare management and policy, and nursing education. Understanding ethical issues and the context, in which they emerge, allows to identify shortcomings and deficiencies in clinical practice, that contribute to the ethical issues and affect the quality and safety of care. To enhance understanding of ethical issues and their associated conditions, and to ensure the provision of ethical care for patients, it is crucial to consider the factors that contribute to ethical issues for nurses. International research on ethical issues in nursing care, including during the COVID-19 pandemic, has grown extensively during recent years (Beheshtaeen et al., 2023; Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021; Oh & Gastmans, 2023; Silverman et al., 2021; Villa et al., 2021; Yasin et al., 2023). However, there is still a continuing need for further research to enhance existing knowledge, especially in Estonia, where knowledge in this field is missing. Regarding ethical issues during the COVID-19 pandemic, there is so far a lack of comparisons between nurses working in different contexts at various stages of the pandemic. Such comparisons are essential to deepen our understanding of that complex and dynamic phenomenon of ethical issues. The findings of this study help to highlight the significance of ethical issues concerning the quality and safety of care, understand and prevent ethical issues in nursing and prepare for the provision of good and sustainable care in future health crises.

2. LITERATURE REVIEW

2.1 Ethics and ethical issues in nursing

2.1.1 The ethical foundation of nursing

Ethics has been a fundamental part of nursing care from the very early days to the contemporary nursing profession (Bishop & Daly, 1995; Jameton, 1984; Thompson et al., 2006). Ethics of nursing, which evolved originally as a part of the formally recognized profession in the early 1900s (Bishop & Daly, 1995), express the basic values of a humanistic society and human rights (The Universal Declaration of Human Rights [UDHR], 1948). The core values of contemporary nursing care have been emphasized by professional nursing associations in the codes of ethics for nurses from the early 1950s and are essential for ensuring ethical practice, safeguarding patients' rights, and maintaining the integrity and reputation of the nursing profession (ANA, 2015; ICN, 2021). The most important deontological values of nursing are related to patient well-being and caring for patients, including human dignity, social justice, equality, individuality, altruism and autonomy (Rassin, 2008; Thompson et al., 2006). Additionally, values such as promoting the health of society, professional competency, autonomy and accountability are more and more addressed in nursing ethics (Rassin, 2008; Shahriari et al., 2013). Since the formation of bioethics in the 1970s, nursing ethics is strongly influenced by its principles, which include autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2019). However, from the middle of 20th of century, nursing ethics has been addressed as substantially more than deontological principles and competencies. From a virtue ethical perspective, nursing as moral practice is not *doing* something but rather *being* a nurse as a whole (Bishop & Scudder, 1990; Fowler, 2024). Moreover, influenced by feminist ethics and philosophical works the ethics of care in nursing emphasizes compassionate, empathetic, and patient-centred care prioritizes relationships, individual needs, and the well-being of patients within their unique contexts (Lachman, 2012).

Patient care is expected to follow high clinical, quality and ethical standards (Kangasniemi et al., 2015; Limentani et al., 1999; Thompson et al., 2006). At the same time, the healthcare field tends to be quite rigid with an internal hierarchy, highly standardised and economically more and more productivity-oriented (Kieft et al., 2014). All healthcare professions are dedicated to helping people, but the understanding of morally good and valuable action can vary from the perspective of different professions (Redman & Fry, 2000) and different ethical reasoning (Thompson et al., 2006). Nursing care, as an autonomous value-based practice, is primarily based on the individual needs of the patients (Fowler, 2024; Thompson et al., 2006). Nursing ethics and its core values guide nurses deontologically in making ethical decisions and providing compassionate patient-centred care (Thompson et al., 2006). Public-health ethics on the other hand prioritises utilitarian ethics and values the interests of the community (Childress

et al., 2002). To address the complexities of modern, team-based care and to reflect a commitment to fostering ethical, collaborative environments that enhance both professional integrity and patient care, in recent years, interprofessional ethics in healthcare has developed significantly (Engel & Prentice, 2013).

2.1.2 The sociocultural context for nursing in Estonia

The ethical foundation and values of nursing are similar in most cultures, but the practical meaning and interpretation of globally accepted values are influenced by the overall sociocultural context (DeKeyser Ganz & Berkovitz, 2011; Kangasniemi et al., 2015; Ludwick & Silva, 2000; Lützén, 1997; Rassin, 2008; Shahriari et al., 2013; Thompson et al., 2006; Verpeet et al., 2003; Wros et al., 2004). As a specific sociocultural context for nursing and ethical issues in nursing in Estonia, the historical (Ernits et al., 2019; Pop-Eleches & Tucker, 2011), demographical (Estonian Ministry of Social Affairs, 2021; Kaelep et al., 2020; Themas et al., 2015) and legal (Kõrran et al., 2008; Lai et al., 2013) position of Estonia as one of the post-Soviet countries has been in many ways different from other Western countries, a group to which it now belongs after its rapid development since re-independence (Ernits et al., 2019; Kõrran et al., 2008). During the Soviet era (1944-1991), nursing in Estonia was considered inferior to medicine, with low professional status. Nurses received education in technical schools after completing primary school and served primarily as executors of doctors' orders. They had minimal opportunities for independent action and effectiveness, speed and technical skills were assumed instead of an individualised approach and quality of care (Ernits et al., 2019). Patients' relations with healthcare professionals were also based on paternalistic principles, where the professionals had power and decision-making rights over the patient's life and health.

Contemporary nursing education in Estonia is based on the Bologna declaration and corresponds to the EQF6 level (The European Qualifications Framework [EQF], 2017). National nursing association (Estonian Nurses Union) and nurses have adhered to the code of ethics of International Council of Nurses (ICN) since 1996 and can work as independent healthcare providers (Ernits et al., 2019). Majority of approximately 8500 of Estonian' nurses are working in public hospitals (National Health Foundation). Many nurses work with more than full-time workload, however, official statistics does not reflect the true extent of the problem. Important reasons for overload are relatively low salary and scarcity of workforce (Healthcare Trends in Estonia, 2022). 97% of nurses are woman, with the average age 46 years (National Health Foundation). The gender distribution in nursing is even more inclined towards women in Estonia than the average across the OECD countries (OECD, 2020). The scarcity of nursing workforce is especially acute problem in Estonia. Based on the OECD, there is six nurses working per 1000 inhabitants and less than two nurses per one physician, which places country to the end of the list of the ranking among OECD (OECD, 2021).

Nowadays, patient-centredness is a leading international principle in Estonia's healthcare system (Estonian Ministry of Social Affairs, 2021; Lai et al., 2013).

Estonia has mandatory social health insurance system, based on solidarity since 1991 (Health Insurance Act of the Republic of Estonia, 1991) and patients mostly do not have to pay for the services. Since 2002, patients' rights have been protected by legislation and international agreements, ensuring patients are involved in decisions about their health, with rights to informed consent, confidentiality, and privacy, while also being required to provide relevant health information to professionals (Law of Obligations Act, 2001; World Health Organization-Europe, 1994). Patients also have the right to file complaints about malpractice, substandard care, or limited access to services (Habicht et al., 2018). However, the protection of patients' rights is still weak in practice (Lai et al., 2013). As the legacy of Soviet era, 24% of population in Estonia speak Russian as an addition to native Estonian speakers. From the religious background, Estonia is rather secular country, where majority of population declare themselves as not following any religion. (Statistics Estonia, 2022.)

2.1.3 Ethical issues in nursing

Although nursing is considered a moral practice (Bishop & Scudder, 1990), there is an ethical paradox involved in nursing care. All patients have right for ethical care, but at the same time, ethical issues are frequent in care when different parties strive to fulfil their needs, goals, and objectives in the delivery of care (Gaudine & Thorne, 2012; Kälvemark et al., 2004; Thompson et al., 2006). Nurses have close and long-term contact with patients and their loved ones. At the same time, they work in a rapidly changing and complex field. They cannot always adhere to professional values and principles in daily practice and may therefore experience different ethical issues (Falco-Pegueroles et al., 2016; Falco-Pegueroles et al., 2015; Gaudine et al., 2011; Gaudine & Thorne, 2012; Redman & Fry, 2000). Ethical issues, especially ethical conflicts, have an adverse effect on nurses' motivation and job satisfaction and foster burnout, depression and resignation from the job (Falco-Pegueroles et al., 2016; Gaudine & Thorne, 2012; Thorne, 2010). Consequently, they affect the quality and safety of care (Kieft et al., 2014; Kutney-Lee et al., 2009). Ethical issues in nursing reflect shortcomings and deficiencies in patient care, teamwork and management, which are a source of ethical issues for nurses. Therefore, they work as markers of the quality of care.

The concept *ethical issue* in nursing, also *ethical concern, challenge, difficulty* or *problem,* is often not specifically defined (Rainer et al., 2018; Thompson et al., 2006). Different concepts that refer generally to questions about what is right or wrong and how to adhere to ethical principles in patient care (Ulrich et al., 2010) have been used interchangeably and existing definitions are challenged (Fourie, 2015). Ethical issues may lead to *ethical* or *moral conflict*, a clash or contradiction between opposing values, principles or beliefs without a good solution (Thompson et al., 2006). Andrew Jameton (1984) described ethical conflict in nursing as *moral dilemma, moral uncertainty,* and *moral distress (MD)*. According to Jameton, a moral dilemma consists of choosing between two conflicting ethical principles or actions, both of which have significant moral consequences. Moral

uncertainty is the state of being unsure about what moral principles, values, or actions are correct or most justified in a given situation. Moral distress in nursing is knowing the ethically appropriate action to take but feeling constrained from acting due to institutional, legal, or interpersonal barriers. *Moral outrage* was later added to those three by Judith Wilkinson (Wilkinson, 1987). According to Liu et al (2022) ethical conflicts are emotional reactions to morally challenging situations arising from conflicting values, competing interests among stakeholders, and unclear obligations within nursing practice. However, the scientific literature on the topic is characterised by the use of different concepts interchangeably, and the search for conceptual clarification is still ongoing and existing definitions are challenged (Fourie, 2015).

Ethical issues and the way they are interpreted and understood are context-sensitive and related to different aspects that influence healthcare providers, politics, nurses, patients and larger communities (DeKeyser Ganz & Berkovitz, 2011; Leuter et al., 2012; Rassin, 2008; Toliusiene & Peicius, 2007). Socio-cultural and historical context, the influence of economic and societal changes (Bortoluzzi & Palese, 2010) and health crises influence ethical issues. In addition to specific aspects relevant on a clinical level, these aspects include the status of the profession in society, legislation and regulation steering the profession (Kangasniemi et al., 2015; Lützén, 1997). These contextual aspects influence ethical issues, but also the way ethical issues are interpreted and understood (Kangasniemi et al., 2015; Lützén, 1997).

An important number of ethical issues in nursing are related to the violation of patients' rights, preferences, or well-being. Ethical issues often arise when nurses are unable to safeguard patients' rights or provide the highest standard of care. (Falco-Pegueroles et al., 2015; Gaudine et al., 2011; Gaudine & Thorne, 2012; Haahr et al., 2020; Pavlish et al., 2011; Ulrich et al., 2010.) This may be due to situations where a patient's autonomy and privacy are compromised (Fernandes & Moreira, 2013; Haahr et al., 2020; Park et al., 2014), their preferences are disregarded or communication with patients and their families is inadequate (Falco-Pegueroles et al., 2016; Gaudine et al., 2011; Pavlish et al., 2011; Ulrich et al., 2010). Numerous ethical issues emerge when providing care for patients with diminished decision-making capacity, particularly at the end of their lives (Kisorio & Langley, 2016; Pavlish et al., 2011; Rainer et al., 2018). Additionally, treating patients paternalistically or unequally based on their social background has been a source of ethical issues in nursing (Varcoe et al., 2012). Important factors forcing ethical issues in nursing also include the shortage of human resources (Haahr et al., 2020; Henrich et al., 2016; Leuter et al., 2012; Ulrich et al., 2010) and an excessive workload which prevent nurses from providing care according to established standards and their ideal of a good nurse (Haahr et al., 2020; Varcoe et al., 2012; Wlodarczyk & Lazarewicz, 2011). Nurses' lack of knowledge and skills is a source of ethical issues by compromising patient safety, autonomy, confidentiality, advocacy, and professional accountability (Gaudine et al., 2011; Rainer et al., 2018; Varcoe et al., 2012). The professional opinions of nurses are not always respected within healthcare teams

and on an organisational level (Henrich et al., 2016; Kisorio & Langley, 2016; Wilson et al., 2013). Hierarchy and poor teamwork can impact their roles and autonomy in teams, and their willingness to express their beliefs and values in the work process (Gutierrez 2005; Lievrouw et al., 2016).

2.2 Nursing, crises and ethics

Professional nursing was born in wars and from the early days of nursing, crises have been challenges nurses must face (Fletcher et al., 2022). The meaning of crisis still remains ambiguous because it is context-dependent, varying across disciplines, and can refer to both subjective experiences and objective events, each with differing interpretations and thresholds of severity. Crises disrupt the status quo, creating opportunities for transformation but also exposing vulnerabilities. (Abdelrahman, 2022; Dafermos, 2024; Lawrence et al., 2024; Nteka, 2021.) The word *crisis* originally in Greek meant time to make decision, not necessarily something extraordinary or dramatic, although those events also require decisions. Commonly the word *crisis* has been used in nursing to refer to some important, major events and turning points (Thompson et al., 2006). According to Andrew Jameton (1984), the healthcare system is in constant crisis as a process of broad social changes. It includes increased health needs, especially regarding chronic diseases, changed meaning of health and illness, expectations of patients and health professionals, development in healthcare technology and patients' rights, inequalities, and scarcity of resources, which have shaped care provision during the last decades. Thompson with colleagues (2006) described that a crisis with feelings of frustration has caused chaos for both community members and health professionals (Thompson et al., 2006). Both Jameton (1984) and Thompson with colleagues (Thompson et al., 2006) also argue that these changes have challenged traditional values and principles of healthcare. Changes in healthcare and in society continue to occur nowadays, which places healthcare and nursing work in constant crisis, which therefore seems to be a normal part of the work (Abdelrahman, 2022; Lawrence et al., 2024). However, these changes have taken time and have progressed over the years enabling stakeholders to adapt them to some degree.

Crises due to disasters like epidemics and pandemics, natural and mankind disasters, terrorist attacks and wars hit countries and regions suddenly and unexpectedly. Their influence on society and care provision can be tremendous and multifaceted. In that sense, the crises are a sudden and significant process that cause disruption or disturbance in the normal functioning of a system. They have severe social, economic, environmental or organisational consequences which have a destructive effect on people that requires immediate and effective intervention to prevent substantial negative outcomes. (Abdelrahman, 2022; Lawrence et al., 2024.) In the healthcare system, important causes of crises are related to the scarcity of resources and increased need for care, which affect the continuity of care (Nteka, 2021). Increased needs exceed the capacity of

outpatient facilities, emergency departments (ED), hospitals and intensive care units (ICU) and can result in severe shortages of staff, space and supplies. In addition, they cause serious consequences for patient outcomes (Hick et al., 2020; Minnesota Department of Health, 2021), social security and economy (Abdelrahman, 2022). Such events often consist of several crises, that are interrelated and affect each other. This has enhanced the understanding of crises as *polycrisis* (Lawrence et al., 2024). The COVID-19 pandemic, one of the most extensive recent crises that the global community has witnessed (Buheji & Buhaid, 2020; Clari et al., 2021; Llop-Gironés et al., 2021; LoGiudice & Bartos, 2021), corresponds to all characteristics of *polycrisis* (Lawrence et al., 2024).

Crises standards of care (CSC) need a different approach from those used in the provision of care regularly. Traditional deontological patient-centred care may not be completely achievable due to the discord between needs and resource capacity (International Council of Nurses, 2019; Leider et al., 2017). To manage a crisis and its consequences, the focus is placed on a utilitarian approach and maximising values regarding the safety and well-being of communities, prioritising population health over individual outcomes. Regulatory requirements are adjusted to protect healthcare providers making resource allocation decisions, and triage models are modified to cope with scarce resources. (International Council of Nurses, 2019; Johnstone & Turale, 2014.) Fairness, equity, duty to care, transparency, proportionality consistency and trust are still important values of care, but more on population level, less on individual level (Institute of Medicine (US)…., 2009). However, a pandemic demands systematic and sustained understanding and application of ethical standards for providing care in terms of scarce resources (Minnesota Department of Health, 2021). Therefore, different countries established or revised also ethical recommendations for providing care during the COVID-19 pandemic (Minnesota Department of Health, 2021; Riccioni et al., 2020; Sutrop & Simm, 2020). The main criteria for prioritising patients were related to their prognosis and age. Caring for and respecting human dignity and the patient's wishes remained important, together with good palliative care and involvement of patients, their loved ones and healthcare staff in decision-making processes. (Riccioni et al., 2020; Sutrop & Simm, 2020.)

2.3 The impact of the COVID-19 pandemic on nurses' work and ethical issues

2.3.1 The progress of the COVID-19 pandemic and the response in Estonia and Italy

Although the COVID-19 pandemic affected healthcare systems globally, it influenced countries differently. In Estonia, the first wave started later than in many other European countries and progressed much less aggressively (European Observatory on Health Systems and Policies., 2020). This resulted in infection rates and a death toll (approximately 48 per 1 million inhabitants) that was among the lowest in Europe (World Health Organisation), with an adequate level of accessibility to hospital beds, especially to intensive care (Bauer et al., 2020). Still, at the beginning of the pandemic, there was a scarcity of COVID-19 tests, which led to selective testing with a focus on symptomatic people and the elderly (European Observatory on Health Systems and Policies, 2020). A year later, during the second wave in March 2021, Estonia had the world's highest rates of infection (LETA/BNS/TBT, 2021), while daily numbers increased more than tenfold, from 134 to almost 2000 confirmed cases per day, compared to the previous year (World Health Organisation).

Differently from Estonia, Italy was the first European country to be hit by the COVID-19 and one of the countries, in which the pandemic progressed most severely, especially in Northern Italy (Ferrante, 2022; Indolfi & Spaccarotella, 2020). The spread of infection started at the beginning of February 2020, reaching more than 4000 cases and a death rate close to 600 per million inhabitants during the first wave (Ferrante, 2022; World Health Organisation, n.d.). This affected the functioning of the healthcare system heavily, causing overcrowding in hospitals and a lack of hospital beds, especially intensive care beds (Nacoti et al., 2020), PPE and tests (Capuzzo et al., 2022).

To respond to the situation and avoid worse scenarios, the governments of both countries established different restrictions step-by-step, including requirements for social functioning, extensive testing and isolating positive cases and contacts (European Observatory on Health Systems and Policies, 2020; Ferrante, 2022). Additionally, to prevent the spread of infection and to maintain the functioning and continuity of the healthcare work as a whole was reorganised extensively. This included restricting visits to hospitals and care homes, postponing or cancelling scheduled work, and setting up special COVID-19 departments in hospitals and in primary care. (Bauer et al., 2020; Sutrop & Simm, 2020.) Both countries also established ethical recommendations for providing care with a scarcity of resources. The prognosis of treatment success and future quality of life were determined as the main criteria for treatment decisions in those in both countries (Riccioni et al., 2020; Sutrop & Simm, 2020). In addition, caring, human dignity and patient autonomy were prioritised in recommendations in Estonia (Sutrop & Simm, 2020), while age, good palliative care and involving patients, their loved ones and healthcare staff in the decision-making process

were emphasized in Italy (Riccioni et al., 2020). Mutual support between healthcare personnel and care institutions was highlighted in both guidelines (Riccioni et al., 2020; Sutrop & Simm, 2020).

2.3.2 Nurses' work during the COVID-19 pandemic

The pandemic increased nursing time, working hours and the workload of nurses significantly (Batassini & Beghetto, 2024; Bruyneel et al., 2021; Falk et al., 2022; Galehdar et al., 2020). The workload increased due to both a higher number and a greater workload per nurse (Hoogendoorn et al., 2021). It increased especially in the ICU, where an extensive number of patients with COVID-19 were treated. Taking care of patients with COVID-19 was very demanding. Nurses needed to carry out more intense hygienic procedures, mobilisation, positioning, support for patients' loved ones and respiratory care (Batassini & Beghetto, 2024; Hoogendoorn et al., 2021), driven by patients' medical conditions, advanced age and complex care needs (Asghari et al., 2021; Batassini & Beghetto, 2024; Bruyneel et al., 2021). Essential nursing activities such as respiratory care, hygienic procedures, mobilisation, positioning (Hoogendoorn et al., 2021), safety and physiological support (Asghari et al., 2021) also became more demanding due to the complicated condition of patients, isolation requirements and high workload. In addition to direct patient care, nurses carried out diverse roles in managing the health crisis and mitigating its consequences. (Arasli et al., 2020; Buheji & Buhaid, 2020; Thobaity & Alshammari, 2020.)

The COVID-19 pandemic affected all dimensions of nurses' work and personal lives, and nurses faced physical (Bruyneel et al., 2021; Kumar & Ranjan, 2020) and mental (Chen et al., 2021; Lai et al., 2020) challenges. Extensive workload caused nurses to experience significant levels of stress, anxiety (Galehdar et al., 2020; Labrague & De los Santos, 2020), exhaustion (Arasli et al., 2020), fatigue and burnout (Schwerdtl et al., 2020). They had to work on the verge of exhaustion and adjust to wearing full personal protective equipment (PPE) for long periods, which caused additional discomfort and hindered communication with patients and colleagues (Liang et al., 2021; Santos et al., 2021). Nurses were concerned about the risk of getting infected, as they were frequently exposed to infected patients. The risk of infection added more stress, especially when PPE was in short supply. (Liang et al., 2021; Santos et al., 2021.) Many feared bringing the virus home, leading to increased stress and anxiety (Aydogdu, 2022; Beheshtaeen et al., 2023; Falcó-Pegueroles et al., 2023; Firouzkouhi et al., 2021; Gebreheat & Teame, 2021; Oh & Gastmans, 2023; Yasin et al., 2023). Some nurses even isolated themselves from their loved ones to protect them (Villa et al., 2021). The overall burden of nurses increased also because the majority are women, who also play a significant role outside their professional life. The pandemic affected their roles at home and in caring for children and family. (Lakshmi & Prasanth, 2018; OECD, 2020.)

Healthcare institutions were unprepared to provide care during the pandemic due to the increased number of patients with complex conditions. It led to a severe

shortage of resources such as hospital beds, medical equipment, and staff. Lack of preparedness overwhelmed the system, causing delays in care, insufficient protective gear, and difficulties in managing critical cases efficiently. (Galehdar et al., 2020.) Moreover, nurses were not prepared to fight the pandemic (Bruyneel et al., 2021; Kumar & Ranjan, 2020) since they did not have enough evidence-based knowledge, experience, skills or relevant training to deal with that unexpected situation (Galehdar et al., 2020; Kalateh et al., 2021; Labrague & De los Santos, 2020). The need for upskilling in a short time added to the pressure on nurses, especially as the pandemic evolved and new treatments and protocols were introduced (Falcó-Pegueroles et al., 2023). Nurses had to adapt to using new technologies and remote care, which meant not only less face-to-face patient interaction but also facing challenges in managing patient care virtually (LoGiudice & Bartos, 2021).

2.3.3 Ethical issues in nursing during the COVID-19 pandemic

The COVID-19 pandemic changed the care context and nurses' work significantly. Processes that change the care context to such an extent also inevitably cause ethical issues for nurses. As systematically searched (Appendix 1) research literature (Appendix 2) shows, nurses faced multiple ethical issues, especially regarding patient care, professional confidence and nurses' work in healthcare teams.

With regard to patient care, it was difficult for nurses to provide sufficient bedside presence and equal, holistic, individualised and dignified care, especially at the end of life (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021; Oh & Gastmans, 2023). It was difficult to provide equal care to all patients and nurses realised that they could not provide the same opportunities to all patients (Falcó-Pegueroles et al., 2023; Firouzkouhi et al., 2021). As prioritising principles were not always clear, it led to uncertainty for nurses, who they should help (Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021). When patients were prioritised mainly based on their age, nurses perceived it as being discriminative and unfair (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Muñoz-Quiles et al., 2022). The autonomy of patients was affected when they were not able to communicate and participate in their treatment or care plan (Aydogdu, 2022). In such cases, their preferences and needs were not considered enough (Aydogdu, 2022; Gebreheat & Teame, 2021). Patients' privacy was neglected due to the scarcity of hospital beds and placing too many patients in one room (Aydogdu, 2022; Falcó-Pegueroles et al., 2023).

From deontological perspective, dignified and holistic care was affected when hospital visits were restricted on utilitarian ground and this prevented patients from seeing their families (Aydogdu, 2022; Firouzkouhi et al., 2021; Oh & Gastmans, 2023), and some even had to die without feeling their loved ones nearby (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Firouzkouhi et al., 2021; Oh & Gastmans, 2023). Nurses witnessed the suffering of patients who did not have the usual support of family visits due to restrictions (Aydogdu, 2022). It was also

against the principles of dignified and holistic care, to not let loved ones to see their deceased family member and to not treat the dead body with the same respect as was not normally given (Falcó-Pegueroles et al., 2023). Empathetic and attentive individual communication, lack of closeness and individual contact between nurses and patients were affected due to the isolation requirements and constant use of PPE (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Firouzkouhi et al., 2021; Muñoz-Quiles et al., 2022; Oh & Gastmans, 2023; Silverman et al., 2021). With respect to nurses' professional confidence, this was affected by the pandemic in many ways (Silverman et al., 2021). Nurses were often put in difficult positions where they had to make decisions regarding the allocation of limited resources (Aydogdu, 2022; Falcó-Pegueroles et al., 2023). They were concerned about potentially harming patients and failing to provide adequate care due to scarce resources, lack of skills, ethical guidance and their fears (Aydogdu, 2022; Oh & Gastmans, 2023). The rapid shift from patient-centred to public-health-centred care shook the foundation of the nursing profession (Aydogdu, 2022) when they could not help everyone who needed help (Muñoz-Quiles et al., 2022; Silverman et al., 2021). Nurses felt personal failure, guilt and loss of professional identity and purpose (Muñoz-Quiles et al., 2022) when they perceived that the care provided was unsafe and below established standards because of a lack of resources, time and protocols (Falcó-Pegueroles et al., 2023; Oh & Gastmans, 2023; Silverman et al., 2021) and because of not knowing what the standards were (Falcó-Pegueroles et al., 2023).

Nurses' professional confidence was affected also due to inconsistencies between their commitment and duties towards patients and their right for safety (Aydogdu, 2022; Oh & Gastmans, 2023; Silverman et al., 2021). Nurses were afraid for the health and safety of themselves and their loved ones while caring for infected patients. This forced them to find a balance between their duty to care for patients and their right to feel safe, which influenced their confidence (Aydogdu, 2022; Beheshtaeen et al., 2023; Falcó-Pegueroles et al., 2023; Firouzkouhi et al., 2021; Gebreheat & Teame, 2021; Oh & Gastmans, 2023; Yasin et al., 2023). Nurses professional confidence was also questioned when nurses struggled with what to share with their loved ones about the pandemic. They were trusted spokespersons for their loved ones, who needed information related to the virus and the condition of infected patients. However, for nurses it was unclear what the relevant information was given the constantly changing nature of the information and the need to protect their loved ones and the confidentiality of patients. In addition to their positive professional image, nurses and their families felt stigmatisation as they were considered the source of infection and were even left out of their normal social interactions. (Oh & Gastmans, 2023.)

Regarding teamwork, this is very important for nurses during crises as it fosters collaboration, enhances communication and allows for efficient resource management. Ultimately, it improves patient care and supporting each other in a high-stress environment. (Fernandez et al., 2020.) However, teamwork was also a source of ethical issues during the pandemic due to communication breakdowns, role ambiguity, and increased stress, which hindered collaboration.

According to the nurses, communication within teams was poor, and sharing information was often done on the fly. (Silverman et al., 2021.) Nurses were sometimes unequally forced to provide direct care even if their team members avoided patients due to fear of infection (Aydogdu, 2022). Nurses' professional autonomy was affected when their voice was not heard by the team and they were rejected from the decision-making process in the team. That left them with little choice but to adopt fewer standards (Aydogdu, 2022; Beheshtaeen et al., 2023; Silverman et al., 2021), futile care (Silverman et al., 2021) or doing tasks that are normally not their duties (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021; Oh & Gastmans, 2023). It caused mistrust and tensions, when the teams the nurses worked in were constantly changing and included reassured members, who had inadequate training and skills (Muñoz-Quiles et al., 2022; Silverman et al., 2021).

2.4 Summary of the literature review

Ethics has been integral to nursing since ancient times and continues to be a core component of contemporary nursing. It includes shared values that prioritise patient safety, clinical excellence and ethical care. However, various ethical issues are also inherent in nursing due to conflicting needs and objectives in care delivery. They arise when patients' rights, autonomy or well-being are compromised, or the position of the nursing profession is not supported in society and healthcare.

During health crises, which are a regular part of care, resource scarcity requires prioritisation of population health over individual outcomes, exacerbating existing issues and introducing new ones. The COVID-19 pandemic affected the work of the whole healthcare system and all aspects of nurses' work and personal lives, increasing their workload, working hours and stress levels. Neither healthcare systems nor nurses were completely ready for that. However, despite its global impact, the pandemic's effects on healthcare systems and nurses varied by country and wave, making it a unique and non-uniform phenomenon.

The COVID-19 pandemic has raised multiple ethical issues for nurses in relation to providing equal, holistic, individualised, dignified and safe care for patients and their work in healthcare teams. The shift from patient-centred to public health-centred care and the lack of clear evidence-based knowledge and skills undermined nurses' professional confidence. For nurses, it was also challenging to balance between a strong commitment to patient care and concerns for their own and their loved ones' safety.

Ethical issues in nursing need continuing investigation in different contexts, during regular times and crises, to deepen our understanding of them as a reflection of shortcomings and deficiencies in care contexts. It enables the identification of issues that endanger healthcare quality and safety and enhances ethical care for patients. This is also needed to prepare for future crises. It also helps to

maintain and improve the performance of nurses at work and reduce their burnout, as well as to evaluate and mitigate the long-term impact of crises.

Ethical issues before and during the COVID-19 pandemic have received considerable attention in recent research literature. However, no research has been conducted in Estonia so far and the research in other Baltic countries with Soviet history is scarce as well (Cerela-Boltunova, 2024; Luneckaitė & Riklikienė, 2022; Nagle et al., 2023). Knowledge of ethical issues in nursing in Estonia is needed to complement international research considering the unique sociocultural context of Estonia as one of the former Soviet countries (Nagorska, 2022; Pop-Eleches & Tucker, 2011; Sandin & Walldal, 2002; Toliusiene & Peicius, 2007). Research on the pandemic's influence on nursing care has been published from the beginning of the pandemic. However, there has been less focus so far on comparing ethical issues during the COVID-19 pandemic across different contexts and between nurses working with patients with and without COVID-19.

3. AIMS OF THE STUDY

The main purpose of the study was to describe and explain the ethical issues in nursing in different contexts before and during the COVID-19 pandemic. Provided knowledge enables to deepen the existing knowledge of ethical issues with their contextual aspects in the changing healthcare environment and health crises.

The specific research questions were:

- What were the ethical conflicts in nursing before the COVID-19 pandemic? (Phase I, paper 1)
- How did the work of nurses change during the various phases of the COVID-19 pandemic? (Phase II, paper 2)
- What were the ethical issues for nurses working in different contexts during the COVID-19 pandemic? (Phase II, paper 3)

4. MATERIALS AND METHODS

A multi-method study design (Anguera et al., 2018; Vivek & Nanthagopan, 2021) with two study phases (Figure 1) was used. This included both qualitative and quantitative methods with data collection from multiple sources at different time points. Because there was no previous knowledge of ethical issues of Estonian nurses in their daily work, qualitative methods in the first phase of the study were used to explore and understand the complex phenomenon of ethical conflicts in nursing that is not easily quantifiable. The second study phase consisted of a cross-sectional study design to gain knowledge of ethical issues and their accompanying aspects during the COVID-19 pandemic. Data collection from multiple sources and at different time points enabled the comparison of ethical issues between nurses working in different contexts during the pandemic.

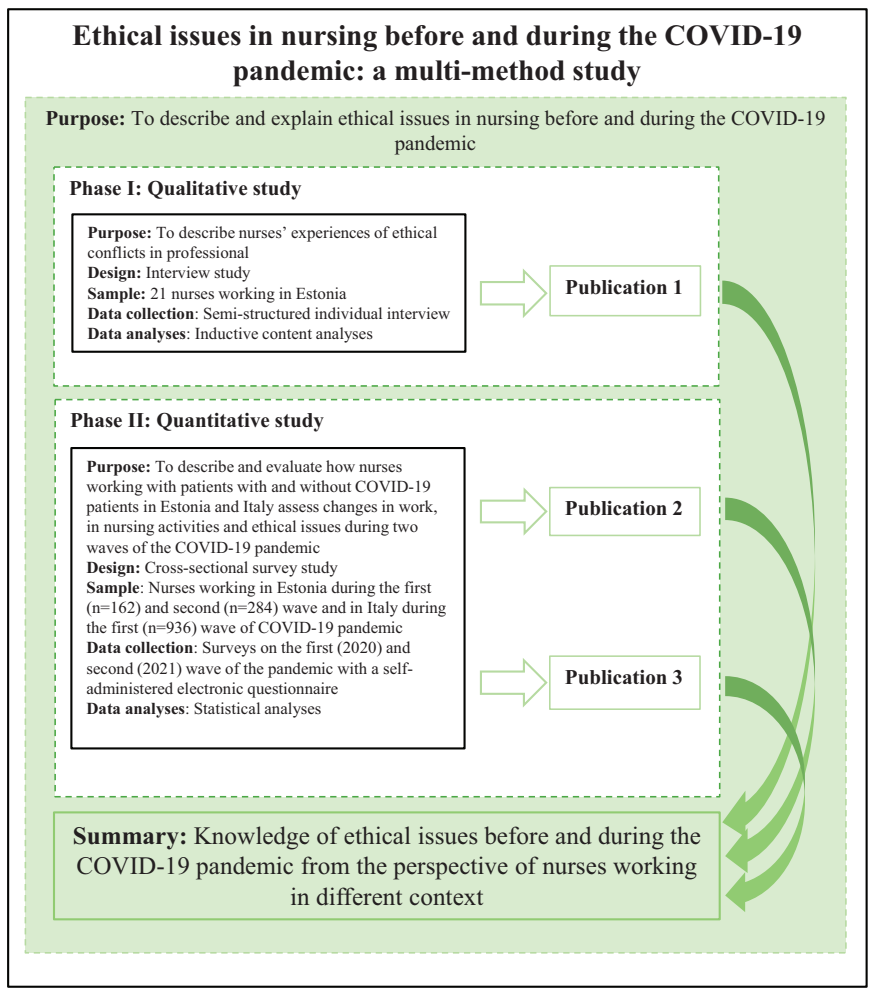

Figure 1. Study design.

4.1 Research environment

The study was conducted among nurses working in Estonia. To illustrate better the contextual aspects of ethical issues in various nursing contexts during the COVID-19 pandemic, data of Italian nurses' ethical issues during the first wave of the pandemic were added to the Estonian data in the second study phase. Estonia and Italy have in many ways different sociocultural context as well as they had different clinical context during the first wave of the COVID-19 pandemic. The Italian data were collected regarding the first wave of the pandemic with the same instrument as the Estonian data. This enabled comparison of ethical issues between nurses who worked in countries with different sociocultural backgrounds and in different contexts of the pandemic. Research ethics approvals were obtained in both countries in accordance with the local requirements. In Estonia, there are approximately 8400 registered nurses per 1.3 million inhabitants (National Health Foundation, n.d.), with 6.5 nurses per 1000 inhabitants (OECD, 2021). In Italy, there are approximately 264 500 nurses for its 59 million inhabitants (OECD, 2021), with 6.2 nurses per 1 000 inhabitants (OECD, 2021). In both countries, nursing education corresponds to the EQF6 level (European Union). Most nurses work in public hospitals and are free to join professional nursing associations and trade unions.

4.2 Interview study

Due to the lack of previous knowledge of ethical issues in nursing in Estonia the first phase of the study with the hermeneutic-phenomenological (Van der Zalm & Bergum, 2000) study design was aimed to capture the depth and richness of nurses' experiences with ethical conflicts and provide insights into their perceptions.

The semi-structured interview (Ryan et al., 2009) guide consisted of questions based on Jameton's ethical conflict types (Jameton, 1984) and previous research (Gaudine et al., 2011; Varcoe et al., 2012), covering four themes. The first theme was the warm-up question, where participants were asked to describe their understanding of ethical conflict. After that, participants were asked to share their experiences with ethical conflicts in their professional practice and the consequences of ethical conflicts they had experienced through responses of themselves and other people to those situations. Follow-up questions were used to support participants in sharing more details and aspects of their experiences. The exact number and order of questions were flexible and depended on the flow of every interview and the unique experiences of participants (Roberts, 2020; Ryan et al., 2009). According to the research questions, responses covering experienced ethical conflicts were reported.

4.2.1 Participants and recruitment

Nurses working in Estonia were the target group for the interview study. To enable equal opportunity for nurses in different parts of Estonia to participate in the study, the purposive sampling method (Palinkas et al., 2015) was used to recruit participants through all professional organisations and associations for nurses (n=8 as of 2020). In addition, social media channels gathering the target group were used for recruitment. Nurses enrolled voluntarily in the research. Exposure to ethical conflicts in professional practice was the main inclusion criterion for participants.

4.2.2 Data collection

Data were collected by individual face-to-face interviews, which enabled a flexible and in-depth approach for gathering the unique and individual experiences of participants in a private and easy environment (Ryan et al., 2009). To ensure a similar understanding of ethical conflict and its subtypes between the researcher and interviewees, a reminder was sent to the interviewees before the interview by e-mail, in which they were asked to recall experienced situations that correspond to Jameton's characteristics of moral dilemma, uncertainty and distress. To ensure the confidentiality of participants and due to the sensitive nature of the research topic, only individual interviews were carried out (Ryan et al., 2009).

For the convenience of the participants, interviews were carried out in places suitable for participants. The data were saturated with 19 interviews, when no new information was added and enough data to comprehensively understand nurses ethical conflict experiences was achieved. After that, two more interviews were conducted to confirm the data saturation (Morse et al., 2002). Interviews were audio recorded, transcribed as soon as possible after the interview and included in the study data. The recorded interviews lasted from 28 to 120 minutes with a mean duration of 77 minutes.

4.2.3 Data analyses

A total of 268 pages of transcripts were composed from 21 recorded interviews. The inductive content analysis method was used to gather rich descriptions and various interpretations regarding the studied topic (Graneheim & Lundman, 2004). All transcribed texts were included in the data analyses as participants were able to share their experiences with ethical conflicts freely throughout the entire interviews, not only as answers to certain questions. The data were extracted into meaning units, which were sentences or entire paragraphs that corresponded to Jameton's (1984) definition of ethical conflicts. The meaning units were condensed and grouped based on their similarities and differences and abstracted first to sub-categories and then to the main categories. Categories were named inductively based on the data (Graneheim & Lundman, 2004) and reported as covering themes.

4.3 Survey study

The second study phase included three cross-sectional surveys, conducted with the same electronic self-reported questionnaire (Clari et al., 2021) among Estonian and Italian nurses working during the COVID-19 pandemic.

4.3.1 Study instrument

The questionnaire *The impact of the COVID-19 emergency on nursing care* (Clari et al., 2021) was used for the survey study. The aim of the instrument is to evaluate the impact of the COVID-19 pandemic on nursing care. It was created in Italian and translated into English. For surveys in Estonia, the questionnaire was translated from English to Estonian and Russian in collaboration with the research team and professional language editors and adapted for local use (Figure 2). The original questionnaire consisted of 28, translated and adapted questionnaires of 26 questions. Two questions were removed during the adaption process. All changes made in the translated and adapted questionnaires were made in accordance with the authors of the original instrument. In addition, the questionnaire consisted of 14 background questions.

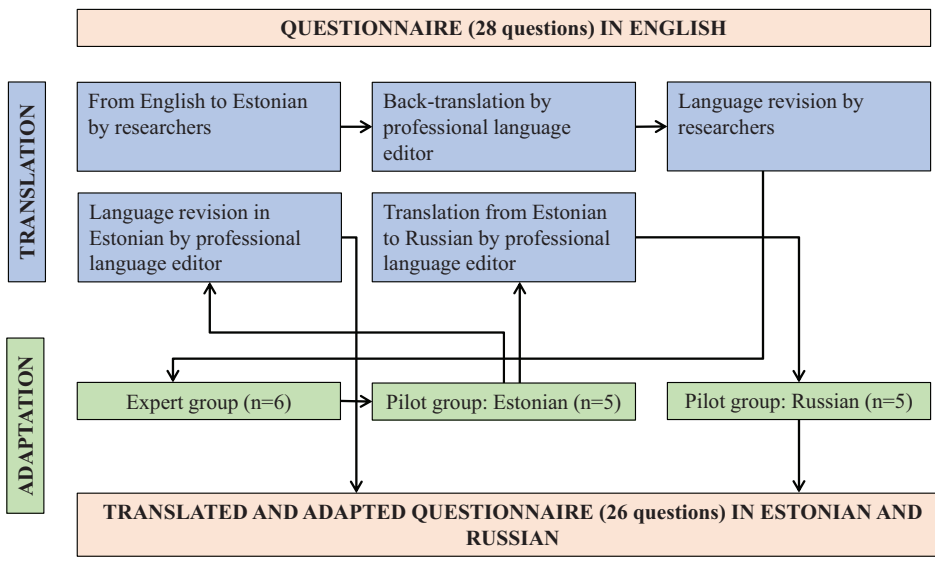

Figure 2. Instrument translation and adaption process.

The adapted instrument was divided into five sections regarding the impact of the COVID-19 pandemic on the nurses' work organisation, working context, frequency of nursing activities, ethical questions in care, and training and educational needs for COVID-19 nursing. Additionally, background questions were

included. Questions of the instrument contained several sub-questions (variables), which required rating via multiple-choice or a 5-point Likert-scale, or numerical or open-ended responses similarly to the original questionnaire. The instrument was descriptive and had no instructions for scoring and cut-off points provided by the developers.

4.3.2 Study variables

In this study, responses to four questions containing altogether 29 variables were included in the data analyses (Table 1) according to the research questions. Age, gender, level of education, working years, workplace, type of working contract, and religious identity were considered the respondents' sociodemographic background variables.

Table 1. Study questions and variables.

Question	Variables	Rating scale
Frequency of nursing activities	How frequently had you performed the following nursing tasks? • Fundamental care (patient hygiene, feeding, mobilisation...) • Nursing techniques (venous access management, respiratory support…) • Patient education • Symptom management (pain or dyspnoea management…) • Nurse-patient relationship • Non-nursing tasks (administrative work, transports…)	5-point Likert-scale from 1 *never* to 5 *most of the time* estimated before the COVID-19 pandemic and during the worst week of the pandemic
Change in number of patients compared to the time before the pandemic	Compared to the number of patients you took care of before COVID-19 emergency, did this number changed?	• Increased • Decreased • Stayed the same

Table 1. Study questions and variables. (continued)

Question	Variables	Rating scale
Estimated change in aspects of work	How much do you think the COVID-19 emergency changed the following aspects of your job? • Workload • Nurse-patients ratio • Presence of nursing aides / assistants • Working space organisation • Patients' complexity • Shifts • Usage of PPE • Relationship with patients' family • Relationship with colleagues • Work-life balance • Training colleagues and new nurses • Training students • Bureaucratic activities	5-point Likert-scale from 1 *not at all* to 5 *very much*
Frequency of perceived ethical issues	During the COVID-19 emergency, have you ever had to face these ethical choices? • Put my loved ones and my health at risk to take care of others • Follow employer directives even if they contrast with my ethical and deontological principles • Guarantee non COVID-19 patients an adequate access to care • Decide which patients to prioritise • Give transparent information to patients and their loved ones • Give complete information to colleagues • Guarantee patients an adequate end-of-life care • Guarantee patients to die feeling their loved ones close • Guarantee a respectful care for the dead body	5-point Likert-scale from 1 *not at all* to 5 *very often*

4.3.3 Participants and recruitment

Registered nurses working during the COVID-19 pandemic were the target group of the survey study and the main inclusion criterion. The convenience sampling method was used to recruit participants (Etikan, 2016) through professional organisations and associations for nurses and social media platforms gathering registered nurses.

4.3.4 Data collection

The data were collected with three surveys: in Estonia from the first (2020) and second (2021), and in Italy from the first (2020) wave of the COVID-19 pandemic. The data from the first wave in Italy were collected by the authors of the original instrument and were included in the study to compare ethical issues between nurses working in different contexts during the pandemic (Figure 3).

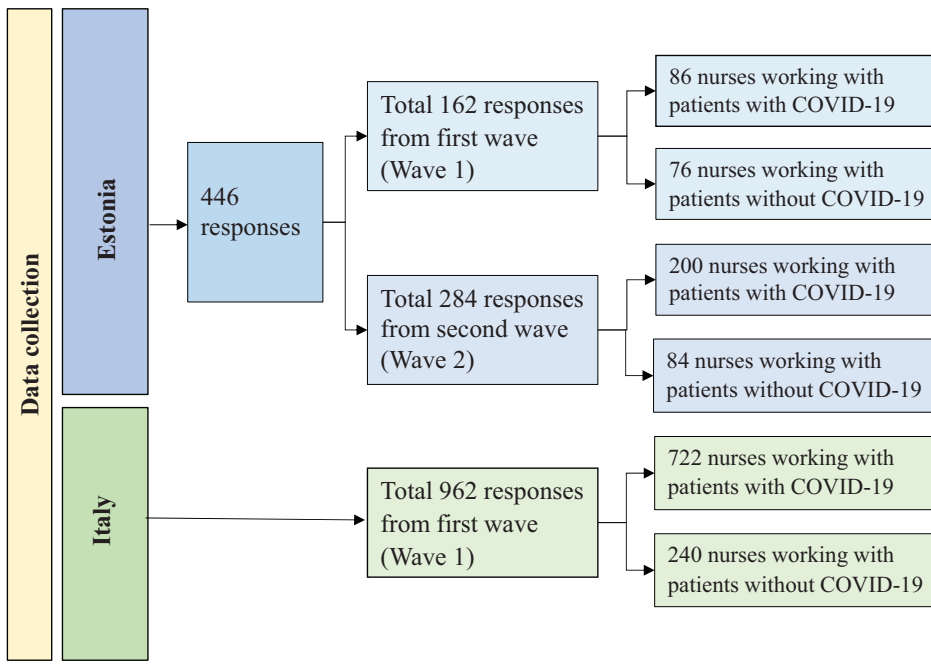

Figure 3. Flowchart of formation of the final database in the survey.

4.3.5 Data analyses

Descriptive statistics and advanced statistical tests were performed with Microsoft Excel 2016 and STATA 14. Data were divided based on countries and by the data collection period. Further, the data were divided into two groups based on nurses caring for patients with or without COVID-19 (Figure 3). Likert scores were then dichotomised into two groups: *seldom* or *not so much*, incorporating

responses from 1 to 3, and *often* or a *lot*, incorporating responses 4 and 5. Further, a 60% cut-off point for incorporated Likert scores was used. If 60% or more respondents rated a change in a work aspect, in the frequency of nursing activity, or in the frequency of ethical issues faced as *seldom/not so much* or *often/a lot*, we interpreted it as such at the group level. Descriptive statistics to identify the distribution of responses and Fisher's exact test, McNemar's test, Student's T-test (p-value<0.05 for all), and 95% confidence intervals (CI) for the statistical significance of the differences between groups were calculated.

5. RESULTS

5.1 Ethical conflicts in nursing before the COVID-19 pandemic (Paper 1)

Experiences with ethical conflicts that nurses shared, covered ethical dilemmas, uncertainty and distress. Based on the results (Table 2), nurses have experienced ethical conflicts both as an internal value conflict experienced individually because of some values or goals perceived incompatible or difficult to reconcile in a particular situation, and as a bi- or multilateral value conflict between people they contact in the provision of care regarding good care for patients, nurses as healthcare professionals and nurses working in care organisations.

Table 2. Themes of ethical conflicts of nurses.

Themes	Main categories	Sub-categories
Good care for patients	Dehumanising patients	• Treating patient as an object Insufficient involvement of patient and/or family Lack of care towards patient suffering Paternalistic behaviour towards patient Forcing helplessness or inactivity of patient • Endangering patient's privacy Talking publicly about patient • Labelling patient • Unequal attitude due to patient's social background
	Disagreement with treatment decisions	• Insufficient treatment or care Aggressive treatment at the end of life instead of palliative treatment • Questionable harm/benefit ratio of treatment or care
Nurses as healthcare professionals	Nurse profession perceived as not valued and respected	• Lack of involvement in the decision-making process • The salary does not match the job contribution • Limitations in informing patients and relatives Hierarchy within the team Inappropriate behaviour of patients and relatives

Table 2. Themes of ethical conflicts of nurses. (continued)

Themes	Main categories	Sub-categories
	Perceived insufficiency of professional competence	• Lack of competence on following patient's actual will • Lack of competence in giving appropriate end-of-life care • Lack of competence in giving appropriate support to relatives of patient • Uncertainty about impact of own action or disregard for other's life and death • Professional image perceived as a burden
Nurses working in healthcare organisations	Unprofessional relationships within the healthcare team	• Disrespectful behaviour towards nurses • Team members dealing with personal matters during work • Team members playing out their tensions on others • Fighting in front of the patient • Bullying within the team
	Unsupportive working environment	• Institutional values conflicting with nursing values • Lack of support from managers • Working organisation preventing provision of good care • Unclear or excessive rules and demands • Lack of cooperation within healthcare system

5.1.1 Ethical conflicts related to providing good care for patients

Regarding good care for patients, nurses identified *dehumanising patients* and *disagreements with treatment decisions* important sources of ethical conflicts. Regarding *dehumanising patients*, they shared different situations they experienced that conflicted with the core principles of humanity and patient-centred care, such as patient autonomy, privacy, dignity, equality, and empathy. Ethical conflicts arose when patients were treated as objects or ill body parts, and their rights, needs, or preferences were endangered or violated, often due to paternalistic, disrespectful, careless, or unequal behaviour by healthcare staff. Also, patients and their loved ones were not always sufficiently involved in the decision-making process regarding their health, treatment and care. Patients' autonomy was compromised by neglecting their preferences for staff convenience and thus

forcing helplessness and inactivity or applying physical restraint too lightly. According to the nurses, patients' privacy, both physical and informational, was endangered in different ways during the care provision. This included unnecessary exposure of the patient, improper disclosure of personal health information to unauthorised individuals through conversations being overheard publicly or sharing health information with family members instead of the patient. Patients were not always treated equally based on their social background, and even prejudices towards certain groups were expressed sometimes through labelling them by healthcare staff. In contrast, patients with better social standing or publicly known received better and more attentive treatment.

Nurses identified *disagreements with treatment decisions* as another source of ethical conflict regarding good care, especially when they did not follow primarily the patients' rights, needs and preferences, but were rather justified by other reasons based on the nurses' responses. Patients received both excessive and aggressive treatment or procedures without a clear or achievable goal or instead of good palliative care and they did not receive the necessary treatment and procedures. As a result, patients experienced unnecessary pain and discomfort that nurses said could have been avoidable. Nurses were not part of the decision-making process regarding treatment and care they had to implement those decisions or witness them as bystanders. However, they sought a balance between good and harm and the meaningfulness of the treatment decisions, especially at the end of the life of patients.

5.1.2 Ethical conflicts regarding nurses as healthcare professionals

Regarding being healthcare professionals, nurses experienced ethical conflicts when they perceived their *profession as not valued and respected in society* and they were *insufficiently competent*. Nurses perceived their *profession was not valued and respected* when they were excluded from the decision-making process related to treatment and care decisions or those concerning their work. From the nurses' perspective, their low salary was also a sign of their profession not being valued in society. An important concern was the unclear roles and autonomy of nurses, especially in informing patients and their loved ones. This prevented them from providing the care, that patients and their loved ones needed. For nurses, the rules regarding the process of informing patients and what was prioritised was not always the needs of the patients and their loved ones but the rules and legislation itself. Strict hierarchy in the healthcare team affected nurses' position and professional autonomy. Nurses experienced ethical conflicts also due to patients' and their loved ones' inappropriate behaviour as a sign of disrespect towards them as professionals, including expressing anger and aggression. Also, gifts from patients and their loved ones were a regular tradition in care provision, a practice nurses found inappropriate in a professional setting and were unsure how to behave in such situations. However, at the same time, they did not want to hurt patients' feelings by refusing gifts.

Regarding their role and responsibilities as healthcare professionals, nurses felt they were *insufficiently competent* regarding various knowledge, skills and competencies. They had doubts regarding their decisions and actions and the influence of those on patients. Additionally, it was challenging to understand what the real will of the patient was, especially in end-of-life situations. It was difficult for nurses to mitigate suffering and provide dignified end-of-life care based on patients' preferences. Sometimes it was difficult to mediate between the controversial preferences of patients and their loved ones. For nurses, it was essential to support loved ones of critically ill patients, but often they perceived limited time and competence to do so. They questioned the compatibility of their professional position and duties with their personal values, for example, the risk of contributing to euthanasia through medication choices or resuscitation decisions in emergency contexts. Nurses sometimes perceived their profession as a constant burden they had to carry even outside the working hours to protect the professional image of nurses.

5.1.3 Ethical conflicts regarding nurses working in care organisations

Regarding nurses working in care organisations *unprofessional relationships within the healthcare team* and an *unsupportive working environment* were sources of ethical conflicts for nurses. Nurses experienced ethical conflicts due to *unprofessional relationships within the healthcare team* and the disrespectful behaviour of their team members. This included addressing personal issues during work hours and projecting tensions onto colleagues, which nurses considered unacceptable in professional relationships. Nurses reported experiencing insults, humiliation, disrespect and vulgarity. They also experienced bullying due to religious beliefs, different languages or culture, or for reason they did not know or understood. Power struggles among team members, that sometimes escalated to fights in front of the patient, limited nurses' ability to fulfil their duties, risking patient safety by compromising working principles. Nurses prioritised patient-centred care but perceived an *unsupportive working environment* to prevent it when institutional values conflict with nursing ethics, emphasizing cost-saving and efficiency. At the same time, nor they did they find enough support from managers or organisations. Poor organisation of work and excessive workload were also reasons that prevented nurses from following nursing values, and this led to incomplete care. Staff shortages forced nurses to undertake tasks beyond their competence, which caused ethical conflicts. Based on the results, some rules and guidelines that frame the organisation of the health services seemed impractical for nurses and were contradictory to patient-centred care and nursing values. In addition, the lack of interprofessional cooperation in the healthcare system placed them in the middle of conflicting or ambiguous demands.

5.2 Changes in nurses work during the various phases of the COVID-19 pandemic (Paper 2)

5.2.1 Respondents' sociodemographic characteristics

Altogether 446 nurses working with patients with and without COVID-19 were surveyed during the first (n=162) and second (n=284) wave of the pandemic in Estonia to evaluate the changes that the COVID-19 pandemic brought to nurses' work and nursing activities. Most of the respondents were women, held higher education degrees in nursing and worked full-time in hospitals (Table 3). Approximately half of the nurses in the first wave and three-quarters in the second wave had worked with patients with COVID-19.

Table 3. Sociodemographic data (%) of nurses working in Estonia with patients with (COVID-yes) and without (COVID-no) COVID-19.

	1st wave			**2nd wave**		
	COVID -yes n=86	**COVID -no n=76**	***Differences****	**COVID -yes n=200**	**COVID -no n=84**	***Differences****
Average age (SD)	42 (11)	47 (11)	**0.028**	46 (12)	48 (10)	0.344
Gender			0.068			0.185
Women	92	99		94	98	
Men	8	1		4	0	
Other	0	0		2	2	
Education			**0.036**			0.721
Secondary special education in nursing	5	17		18	16	
Higher education in nursing	48	43		43	49	
Advanced specialist[a]	47	40		39	35	
Working years, mean (SD)	17 (13)	24 (13)	**0.002**	22 (13)	22 (13)	0.831
Type of organisation			0.869			0.267
Hospital	66	65		70	63	
Other	34	35		30	37	
Religious identity			0.561			0.406
Atheist	36	31		39	45	
Christian denominations	55	54		42	42	
Other	9	15		19	13	

*Fisher's exact test to test for differences between groups; Student's t-test to test for differences of means; [a] Specialisation in advanced nursing, Master's degree, PhD.

5.2.2 Changes in nurses' work context

Based on the results, the three aspects that the first and second waves of the COVID-19 pandemic most influenced were nurses' workload, workspace organisation, and the usage of PPE (Figure 4). Furthermore, there was a reported decrease in the number of patients during the pandemic in the first wave and an increase in the second wave compared to the period before the pandemic (Table 4). Three-quarters of nurses in the second wave perceived considerable changes in the nurse-patient ratio and patient' complexity as well (Figure 4). Based on the results, nurses' work context changed more during the second wave, when the workload, presence of nursing aids/assistance, nurse: patient ratio, patient complexity, planned working, relationship with patients' family, and training students changed statistically significantly more ($p<0.005$) compared to the first wave.

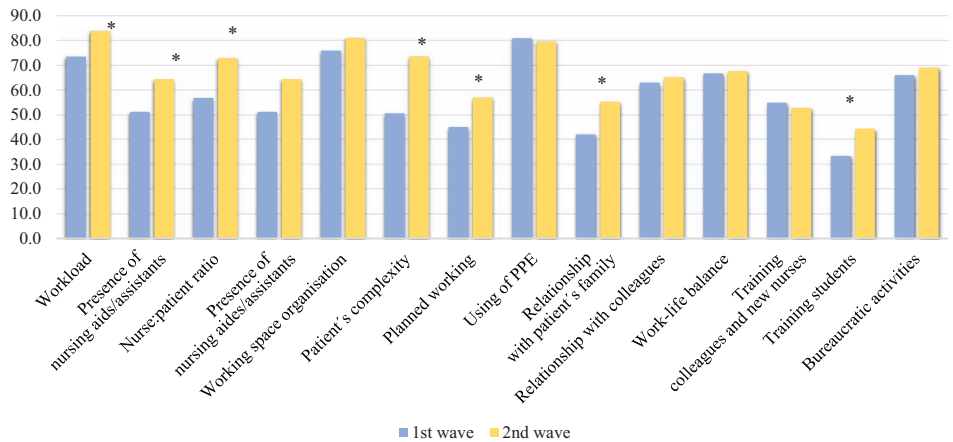

Figure 4. Change in aspects of nurses' work during the 1st (n=162) and 2nd (n=284) wave of the COVID-19 pandemic in Estonia. Based on the proportion (%) of nurses, who taught the change was considerable (scores 4 and 5). *Statistically significant differences between waves, p<0.05, Ficher's exact test.

Table 4. Differences in work context of nurses working with patients with (COVID-yes) and without COVID-19 (COVID-no).

	1st wave			2nd wave		
	COVID −yes n=86	**COVID −no n=76**	***p-value****	**COVID −yes n=200**	**COVID −no n=84**	***p-value****
		% (95% CI)[1]			**% (95% CI)[1]**	
Number of patients			0.351			0.305
Unchanged	23 (15−34)	28 (19−39)		19 (14−25)	26 (18−37)	
Decreased	50 (39−61)	55 (44−66)		19 (14−25)	19 (12−29)	
Increased	27 (18−37)	17 (10−28)		62 (56−70)	55 (44−65)	
Change in working aspects						
Workload	84 (74−90)	61 (50−72)	**0.002**	90 (84−93)	70 (59−79)	**<0.001**
Nurse-patient ratio	64 (53−74)	49 (38−60)	0.058	78 (71−83)	62 (51−72)	**0.009**
Presence of nursing aides/assistants	62 (51−71)	40 (29−51)	**0.007**	69 (62−75)	55 (44−65)	**0.030**
Workspace organisation	83 (73−89)	68 (57−78)	**0.043**	87 (82−91)	67 (56−76)	**<0.001**
Patients' complexity	56 (45−66)	45 (34−56)	0.208	77 (71−82)	66 (55−75)	0.055
Use of PPE	81 (72−88)	80 (70−88)	1.000	82 (76−87)	74 (63−82)	0.146
Relationship with patient's family	40 (30−50)	45 (34−56)	0.527	57 (50−63)	52 (42−63)	0.601
Relationship with colleagues	77 (67−85)	47 (36−59)	**<0.001**	69 (62−75)	56 (45−66)	**0.041**
Work-life balance	78 (68−86)	54 (36−59)	**0.002**	71 (64−77)	61 (50−71)	0.127
Training colleagues and new nurses	61 (50−70)	49 (38−61)	0.156	60 (53−67)	36 (26−47)	**<0.001**
Training students	36 (27−47)	30 (21−42)	0.505	47 (40−54)	38 (28−49)	0.191
Bureaucratic activities	74 (64−83)	57 (45−68)	**0.020**	75 (69−81)	55 (44−65)	**<0.001**

[1] Based on nurses, who evaluated the change considerable (scores 4 and 5) *Fisher's exact test

Compared to nurses working with patients without COVID-19, for those working with patients with COVID-19 the workload, presence of assistants, workspace organisation, planned working and relationships with colleagues changed more in both waves (Table 4). Additionally, nurses working with patients with COVID-19 noted significant changes in work-life balance in the first wave and the nurse-patient ratio and training colleagues/new nurses in the second wave compared to nurses working with patients without COVID-19.

5.2.3 Changes in nursing activities

The most frequent nursing activities both before and during the COVID-19 pandemic, in both waves were activities related to the nurse-patient relationship, patient education, and symptom management. During the first wave, the frequency of nursing activities remained statistically unchanged compared to pre-pandemic times. There were statistically significant increases during the second wave in the fundamental care activities ($p=0.0001$), nursing techniques ($p<0.001$), symptom control ($p<0.001$) and non-nursing tasks ($p<0.001$) compared to before the pandemic (Figure 5).

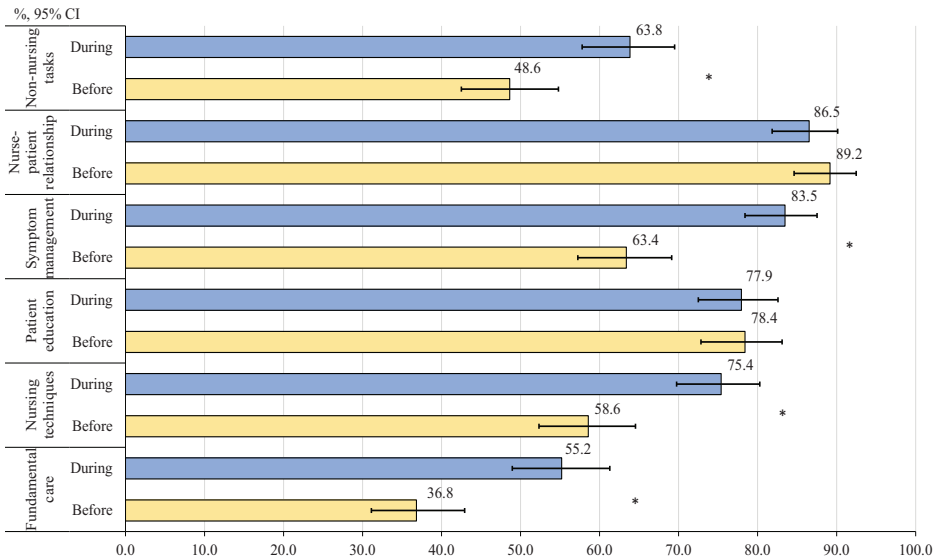

Figure 5. The frequency of nursing activities before and during the 2nd wave. Based on the proportion (% and 95% CIs) of nurses working in Estonia (n=284), who considered the frequency was high (scores 4 and 5). *Statistically significant differences, p<0.05, Fisher's exact test.

The frequency of nursing activities during the first wave did not vary statistically significantly between nurses working with patients with and without COVID-19. This was different from the second wave when nurses working with patients with COVID-19 performed fundamental care activities (*p=0.003*), nursing techniques (*p=0.004*), and tasks related to symptom management (*p=0.003*) more frequently compared to those working with patients without COVID-19 (Figure 6).

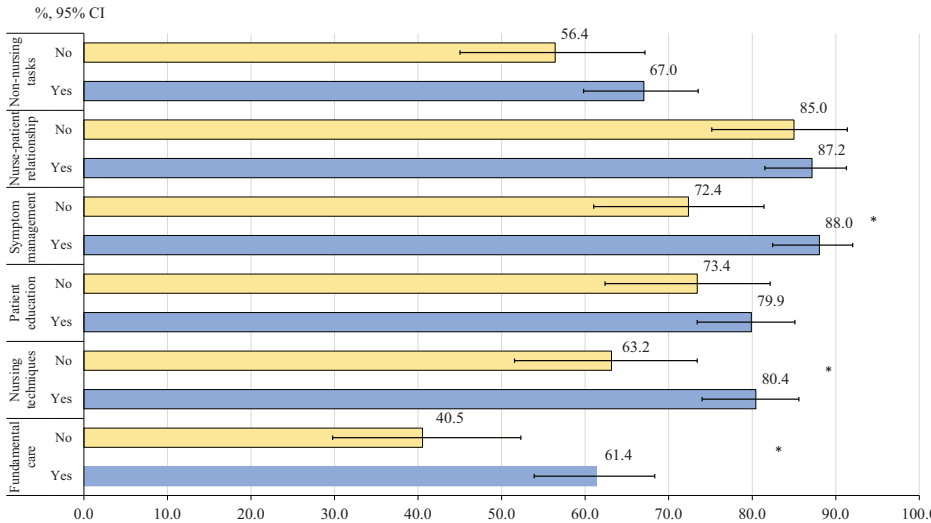

Figure 6. The frequency of nursing activities during the 2nd wave. Differences between nurses working in Estonia with patients with (Yes, n=200) and without COVID-19 (No, n=84). Based on the proportion (% and 95% CIs) of nurses, who considered the frequency was high (scores 4 and 5). *Statistically significant differences, p<0.05, Fisher's exact test.

5.3 Ethical issues for nurses working in different contexts during the COVID-19 pandemic (Paper 3)

5.3.1 Respondents' sociodemographic characteristics

Nurses working in Estonia during the first (n=162) and second (n=284) waves were surveyed. To increase the variety contexts in which to investigate ethical issues, data of ethical issues in nursing in Italy (n=936) during the first wave were added to the Estonian data. Most respondents from both countries were employed in hospital settings (Table 5). When comparing respondents from Estonia and Italy, it was observed that nurses in Estonia were significantly older with longer working experience in the nursing profession and were less likely to identify as religious compared to their colleagues in Italy. Additionally, Estonian nurses were more predominantly female compared to Italian nurses. Approximately half of the Estonian nurses and three-quarters of the Italian nurses reported working

with patients with COVID-19 during the first wave, with the percentage significantly higher in Italy (Table 5). When comparing respondents in Estonia in the two waves, during the first wave, nurses who provided care to patients with COVID-19 were younger, had fewer years of working experience, and had a lower level of education compared to their colleagues working with patients without COVID-19 (Table 3). During the second wave, there were no statistically significant differences in sociodemographic data between Estonian nurses.

Table 5. Sociodemographic data (%) of nurses working in Estonia and Italy during the first wave of the COVID-19 pandemic.

	Estonia			**Italy**	
	1st wave	**2nd wave**	***Differences between waves****	**1st wave**	***Differences between countries****
Working with or without COVID-19 patients			**<0.001**		**<0.001**
With COVID-19 patients	53	70		77	
Without COVID-19 patients	47	30		23	
Average age (SD)	44 (11)	46 (11)	**0.019**	40 (11)	**<0.001**
Gender			0.097		**<0.001**
Women	95	95		68	
Men	5	3		16	
Other	0	2		16	
Education			0.122		**<0.001**
Secondary special education in nursing	10	17		25	
Higher education in nursing	46	45		40	
Advanced specialist[a]	44	38		35	
Working years, mean (SD)	20 (13)	22 (13)	0.451	19 (12)	**<0.001**
Type of organisation			0.585		**<0.001**
Hospital	65	68		83	
Other	35	32		17	
Religious identity			**0.040**		**<0.001**
Atheist	34	40		30	
Christian denominations	54	43		68	
Other	12	17		2	

*Fisher's exact test to test for differences between groups; Student's t-test to test for differences of means; [a]Specialisation in advanced nursing, Master's degree, PhD

5.3.2 Ethical issues for nurses during the first and second wave of the COVID-19 pandemic

The most frequent ethical issues for Estonian nurses were similar during the first and second wave. During both waves, the most frequent ethical issues were ensuring adequate access to care for patients without COVID-19 and providing complete and transparent information to colleagues as well as patients and their families (Figure 7).

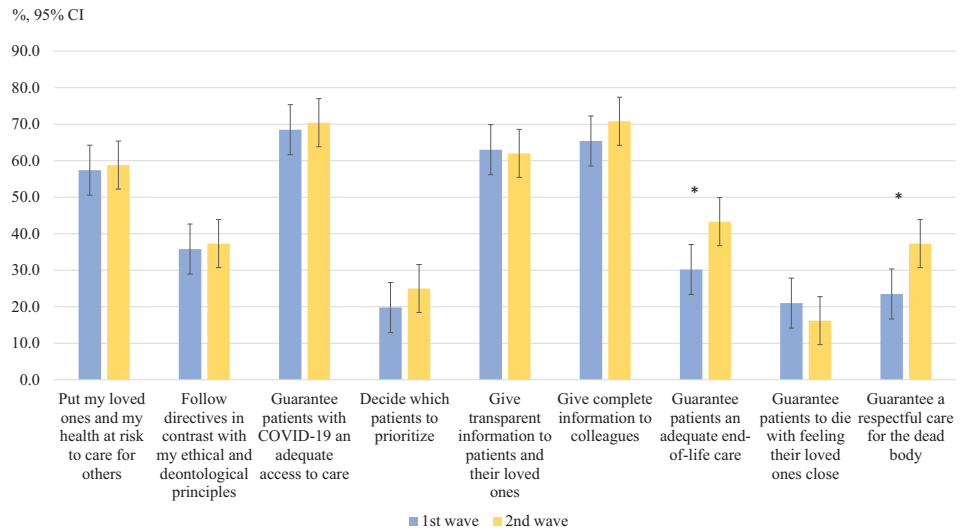

Figure 7. The frequency of ethical issues among nurses working in Estonia during the 1st (n=162) and 2nd (n=284) wave. Based on the proportion (% and 95% CIs) of nurses, who considered the frequency was high (scores 4 and 5). *Statistically significant differences, $p<0.05$, Fisher's exact test.

The most frequent ethical issues for nurses working with patients with or without COVID-19 in Estonia were also the same during the first and second wave (Figure 8). For nurses working with patients with COVID-19 the most frequent ethical issues during both waves were providing complete information to colleagues and ensuring adequate access to care for patients without COVID-19. They also reported the importance of communication with patients and their families and the personal challenge of putting their loved ones and themselves at risk while caring for others. For nurses working with patients without COVID-19 the most frequent ethical issues during both waves were regarding adequate access to care for patients without COVID-19, giving transparent information to patients and their families and providing complete information to colleagues.

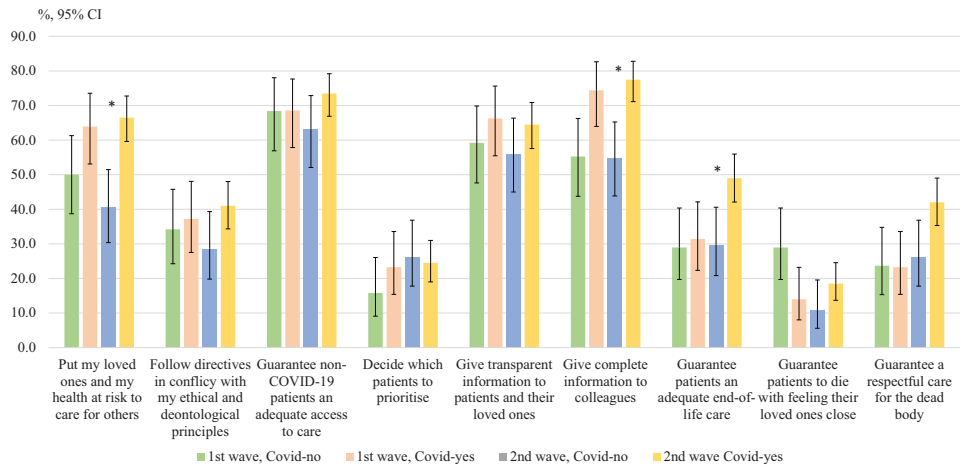

Figure 8. The frequency of ethical issues among nurses working in Estonia with patients with (Covid-yes) and without (Covid-no) COVID-19 during the 1st (n=162) and 2nd (n=284) wave. Based on the proportion (% and 95% CIs) of nurses, who considered the frequency was high (scores 4 and 5). *Statistically significant differences, *p<0.05,* Fisher's exact test.

During the first wave, for nurses working in Italy, the most frequent ethical issues were related to endangering themselves and their loved ones to care for others, giving complete information to colleagues, and ensuring adequate end-of-life care for patients (Figure 9). Italian nurses working with patients with COVID-19 reported the most prevalent ethical issue as putting their loved ones and themselves at risk to care for others. Giving complete information to colleagues, ensuring adequate end-of-life care for patients, and maintaining respectful care for deceased individuals were also frequent. In contrast, Italian nurses working with patients without COVID-19 reported the importance of guaranteeing patients' adequate access to care, managing the risk of putting their loved ones and themselves at risk to care for others, and giving complete information to colleagues and patients and their families as frequent ethical issues.

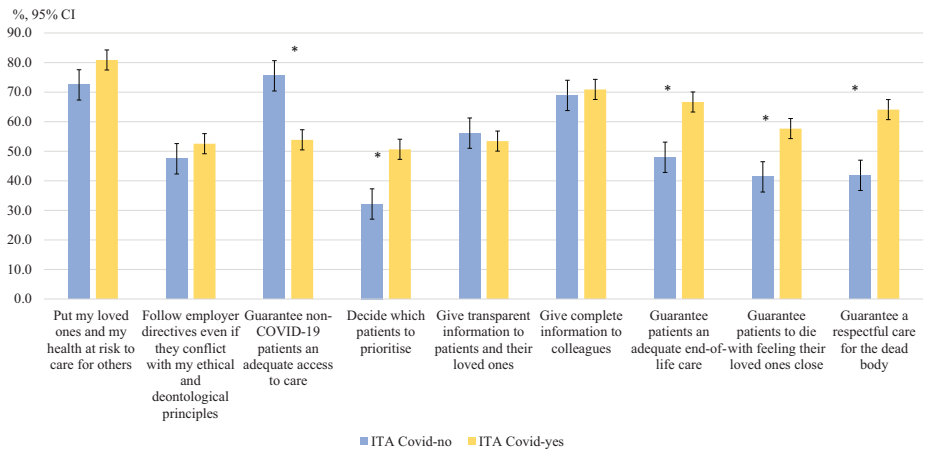

Figure 9. The frequency of ethical issues during the 1st wave of the COVID-19 pandemic among nurses working in Italy with patients with COVID-19 (Covid-yes, n=722) and without COVID-19 (Covid-no, n=214). Based on the proportion (% and 95% CIs) of nurses, who considered the frequency was high (scores 4 and 5). *Statistically significant differences, $p<0.05$, Fisher's exact test.

5.3.3 Differences in ethical issues between nurses working in different contexts

During the first wave, compared to the Estonian colleagues, Italian nurses faced statistically significantly more (all $p<0.001$) ethical issues regarding putting themselves and their loved ones at risk while caring for others. It was the same with following employer directives, even when they conflicted with their ethical beliefs compared to the Estonian nurses (Figure 10). Similar results were observed regarding prioritising Italian patients and handling all end-of-life issues.

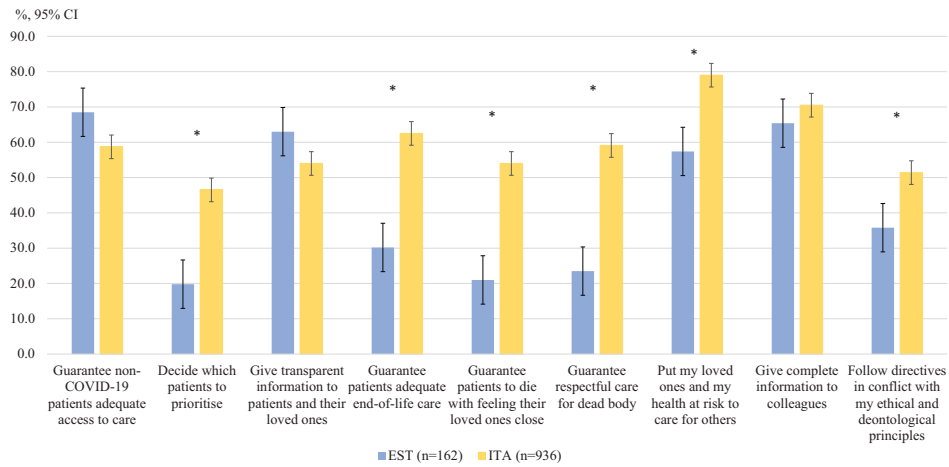

Figure 10. The frequency of ethical issues during the 1st wave among nurses working in Estonia (n=162) and Italy (n=936). Based on the proportion (% and 95% CIs) of nurses, who considered that the frequency was high (scores 4 and 5). *Statistically significant differences, $p<0.05$, Fisher's exact test.

When comparing nurses working in Estonia during different waves, in the second wave nurses faced statistically significantly more ($p<0.005$) ethical issues regarding guaranteeing adequate end-of-life care for patients and respectful care for dead bodies compared to the first wave (Figure 7).

When comparing nurses based on their working with patients with and without COVID-19 in Estonia, no significant differences were found in the first wave (Figure 8). In the second wave, nurses working with COVID-19 patients had to put themselves and their loved ones at risk to care for others more frequently ($p<0.001$) compared to their colleagues working with patients without COVID-19. Also, they faced ethical issues with giving complete information to colleagues more frequently ($p<0.001$) as well as with guaranteeing respectful care for the dead body ($p=0.004$). When comparing nurses working with patients without COVID-19 across the two waves, there were no statistically significant differences in the frequency of ethical issues (Figure 8). Nurses working with patients

with COVID-19 in the second wave faced ethical issues regarding guaranteeing respectful care for the dead body significantly more frequently ($p=0.003$) compared to the first wave.

During the first wave in Italy, nurses caring for patients with COVID-19 encountered statistically significantly more ethical issues with respect to deciding which patients to prioritise and end-of-life scenarios ($p<0.001$ for all) compared to those caring for patients without COVID-19 (Figure 9). Conversely, nurses working with patients without COVID-19 faced more ($p<0.001$) ethical issues related to ensuring adequate access to care for patients without COVID-19.

6. DISCUSSION

6.1 Discussion of main results

The study provides an overview of ethical issues and their contextual aspects in nursing before and during the COVID-19 pandemic. Before the pandemic, nurses experienced ethical dilemmas, uncertainty and distress regarding good care for patients, nurses as healthcare professionals and their working in healthcare organisations. The COVID-19 pandemic significantly altered nurses' work, especially for nurses working with patients with COVID-19 with the second wave bringing more pronounced changes in nurses' work and nursing activities compared to the first wave. The COVID-19 pandemic caused various ethical issues in nursing, which correlated with the progress and intensity of the pandemic and nurses working with infected patients. Study results show that the position of patients' rights, nurses' professional roles and autonomy, workload, demographic and socio-cultural position and preparedness for crises create specific contextual aspects that shape the ethical issues in nursing.

6.1.1 Ethical issues in nursing regarding patients' rights

Results of the study show that nurses face various issues concerning patients' rights in care provision that prevent them from following the professional values of nursing and cause ethical issues (Papers 1 and 3). Protecting patients' rights and providing patient- and family-centred care is challenging for nurses both in pre-pandemic time (Paper 1) and during the pandemic (Paper 3). This aligns with the core of the nursing profession, which emphasises a holistic focus on patients, the attentive presence of nurses, the identification of patients' needs and respect towards their preferences (International Council of Nurses, 2021). Before the pandemic, when, despite some inadequacies, healthcare resources and nurses' skills were generally sufficient in Estonia, patients' rights to privacy, confidentiality, involvement, equality, dignity, and autonomy were, according to the nurses, compromised in many ways (Paper 1). These findings align with existing knowledge of the most significant sources of ethical issues in nursing in daily care (Falco-Pegueroles et al., 2015; Gaudine et al., 2011; Leuter et al., 2012; Pavlish et al., 2011; Shahriari et al., 2013; Ulrich et al., 2010).

Results denote that providing dignified and equal care was particularly challenging for nurses during the COVID-19 pandemic (Paper 3). This corresponds to previous research about ethical issues and their contextual aspects during the pandemic (Bruyneel et al., 2021; Galehdar et al., 2020), which affected the provision of holistic and dignified care (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Villa et al., 2021), especially when taking care of patients with COVID-19 (Aydogdu, 2022; Gebreheat & Teame, 2021; Villa et al., 2021). To provide care during the pandemic, nurses had to reorient from the usual ethical framework to a public health-centred approach, which was difficult for nurses as the results

show (Paper 3). This coincides with previous studies reporting the same difficulty (Aydogdu, 2022; Gebreheat & Teame, 2021).

Results suggest that in clinical practice the protection of patients' rights in Estonia still remain weak (Papers 1 and 3), particularly for vulnerable groups and patients and their families are not always considered partners (Papers 1). Similar concern has been discussed previously in the context of the Estonian health system (Lai et al., 2013) and it is in line with studies conducted in other former Soviet countries (Cerela-Boltunova, 2024; Grabauskas et al., 2004; Luneckaitė & Riklikienė, 2022). However, in Estonia patient-centred healthcare is a national priority (Estonian Ministry of Social Affairs, 2021; World Health Organization-Europe, 1994) and patients' needs and preferences should be prioritized in care provision. Patients' right to informed consent, involvement in care and confidentiality are legally protected (Lai et al., 2013; Law of Obligations Act, 2001; World Health Organization-Europe, 1994) and the nursing profession adheres to ethical codes (International Council of Nurses, 2021). Therefore, the implementation of patients' rights requires continuing attention in nursing practice, management and research. Ethical issues regarding patient care that nurses face should get more attention in clinical practice. They reflect different deficiencies in nursing practice and thus, understanding and analysing ethical issues enables enhancement of care quality and safety.

6.1.2 Ethical issues in nursing regarding nurses' professional roles and autonomy

The study results show that in Estonia, nurses' professional position and roles are unclear, professional autonomy is limited by oppressive hierarchy, and that there are deficiencies in professional communication, teamwork and healthcare regulations (Paper 1). This includes nurses' rights to inform patients and participating in treatment decisions. The results indicate that nurses cannot always represent the patient's preferences and needs (Paper 1). Sometimes they face moral distress when forced simply to implement decisions, including those that contradict their understanding of what is right. This prevents nurses from responding to patients' needs and respecting their preferences according to professional values of nursing. It also undermines nurses' professional autonomy, makes nurses uncertain in their decisions and leaves them with destructive personal guilt due to situations that do not respond to their understanding of right and good. This is in line with the previous study from Lithuania (Laurs et al 2020). Nurses' role in professional teams and communication with colleagues is suppressed due to power imbalance, hierarchy and unprofessional communication, including bullying (Paper 1). Results align with previous studies of nurses' input, which has frequently been undervalued in healthcare teams (Gutierrez, 2005; Lievrouw et al., 2016) and leads to disempowerment and limited authority in decision-making (Henrich et al., 2016; Kisorio & Langley, 2016; Wilson et al., 2013). For Estonian nurses, this creates a feeling that their profession is undervalued both in the healthcare teams and in society as a whole (Paper 1). Focusing on interprofes-

sional ethics instead of professional ethics in healthcare could enhance better understanding between different professionals working together, foster collaboration and shared accountability and navigate complex situations towards better patient outcomes (Engel & Prentice, 2013).

Nurses faced ethical issues due to the struggles between their professional and personal roles also during the pandemic (Paper 3). Nurses are oriented to fulfil their duty to care, but they were also challenged with distinguishing between work and private life, especially in relation to the risk of getting infected and spreading the dangerous virus to their loved ones. This is in line with numerous previous studies of the COVID-19 pandemic, which reported nurses' fear for their health and that of their loved ones (Aydogdu, 2022; Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021). That was not completely new for nurses who had previously worked during crises for example during epidemics (Hsin & Macer, 2004), but it was new for nurses in Estonia, because in Estonia, there has not been nature disasters, terrorist attacks or military conflicts with mass casualties, scarcity of resource and role struggles, that these can cause. It is important to understand that in crises situations nurses may struggle more than usually between their various roles, duties and rights and that can influence their work. It is also important to respect nurses' right to protect their safety and care for themselves and their loved ones and not to consider them solely as public resources obligated to respond during crises.

Good and trustful professional relations are important for nurses during regular times (Paper 1), but they are particularly important during anxious and confusing situations (Paper 3). In crises, when patient care becomes more complex and urgent, effective teamwork ensures that all healthcare providers work efficiently, share information and collaborate on treatment plans. Working in a supportive team where roles are clear and communication is open, reduces stress and prevents burnout and emotional exhaustion (Fernandez et al., 2020). However, ethical issues in relation to professional communication were frequent for nurses during the COVID-19 pandemic (Paper 3). This was highlighted also in a previous study due to regular teams changing constantly, which significantly affected professional relationships, communication, and information (Silverman et al., 2021).

The results indicate that balancing between professional values of nursing and external control framed by formal rules and guidelines is complicated for Estonian nurses (Paper 1). This is especially true in uncertain situations when professional values conflict with the rules or written guidelines, and nurses have doubts which they should follow. The healthcare system is strictly regulated and standardised worldwide (Kieft et al., 2014), but rules and guidelines should be tools to use for the benefit of the patients and families, not the goal itself. Excessive focus on external control makes nurses vulnerable in crisis conditions when clear rules may be absent or constantly changing (Falcó-Pegueroles et al., 2023; Oh & Gastmans, 2023). Therefore, it is important for nurses to internalise the professional values of nursing and be able to use them flexibly in combination with rules and guidelines for the purpose of the patients' best interest in different

situations. For this, it would also be important to strengthen cooperation with legal professionals and officials who are responsible for creating legislation and guidelines. They can support nurses to better understand the use of rules and guidelines in practical situations and to reflect the contradictions related to them. Inconsistencies between regulations and professional values of nursing from the perspective of nurses need further investigation to deepen understanding regarding them.

6.1.3 The role of workload in ethical issues in nursing

The results show that a high workload is an important cause of ethical issues in nursing (Paper 1). When nurses face overwhelming workloads, they shift to a task-based approach to manage time and meet demands, which leave them with the feeling of not being a good nurse and violating important professional values of nursing. It is then a significant challenge for them to fulfil their primary role with high clinical and ethical standards. This is in line with previous research addressing the influence of workload (Haahr et al., 2020; Varcoe et al., 2012; Wlodarczyk & Lazarewicz, 2011) and staff shortages Henrich et al., 2016; Leuter et al., 2012; Ulrich et al., 2010) on the content and quality of nurses' work and ethical issues. In Estonia, the workload of nurses is a topical issue as far fewer nurses are working in the healthcare system than is required to meet the needs of the ageing population (Habicht et al., 2018). Also, nurses often work more than a 1.0 workload to compensate the staff shortages and low salaries (Healthcare Trends in Estonia, 2022). Regulating nurses' workloads is essential to prevent ethical issues by ensuring nurses can provide quality care, avoid burnout and advocate for patients. This is especially important in countries like Estonia, where the number of nurses is significantly lower than the OECD average and the workload is not formally regulated (Kiivet et al., 2013; Lai et al., 2013).

The results demonstrate that the COVID-19 pandemic increased nurses' workload compared to the period before the pandemic, especially during the second wave (Paper 2). They show, that during the pandemic, nurses performed several nursing activities such as fundamental care, nursing techniques and symptom control more frequently than before the pandemic. The same has been reported in previous studies (Galehdar et al., 2020; Radfar et al., 2021). While the frequency of some nursing activities increased, none of the investigated activities decreased in frequency (Paper 2). On the contrary, activities based on close communication between nurse and patient, such as patient education, required just as much effort during the pandemic as before it. Moreover, the scope of nurses' roles and tasks expanded during the pandemic, and they also performed more non-nursing, managerial and organisational tasks. This is in line with previous studies pointing out nurses' multifaceted contribution during the pandemic (Arasli et al., 2020; Buheji & Buhaid, 2020). An important notion of the study is, that nurses perceived increased workload even when the intensity and consequences of the COVID-19 pandemic were relatively mild, and patient flow did not increase (Paper 2). Results are in line with the practical experience from that period in

Estonia, which confirm extensive preparations for more serious scenarios and activities to cope with the pandemic that nurses were related with. Results correspond also with studies that point to different tasks that contributed to the workload nurses during the pandemic (Aydogdu, 2022; Oh & Gastmans, 2023). To manage nurses' workload during a pandemic, it is important to study and identify the components of increased workload and improve working organisation to allow nurses to focus on direct patient care. Non-nursing staff should be trained to handle essential support roles.

6.1.4 The role of demographic and socio-cultural context in ethical issues in nursing

The study results (Papers 1 and 3) point to some demographic and socio-cultural aspects that should be considered to contextualise ethical issues in nursing. They illustrate the cultural and contextual sensitivity of ethical issues, which has been discussed in previous studies (DeKeyser Ganz & Berkovitz, 2011; Leuter et al., 2012; Rassin, 2008; Toliusiene & Peicius, 2007). Despite various similarities in ethical issues in nursing found in this study (Papers 1 and 3) compared to previous studies (Falco-Pegueroles et al., 2015; Gaudine et al., 2011; Leuter et al., 2012; Pavlish et al., 2011; Ulrich et al., 2010), seemingly similar issues can be influenced by different aspects (Ludwick & Silva, 2000; Wros et al., 2004). These aspects need attention to prevent ethical issues in nursing and emphasise the continuing need to examine ethical issues in different contexts.

The study results show that several ethical issues in nursing reflect the heritage of historical paternalistic attitudes, which is revealed in interviews with nurses (Paper 1). Estonian nurses perceive the hierarchy between healthcare professionals and administrators as something inevitable and fundamental. It runs like an invisible filament through various situations causing ethical issues in nursing. From a historical perspective, Estonia is in many ways in a different position compared to other Western countries, which it now forms part of. The Soviet heritage of strong hierarchy, paternalistic attitudes and orientation to the formal rules and external control influences both the healthcare and society in Estonia. The external control on human behaviour is strong and conventional in closed societies, like the former Soviet Union, where personal freedoms were limited (Pop-Eleches & Tucker, 2011). Strong authoritarian control was among the tools of the Soviet regime, and it was a part of the relations between the healthcare parties as well (Ernits et al., 2019; Lai et al., 2013). The results are in line with the relatively low position of the nursing profession in Estonia with limited opportunities for independent work (Ernits et al., 2019). They also coincide with studies conducted in other former Soviet countries (Laurs et al, 2020; Sandin & Walldal, 2002; Toliusiene & Peicius, 2007). However, the career paths in nursing, including independent working, have developed increasingly during recent years. Still the perceived hierarchy and its impact to decisions in clinical practice still needs further investigation.

The results show that the relations of healthcare professionals with patients still reflect a power imbalance, socially unequal treatment and paternalistic attitudes (Paper 1). Patients with a better social position or publicly or personally known may get more attention than those with a lower social one. It is not only the healthcare staff's attitudes. The generation of patients that mainly need nursing care at the present time also comes from the Soviet era, where patients were expected to be passive recipients of care rather than actively involved partners, and they did not have enough information or decision-making power (Lai et al., 2013). Although patients' awareness and willingness to participate in their care have improved nowadays, patients and families can sometimes still be unsure in their rights for autonomy, dignity and equality. Patients also sometimes still perceive that to get the best care one has to be a publicly known person to have personal acquaintances in an influential position. They consider gifts to the health professionals as an expected part of receiving care, which nurses perceive as inappropriate (Paper 1). However, Estonia has mandatory social health insurance system, based on solidarity since 1991 and patients mostly do not have to pay for the services.

Another important contextual aspect of ethical issues in nursing is the population and its demographic composition (Paper 1). In a small society such as Estonia, the risk of breaching patient confidentiality and violating privacy is heightened and personal information may be more easily shared or recognised, even without directly identifiable data, by using indirect situational detail. Additionally, the physical environment of healthcare institutions with modern and spacious designs can further endanger patients' privacy as the results revealed (Paper 1). Privacy and confidentiality issues as sources of ethical issues in nursing have been covered well in previous research (Fernandes & Moreira, 2013; Haahr et al., 2020), and the results of this study complement existing knowledge with a variety of contextual details, emphasise further the importance of confidentiality in nursing and the perception of boundaries between personal and professional life. This further emphasises the need for nurses to internalise ethical values as discussed above, critically evaluate each unique situation and flexibly apply ethical values instead of rigidly following deontological principles. It is important to investigate in more detail how nurses understand, interpret and prioritise different ethical values, how they apply them into practice and which limitations in this face. There is also an increasing need to improve the involvement of patients and families, who should be included in the process of designing, implementing and evaluating healthcare services, including the development of infrastructure and the environment. This would enable us to better identify their perspective and preferences in relation to privacy. There are some good examples in Estonia, but awareness and acceptance of this principle among managers and policymakers in particular need to be improved.

6.1.5 Crises and ethical issues in nursing

The results reveal that nurses were not prepared for a crisis such as the COVID-19 pandemic from an ethical perspective (Paper 3). Unlike countries that have previously faced crises due to large-scale natural disasters, infectious disease outbreaks, acts of terrorism, mass unrest or military conflicts, in Estonia, there has not been another such crisis in recent history. So, the COVID-19 pandemic was not only the first experience with such a large-scale health crisis for nurses and healthcare institutions in Estonia similar to other many countries, but it was the first crisis experience at all. There are international guidelines (International Council of Nurses, 2019) and national legislation and plans for disasters, and nurses are prepared for crises during their education and practice by crisis training (Habicht et al., 2018; Kiivet et al., 2013). However, these cover ethical principles only very superficially. The main focus regarding crisis preparedness so far has been put more on emergency and intensive care nurses. The COVID-19 pandemic highlights the need for all nurses to be prepared for crises (Fletcher et al., 2022). The results are in line with other studies, where was reported that neither care organisations nor nurses were prepared enough to manage a crisis on such a scale, including from an ethical point of view (Johnstone & Turale, 2014).

When the pandemic broke out, clinical ethics recommendations were established in Estonia for such situations (Sutrop & Simm, 2020), but they came after the first wave and there was not enough time for nurses to adapt and internalise them. Moreover, in Estonia nurses were not included in the process of creating those recommendations. In the future, they should participate actively in such processes as advocates of patients and representatives of independent profession. It is equally important to clinical preparedness to also improve the preparedness for crises on an ethical level (International Council of Nurses, 2019; Johnstone & Turale, 2014; Kumar & Ranjan, 2020). Also, community involvement is very important in discussing crisis standards of care (CSC) so that they would be equally understandable and accepted by both nurses and community members. The recent COVID-19 pandemic has created a good ground for this, as the entire population has had direct contact with the crisis.

The results point to an important gender discrepancy needing attention regarding ethical issues in nursing during crises (Papers 2 and 3), as the vast majority of nurses in the study were women. This is in line with the gender distribution in nursing globally (National Health Foundation; OECD, 2020) and in Estonia, where it is even more inclined towards women (National Health Foundation, n.d.). It has been demonstrated that during crises the burden of women is higher than of men as they have important responsibilities also to the family and tasks to carry out at home (Lakshmi & Prasanth, 2018; OECD, 2020). When preparing for future crises the fact, that nurses, who are mainly women, are more sensitive to changes in the work context and more vulnerable to overload should be taken into account (OECD, 2020). As a results of this, they may be also more affected by ethical issues that crises cause. To help nurses balance their work and personal lives during crises, it is crucial to address factors affecting work-life balance in

greater detail, such as by offering flexible childcare options and promoting flexible working conditions. By supporting nurses' responsibilities outside their work their professional roles are also strengthened (OECD, 2020). Another concerning result that emerged was that nurses who were younger and had less work experience were the first to respond to the crisis by starting work in the frontline (Paper 2). This may be due to their greater willingness to undergo new experiences, as well as their fewer responsibilities to family members and children. However, younger nurses with less work experience are less experienced in solving complicated ethical situations (Ulrich et al., 2010) and need support in this.

Finally, based on the study results regarding changes in nurses' work (Paper 2) and ethical issues (Paper 3), and considering the broader perspective and conceptual context regarding crises, the question about when the crisis can be considered over, arises. This question is acute in the conditions of a polycrisis, where several crises are interrelated (Lawrence et al., 2024). There is a danger that somewhat lower CSC that were relevant during the crisis, remain present even after the crisis is over. In a certain sense, healthcare is in a constant crisis considering the challenges of daily practice (Thompson et al., 2006). However, sudden and unexpected crises leave no room for adaptation and require immediate intervention. Another concern is that nurses exhausted by the crisis are eager to return to the normality that preceded the crisis, but this normality may be unachievable. Based on previous studies, crises change care provision and understandings and there is a risk that in the next crisis, the same problems will be repeated if they are not learned from previous ones (Abdelrahman, 2022; Lawrence et al., 2024; Leider et al., 2017; Minnesota Department of Health, 2021). These questions are not merely semantic, but practical, because they concern the basic understandings and standards according to which care is provided. Ethical issues in nursing are a good marker of the areas most in need of change and the issues that need to be solved.

6.2 Ethical considerations of the study

This study followed local legislation, principles of good research practice All European Academies (ALLEA), 2017) and principles for research involving human subjects (World Medical Association, 2013). Ethical approvals were received from the Research Ethics Committee of the University of Tartu (Protocols numbers 281/T-3 from 16.04.2018, 322/T-7 from 17.08.2020 and 341/M-3 from 15.05.2021) and the University of Torino (Approval no. 279061–01/07/2020). Participants of the two study phases were informed beforehand about voluntary participation, the aim and process of the study, and details of confidentiality, participation and cancelling. Written informed consent was used in the interview study. In the survey study, submitting the questionnaire was deemed to constitute informed consent for participation. Participants' confidentiality was guaranteed in both study phases. In the interview study, interviews were coded

by random numbering according to the order of interviews without the possibility of back-coding. All personal data were excluded in the transcription process, and personal quotations were presented in a form, in which it was not possible to recognise participants' identity. Data from survey studies were collected in impersonalised form and analysed and presented in a generalised form.

6.3 Limitations and rigour of the study

The limitations and rigour of the study are related to study design, recruitment of participants, representativeness, data collection and literature used.

The limitation regarding the study design is related to the qualitative and cross-sectional study designs used in this study, which does not enable the investigation of causal inference. However, the lack of previous knowledge of ethical issues in nursing in Estonia justified the use of a qualitative methodology and enabled to provide rich description of ethical conflicts for Estonian nurses. Using 2-point measures and data from different sources in a cross-sectional survey that has not been used in previous studies enabled to compare data from different time points and explore the progress of the phenomenon in different contexts. Collecting data from different sources was used to improve data quality.

The limitations of recruitment used in the study may have prevented the research invitation from reaching all nurses who met the inclusion criteria. The exact number of members of nursing associations was not known and nurses are free to join any association in their speciality, and it is possible that nurses, who are not members of any association, did not get the research invitation. However, both study phases recruited participants through all professional nursing associations and social media, which allowed access to the widest possible number of nurses. Regular re-invitations were sent to increase the response rate and the variability of responses.

Limitation regarding the representativeness is related to the sample size in the survey study, which was relatively low. This may be due to the high workload and exhaustion of nurses during the pandemic when the data collection took place. Also, in the survey study, the sample size was complicated to calculate beforehand as the exact number of nurses, who met the inclusion criteria was not known. Among the sample, nurses who worked with patients with COVID-19 predominated, especially during the second wave, which may indicate that they were more engaged with the topic. However, the sample in the survey study was geographically balanced and representative of nurses in terms of the main background characteristics, such as average age, gender distribution, type of employment contract, and level of healthcare.

Limitations related to the data collection include possible differences in conceptual understanding between the interviewer and interviewees and data comprehensiveness in the first study phase. To guarantee a common understanding between the interviewer and interviewees and to enable participants to prepare for the interview and recall relevant memories, a reminder was sent to

them by e-mail a few days before the interview. This included preparatory questions based on the components of Jameton's definition of ethical conflict as ethical dilemma, uncertainty and distress (Jameton, 1984). To ensure data comprehensiveness, data were collected until saturation of the database. Triangulation of researchers including the main supervisor evaluating primarily identified codes, categories, and themes by the PhD candidate was used to ensure the quality and credibility of data.

An unvalidated instrument was used in the study phase for survey, which was created specifically to investigate the influence of COVID-19. However, the expert group and professional language editor were used for translation and adaption the instrument for local use, and it was piloted among the target group before data collection. The internal reliability of the questionnaire was assessed using Cronbach's alpha coefficient. The alpha value for the instrument in Estonian was 0.92 in wave 1 and 0.94 in wave 2, and for the instrument in Italian it was 0.83.

Limitations of literature used in this study relate the conceptual diversity and complexity of ethical issues. To find relevant articles, multiple synonyms were included in the search. In addition to the title, the search was carried out using the abstract and keywords, and those articles whose primary focus was on ethical issues or their synonyms. However, some papers addressing relevant elements may have been inadvertently excluded. As the search was restricted to papers published in English, it could have resulted in missing data from various cultural contexts.

6.4 Practical implications

The results of the thesis have implications for all healthcare parties, primarily for nurses working in clinical practice and healthcare organisations, but also for policymakers, nursing associations and educational institutions.

- Nurses working in clinical practice play central role in protecting patients' rights and principles of patient-centredness as a foundation of daily care and guaranteeing ethical and safe care for patients in regular times and in times of crisis. For this, nurses should critically evaluate and promote their ethical competence, including in ethical standards of care during crises and be updated in contextual aspects that can endanger ethical care. Collaboration with legal specialists would help to improve the interpretation of legal regulations in various practical situations.
- Healthcare organisations should value nurses' close relationship with patients, promote patients' rights and patient-centredness as a foundation of care to support nurses in providing ethical care. Healthcare organisations should also contribute to safe working environment for nurses with manageable workload and including a culture where open communication, shared decision-making, respectful teamwork and professional empowerment are prioritised. Ethical issues in nursing need constant attention regarding the safety and quality of

care. Improving nurses' preparedness for healthcare crises on an ethical level should be prioritised so that in future crises the transition from patient-centred care to public health-centred care is smooth. There is also continuing need to pay attention to the workload of nurses and various factors influencing it, including during crises. Gender discrepancy and its influences in nursing is increasing concern in the context of workload, during the crises particularly.

- Nursing associations contribution is important to achieve better clarity in professional role of nurses and the boundaries of their autonomy to improve patient-centred care and make the contribution of nurses more expedient and purposeful. Nursing associations have also a sound position to open discussion about the importance and opportunities of interprofessional ethics in improving ethical care and decision-making in complex care context.
- Policymakers should develop ethical standards for care during crises and involve nurses in this. It is also important to involve members of society in the discussion about crisis standards of care so that the ethical principles of providing care during crises are understood and accepted on a wider societal level.
- Educational institutions should improve nurses' preparedness for ethical care, support internalisation of professional values and enhance interprofessional learning in ethics.

7. CONCLUSIONS

Estonian nurses face ethical conflicts due to the violation of patients' rights, unclear professional roles and autonomy, and unsupportive work environments. Despite national and global priorities for holistic and dignified care, these rights are often not fully respected, especially for vulnerable groups and in end-of-life care. Ethical conflicts arise from unregulated workloads and Estonia's historical and sociocultural context. Paternalistic attitudes from the Soviet era might still influence patient care and professional roles. As an autonomous profession, nursing should have a clearer role in patient care. The combination of insufficient protection of patients' rights, excessive workloads, and historical context creates ethical conflicts in nursing. Addressing these issues in research and practice is crucial for improving care quality, safety, and nurses' well-being.

The COVID-19 pandemic affected various aspects of nurses' work, workload, organisation of work and professional relations particularly. The impact of the pandemic on nurses' work depended on the progress and intensity of the pandemic, the preparedness of nurses and working with patients with or without COVID-19. The pandemic caused the largest-scale health crisis in Estonia in the past century, for which neither the healthcare system nor nurses, who played a central role, were adequately prepared, especially from an ethical perspective. Taking care of patients with COVID-19 required more nursing procedures and basic care from nurses compared to other patients, increasing nurses' workload. The increase in non-nursing tasks and crisis management added to this. Balancing these responsibilities can lead to exhaustion, risking patient safety and care quality. Addressing nurses' roles and workload factors during crises is essential for future crisis preparedness.

The COVID-19 pandemic caused various ethical issues in nursing. Ethical issues correlated with the progress and intensity of the pandemic and nurses working with infected patients. The autonomy of patients was the main source of ethical issues in nursing before and during the COVID-19 pandemic. During the pandemic, switching priorities from regular patient-centred care to a public-health-centred approach influenced it among other aspects. Impaired communication with patients and families as well with colleagues contributed to this. Balancing between their duty to care and personal safety became increasingly important during pandemic when nurses risked their health and the health of their loved ones to help others. Nurses' preparedness for CSC requires further improvement and more active involvement of nurses in preparing for crises is needed.

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SUMMARY IN ESTONIAN

Eetilised probleemid õenduses enne COVID-19 pandeemiat ja pandeemia ajal: mitmemeetodiline uuring

Sissejuhatus

Patsientidel on õigus turvalisele, kvaliteetsele ja eetilisele õendusabile. Õendus kui autonoomne väärtuspõhine praktika lähtub eelkõige patsientide individuaalsetest vajadustest ja eelistustest (Fowler, 2024; Thompson et al., 2006). Samal ajal on ka eetilised probleemid õenduse lahutamatu osa (Jameton, 1984; Thompson et al., 2006). Tervishoid areneb kiiresti ning patsiendi- ja perekeskses tervishoius on üha suurem roll kaasamisel ja patsientide õigustel (Thompson et al., 2006). Teisalt on tervishoid üha enam orienteeritud efektiivsusele ja kulutõhususele (Kieft et al., 2014). Teenuseid osutatakse multidistsiplinaarse meeskonna koostöös, kuhu kuuluvad lisaks tervishoiuspetsialistidele ka patsient ja tema lähedased. Kuigi kõigi osapoolte eesmärk on patsienti aidata, võib neil olla erinev arusaam sellest, milline on parim tulemus (Redman & Fry, 2000). Seetõttu ei ole õdedel, kes on patsientidega kõige vahetumas ja pikaajalisemas kontaktis, alati võimalik pakkuda patsientidele just sellist abi, mida nad kooskõlas õenduse põhiväärtustega õigeks peavad (Rassin, 2008; Shahriari et al., 2013). Need olukorrad põhjustavad õdedele eetilisi probleeme, sh eetilisi konflikte (Gaudine & Thorne, 2012; Redman & Fry, 2000).

Õenduse eetiline alus koosneb globaalselt aktsepteeritud väärtustest, millest õed on aastasadade jooksul juhindunud (Thompson et al., 2006). Siiski mõjutab nende väärtuste praktikasse rakendamist, patsientide õigusi, õdede positsiooni ühiskonnas, aga ka eetilisi probleeme ja nende lahendamist nii kliiniline kui ka sotsiaalkultuuriline, sh ajalooline, poliitiline ja majanduslik kontekst, milles õed töötavad (Kangasniemi et al., 2015; Ludwick & Silva, 2000). Selles osas erineb Eesti oma demograafilise positsiooni ja nõukogude pärandi tõttu (Ernits et al., 2019; Pop-Eleches & Tucker, 2011) mitmeski aspektis arenenud riikidest, kelle hulka kuulume tänapäeval. Lisaks muutub maailm meie ümber pidevalt ja kiiresti, suurendades survet tervishoiusüsteemile, muutes arusaamu tervisest ja haigustest ning mõjutades nii patsientide kui ka tervishoiutöötajate ootusi. Tervishoiusüsteem peab möödapääsmatult silmitsi seisma ka kriisidega, nagu näiteks COVID-19 pandeemia, mis oluliselt häirivad tervishoiusüsteemi ja kogu ühiskonna toimimist ning esitavad täiendavaid väljakutseid. Need muutused tekitavad õdedes küsimusi, kuidas erinevates olukordades pakkuda patsientidele turvalist, kvaliteetset ja eetilist abi (Jameton, 1984; Thompson et al., 2006).

Eetilised probleemid põhjustavad õdedele moraalset stressi (Thorne, 2010; Ulrich et al., 2010), ärevust, kaastundeväsimust ja depressiooni ning vähendavad töömotivatsiooni, tähelepanelikkust ja pühendumist patsientidele (Thorne, 2010). Kurnatud ja läbipõlenud õed ei ole suutelised pakkuma patsientidele piisavalt tähelepanelikku, empaatilist ja patsiendikeskset abi (Gustafsson & Hemberg, 2022; McAndrew et al., 2018) ning võivad töölt lahkuda (Gaudine & Thorne,

2012; Gustafsson & Hemberg, 2022). See omakorda süvendab õdede puudust, sealhulgas ka Eestis, kus see on niigi tõsine probleem (Kiivet et al., 2013). Seetõttu vajavad eetilised probleemid piisavalt tähelepanu ohutu, inimkeskse ja kõrgekvaliteedilise õendusabi tagamiseks. Rahvusvaheliste uuringute maht sel teemal, sealhulgas COVID-19 pandeemia perioodist, on küll arvestatav (Falcó-Pegueroles et al., 2023; Gebreheat & Teame, 2021; Oh & Gastmans, 2023; Silverman et al., 2021; Villa et al., 2021; Yasin et al., 2023), ent teadmised vajavad siiski täiendamist, eriti Eestis, kus selleteemalised uuringud seni puuduvad. Seoses eetiliste probleemidega, mida COVID-19 pandeemia laialdaselt kaasa tõi, napib siiani võrdlusi probleemidest erinevates kontekstidess, milles õed pandeemia ajal erinevates riikides ja pandeemia erinevate lainete ajal töötasid. Sellised võrdlused on olulised, et süvendada teadmisi eetilistest probleemidest kui keerukast ja dünaamilisest nähtusest ning rakendada neid teadmisi õenduse kvaliteedi ja ohutuse tagamisel ning tulevasteks tervisekriisideks valmistumisel.

Eesmärgid

Doktoritöö eesmärk oli kirjeldada ja selgitada eetilisi probleeme õenduses enne COVID-19 pandeemiat ja selle ajal, et süvendada teadmisi eetilistest probleemidest ja neid mõjutavatest aspektidest muutuvas tervishoiukeskkonnas ja tervisekriisides. Eesmärgi täitmiseks püstitati järgmised uurimisküsimused:

– Milliseid olid eetilised konfliktid õenduses enne COVID-19 pandeemiat?
– Kuidas muutis COVID-19 pandeemia õdede tööd erinevate lainete ajal?
– Milliste olid eetilised probleemid õenduses COVID-19 pandeemia ajal erinevas kontekstis töötavate õdede jaoks?

Meetodika

Doktoritöös kasutati mitmemeetodilist uuringudisaini. Uuritavast nähtusest mitmekülgse ülevaate saamiseks kasutati kahes etapis erinevatel ajahetkedel kogutud kvalitatiiveid ja kvantitatiivseid andmeid. Uuritavaid värvati mõlemas etapis kõigi Eestis tegutsevate õdede kutse- ja erialaorganisatsioonide kaudu üle kogu Eesti. Doktoritöö esimeses etapis viidi läbi poolstruktureeritud individuaalintervjuud kahekümne ühe Eesti õega, kes jagasid oma kogemusi eetiliste konfliktidega, mida nad olid kogenud. Intervjuukava koostati varasemate uuringute ja Jametoni (1984) eetilise konflikti kontseptsiooni põhjal. Intervjuude kestus varieerus 28 kuni 120 minutini, keskmise pikkusega 77 minutit. Intervjuud salvestati, salvestised transkribeeriti sõna-sõnalt tekstifailideks ning analüüsiti induktiivse sisuanalüüsi meetodil. Transkribeeritud ja analüüsi kaasatud teksti maht oli 268 A4 lehekülge.

Teises etapis kasutati andmete kogumiseks elektroonset küsimustikku *The impact of COVID-19 emergency on nursing care* (Clari et al., 2021), et hinnata, kuidas mõjutas COVID-19 pandeemia õdede tööd Eestis ning milliseid eetilisi

probleeme see kaasa tõi. Selleks, et mõista pandeemia mõju ning kaasuvaid eetilisi probleeme erinevates tingimustes, võrreldi a) Eestis andmeid pandeemia esimese ja teise laine ajal, mis kulgesid üsna erinevalt, b) Eesti andmeid Itaalia õdede hulgas pandeemia esimese laine ajal sama meetodiga kogutud andmetega, c) õdesid, kes pandeemia sama laine ajal töötasid erinevate (COVID-19 patsientide ja mitte COVID-19 patsientidega).

Doktoritöö eetilised aspektid

Doktoritöö mõlemas etapis järgiti teaduseetika üldpõhimõtteid (All European Academies (ALLEA), 2017) ja inimuuringute eetilisi põhimõtteid (World Medical Association, 2013). Uuringuetapid on kooskõlastatud Tartu Ülikooli Inimuuringute eetika komitee (protokollid nr 281/T-3 alates 16.04.2018, 322/T-7 alates 17.08.2020 ja 341/M-3 alates 15.05.2021) ja Torino Ülikooliga (kinnitus nr 279061–01.07.2020). Uuritavad osalesid informeeritud nõusoleku alusel, neid teavitati enne osalemist osalemise vabatahtlikkusest ja katkestamise võimalustest, uuringu eesmärgist ja protsessist ning konfidentsiaalsuse tagamises üksikasjadest.

Tulemused

Eetilised konfliktid õenduses enne COVID-19 pandeemiat

Pandeemiaeelsel perioodil kogesid uuringus osalenud õed igapäevases kutsetöös erinevat tüüpi eetilisi konflikte nii sisemise väärtuskonfliktina kui ka konfliktina inimeste vahel, kellega nad oma töös kokku puutusid. Konfliktid jagunesid temaatiliselt kuude alakategooriasse ja kolme ülakategooriasse. Nendeks olid eetilised konfliktid seoses patsientide õiguste ja patsiendikesksuse põhimõtete rikkumise ning õdede positsiooni ja rollidega tervishoiumeeskonnas ning tervishoiuasutustes.

Olulise eetilise konflikti allikana kogesid õed *patsientide õiguste ja patsiendikesksuse põhimõtete rikkumist* kuni patsientide dehumaniseerimiseni. Patsientide isikuautonoomiat ja privaatsust rikuti, muuhulgas ka personali mugavuse nimel, soodustades liigset abitust või vastupidi, rakendades kergekäeliselt füüsilist ohjeldamist. Puudu jäi empaatiast, sotsiaalsest õiglusest ja isegi väärikusest ning inimlikkusest. Õed kogesid patsientide objektistamist, nende taandamist haiguseks või haigeks kehaosaks ning nende vajaduste ja eelistuste alla surumist ning isegi eiramist. Tervishoiutöötajad väljendasid mõnikord ka eelarvamusi mõnede patsientide või patsientide gruppide suhtes ning see mõjutas nende suhtumist patsientidesse abi andmisel. Patsiente ja nende lähedasi ei kaasatud õdede hinnangul piisavalt nende tervist, ravi ja hooldust puudutavate otsuste tegemisse. Seetõttu ei olnud õed alati raviotsustega nõus ja tundsid, et need ei arvestanud piisavalt patsiendi õigusi, vajadusi ja eelistusi. Õdede jaoks oli keeruline viia ellu otsuseid, milles nad ei olnud osalised või mida nad ei pidanud õigeks, eriti patsientide elu lõpus. Patsiendid said õdede hinnangul nii liigset ja agressiivset ravi,

mis pigem kahjustas neid kui jäid vajalikust ravist ka ilma, kogedes asjatuid ja välditavaid kannatusi.

Seoses oma *rolli ja positsiooniga tervishoiumeeskonnas* tajusid õed, et õe kutse ei ole ühiskonnas piisavalt väärtustud, mida nende jaoks näitas nii madal töötasu, patsientide lugupidamatu käitumine kui ka professionaalne alavääristamine ja raviotsuste tegemisest kõrvale jätmine meeskonnakaaslaste poolt. Tugevalt tajutav hierarhia koos ebaselge positsiooni ja ebaselgete õigustega, eriti patsientide ja nende lähedaste informeerimisel, piiras õdede professionaalset autonoomiat ning takistas neil patsiente aitamast nii nagu nad vajanuks. Seejuures olid ka andmekaitse ja informeerimisega seotud reeglid õdede jaoks mõnikord segased või vastuolulised ega lähtunud nende hinnangul alati patsientide ja nende lähedaste vajadustest. Õed hindasid mõnikord oma pädevust ebapiisavaks ning kahtlesid oma otsustes ja tegudes ning nende mõjus patsientidele. Nende jaoks oli keeruline mõista, milline on patsiendi tegelik tahe, sealhulgas eriarvamuste korral patsiendi ja tema lähedaste vahel, eriti elulõpu olukordades. Nad kogesid raskusi patsientide kannatuste leevendamisel ja väärika elulõpu hoolduse pakkumisel. Õdede jaoks oli oluline toetada kriitilises seisundis patsientide lähedasi, kuid neil nappis selleks nii aega kui oskusi. Õe kutse oli nende jaoks kohati pidev koorem, mida nad professionaalse maine kaitsmiseks pidid kandma ka väljaspool tööaega.

Tervishoiuasutuses töötades kogesid õed ebaprofessionaalseid suhteid nii meeskonnaliikmete kui juhtidega – solvangutest, alandusest, lugupidamatusest ja vulgaarsusest kuni kiusamiseni. Võimuvõitlus, mis mõnikord toimus ka patsientide juuresolekul, seadis nende hinnangul ohtu ka patsiendi turvalisuse. Õdede jaoks oli patsiendikesksus abi andmise aluspõhimõte, kuid nad tajusid ka institutsionaalsete väärtuste vastuolu sellega, mis seadsid olulisemaks kulude kokkuhoidu ja tõhusust. Õed hindasid töökeskkonda mittetoetavaks ebamõistliku töökorralduse ja liigse töökoormuse tõttu, mis ei võimaldanud õdedel järgida kutseeetika väärtusi ja ohustasid õendusabi kvaliteeti. Personalipuudus sundis neid täitma ülesandeid, mis ületasid nende pädevust või vastupidi, nõudis nende kvalifikatsioonist madalama kvalifikatsioonile vastavate egevuste sooritamist.

Muutused õdede töös COVID-19 pandeemia ajal

Tulemused näitavad, *et õdede töös* mõjutasid COVID-19 pandeemia esimene ja teine laine kõige enam õdede töökoormust, töökorraldust ja isikukaitsevahendite kasutamist. Töökontekst muutus ulatuslikumalt ja olulisemal määral teise laine ajal, eeskätt nende õdede hinnnagul, kes töötasid COVID-19-sse nakatunud patsientidega. Kõige sagedasemateks õendustegevusteks nii enne COVID-19 pandeemiat kui ka selle ajal olid tegevused, mis põhinesid õe ja patsiendi vahelisel suhtlemisel, samuti patsiendiõpetus ja sümptomite leevendamine. Kui esimese laine ajal jäi erinevate õendustegevuste sagedus pandeemia ajal pandeemiaeelse ajaga võrreldes muutumatuks, siis teise laine ajal tegid õed, eeskätt need, kes töötasid COVID-19 patsientidega oluliselt rohkem baashooldustoiminguid, erinevaid õendusprotseduure ning tegevusi sümptomite leevendamiseks. Ka nende tegevuste sagedus, mis ei nõudnud otsest kontakti patsiendiga nagu administ-

ratiivsed tegevused, suurenesid teise laine ajal võrreldes pandeemiaeelse ajaga oluliselt.

Eetilised probleemid õenduses COVID-19 pandeemia ajal

Kõige sagedasemad eetilised probleemid Eesti õdede jaoks olid mõlema laine ajal sarnased ning olid seotud abi kättesaadavuse tagamisega patsientidele, kellele ei olnud COVID-19 nakkust ja piisava asjakohase info andmisega nii kolleegidele kui ka patsientidele ja nende lähedastele. Teise laine ajal oli õdede jaoks patsientidele piisava elulõpuhoolduse tagamise ning surnukeha väärika kohtlemisega seotud eetiliste probleemide sagedus oluliselt kõrgem võrreldes esimese lainega. COVID-19 patsientidega töötavad õed seisid mõlema laine ajal kõige sagedamini silmitsi eetiliste probleemidega, mis puudutasid kolleegide ja patsientide ning nende peredega suhtlemist ning ravi kättesaadavust patsientidele, kes vajasid abi muul põhjusel kui COVID-19 nakkus. Lisaks puutusid nad sageli kokku ka riskiga nakatuda teiste eest hoolitsemisel viirusega ise ja levitada seda ka edasi oma lähedastele. Õed, kes töötasid patsientidega, kelle abivajadus ei olnud tingitud COVID-19 nakkusest, kogesid mõlema laine ajal kõige sagedamini probleeme seoses abi kättesaadavuse tagamisega neile patsientidele ning patsiendi, tema lähedaste ja kolleegide informeerimisega seonduvalt. COVID-19 patsientidega töötavad õed puutusid oluliselt sagedamini kokku eetiliste probleemidega kolleegide informeerimisel ja surnukeha väärikal kohtlemisel.

Võrreldes Eesti õdedega puutusid Itaalia õed esimese laine ajal oluliselt rohkem kokku eetiliste probleemidega, mis puudutasid riski ise nakatuda ja levitada nakkust oma lähedastele ja järgides tööandja juhiseid, mis erinesid nende enda tõekspidamistest. Samuti puutusid nad oluliselt sagedamini kokku patsientide prioriseerimise ja kõigi elulõpuga seotud eetiliste probleemidega. COVID-19 patsientidega töötavad õed seisid ouliselt sagedamini silmitsi patsientide prioriseerimise ning kõigi elulõpu olukordadega seotud eetiliste probleemidega võrreldes nende õdedega, kes hoolitsedis patsientide eest, kels vajasid abi muduel põhjustel. Seevastu õed, kes töötasid patsientidega, kellel COVID-19 nakkust ei olnud, seisid oluliselt sagedamini silmitsi abi kättesaadavuse tagamisega nendele patsientidele, kellel ei olnud COVID-19.

Järeldused

Doktoritöö käsitleb eetilisi probleeme õenduses erinevas kontekstis, nii tavapärastes tingimustes õdede igapäevases kutsetöös kui COVID-19 pandeemiast põhjustatud tervishoiukriisi tingimustes.

Õdedele tekivad eetilisi konflikte patsiendi õiguste rikkumine, õdede ebaselge professionaalne roll, piiratud autonoomia ja mittetoetav töökeskkond. Vaatamata sellele, et patsiendi õigused ja patsiendikeskne ning väärikas abi on õenduse tuumpõhimõte, on need väärtused sageli praktikas ohustatud, eriti haavatavate rühmade ja elulõpuhoolduse puhul. Eetilisi konflikte võivad mõjutada õdede reguleerimata töökoormus, Eesti demograafiline ja sotsiaalkultuuriline kontekst. Nõukogudeaegsed paternalistlikud hoiakud võivad mõjutada patsientide õiguste

järgimist ja professionaalseid rolle. Õenduse kui autonoomse professiooni roll ja positsioon tervishoius peaks olema selgepiirilisem. Eetiliste probleemidega tegelemine on õendusabi kvaliteedi ja ohutuse ning õdede heaolu parandamiseks ülioluline.

COVID-19 pandeemia mõjutas õdede tööd mitmeti, eelkõige töökoormust, -korraldust ja -suhteid. Pandeemia põhjustas Eestis viimase sajandi mastaapseima tervisekriisi, milleks ei olnud piisavalt ette valmistatud ei tervishoiusüsteem ega selles keskset rolli kandnud õed. COVID-19 viiruse tõttu hospitaliseeritud patsiendid vajasid võrreldes teiste patsientidega tunduvalt rohkem õendusabi erinevate õendusprotseduuride ja baashooldustoimingute näol, mis suurendasid õdede töökoormust. Lisaks mõjutas õdede töökoormust erinevate organisatoorsete ja administratiivsete ülesannete suurenenud maht, mida viiruse leviku tõkestamiseks ja pandeemia mõjudega toime tulekuks teostati. Kriisi ajal õdede rolli ja töökoormust mõjutavate teguritega tegelemine on kriisivalmiduse parandamiseks tulevikus hädavajalik.

Protsessid, mis muudavad õdede töökonteksti nii ulatuslikult nagu COVID-19 pandeemia, toovad paratamatult kaasa eetilisi probleeme. Abi andmine kriisi tingimustes nõuab tavapärasest erinevaid standardeid, kuid õdedel oli raske lülituda tavapäraselt patsiendikeskselt lähenemiselt rahva tervist prioriseeriva abi andmisele. Õiglase, väärika ja individuaalseid vajadusi arvestava abi andmise häirumine on õdede peamine eetiliste probleemide allikas kriisi ajal. Sellele aitab kaasa häiritud suhtlemine patsientide ja peredega ning kolleegidega. Eetiliste probleemide allikaks kriisi ajal on tasakaalu otsimine töökohustuste ja isikliku turvalisuse vahel – kui õed riskivad iseenda ja oma lähedaste tervisega, et teisi aidata. Õed vajavad tulevasteks kriisideks paremat valmisolekut, sealhulgas valmisolekut lülituda paindlikult ja kiiresti ümber kriisieetika standarditele ning aktiivsemat kaasamist kriisijuhiste koostamisse.

Praktiline väärtus

Doktoritöö tulemused on väärtuslikud kõigile tervishoiu osapooltele: eelkõige kliinilises praktikas töötavatele õdedele ja tervishoiuorganisatsioonidele, aga ka õdede kutseorganisatsioonidele, poliitikakujundajatele ning haridusasutustele.

Kliinilises praktikas töötavad õdede õlul lasub oluline osa patsientide õiguste ja patsiendikesksuse põhimõtete kaitsmisel. Selleks peavad õed arendama oma eetilist pädevust ning olema kursis kontekstuaalsete aspektidega, mis patsientide õigusi võivad ohustada. Koostöö õigusspetsialistidega aitaks paremini m'ista, kuidas tõlgendada formaalseid reegleid erinevates praktilistes olukordades.

Tervishoiuasutused peaksid väärtustama õdede lähedast suhet patsientidega, edendama patsiendi õigusi ja patsiendikeskset õendust. Ka töökoormuse reguleerimine ning ohutu ja toetava töökeskkonna loomine, kus väärtustatakse avatud suhtlust, jagatud otsuse langetamist, lugupidavaid professionaalseid suhteid ja koostööd, on oluline eetilise õendusabi edendamisel. Valmisoleku tagamiseks tulevasteks kriisideks vajavad õed ettevalmistust ka eetilises plaanis.

Õdede erialaliitude panus on oluline, et määratleda selgemini õdede professionaalne roll ja autonoomia piirid. Üha olulisem on tähelepanu pöörata õdede töökoormusele ja seda mõjutavatele teguritele, sealhulgas kriisiaegadel. Oluline on käsitleda soolist ebavõrdsust küsimusi ja selle mõjusid õenduses, eriti kriiside ajal, pöörates tähelepanu paindlike töötingimuste vajadusele. Õdede erialaliitudel oleks oluline algatada arutelu interdistsiplinaarse eetika võimaluste üle.

Poliitikakujundajad peaksid välja töötama eetilised standardid abi andmiseks kriisiaegadel ja kaasama õdesid sellesse protsessi. Samuti on oluline kaasata ühiskonnaliikmeid, et kriisiaja õenduse eetilised põhimõtted oleksid laiemalt mõistetud ja aktsepteeritud.

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APPENDICES

Appendix 1 Strategy of literature search for ethical issues in nursing during the COVID-19 pandemic

A systematic search of the scientific literature on nurses' ethical issues during the COVID-19 pandemic was collected from the electronic databases of EBSCO CINAHL, PubMed, Web of Science, and Scopus (Table 1). The search limitations were that the paper had to be published in a peer-reviewed academic journal, in the English and between 2020 and 2024. The criteria for inclusion were that the focus was on i) nurses (not nursing students, educators or managers), ii) ethical issues, and iii) nurses working during the COVID-19 pandemic. From the 274 items found, 105 items were selected based on the title, 62 based on the abstract and 33 full texts after removing duplicates. Based on the full text, nine items were selected for the review. Five were reviews and four were empirical studies, including three qualitative studies and one cross-sectional survey study (Appendix 2).

Table 1. Literature searches concerning nurses' ethical issues during the COVID-19 pandemic.

Database	**Items found**	**Items selected**			
		Based on title	**Based on abstract**	**After removing duplicates**	**Based on review**
			n		
EBSCO CINAHL	18	11	6	33	9
PubMed	111	22	17		
Web of Science	90	45	26		
Scopus	55	27	13		

Appendix 2 Reviewed articles

Author(s), title, year, country (only for empirical studies)	Purpose	Design and tools	Sample size and characteristics	Main results
Aydogdu ALF, Ethical dilemmas experienced by nurses while caring for patients during the COVID-19 pandemic: An integrative review of qualitative studies, 2022.	To identify ethical dilemmas faced by nurses while caring for patients during the COVID-19 pandemic.	Integrative review of original primary qualitative research articles on ethical dilemmas experienced by nurses while caring for patients during the COVID-19 pandemic. The electronic databases searched were PubMed, Google Scholar, MEDLINE and Scopus was carried out in 2021.	14 research papers from 10 journals reporting ethical dilemmas of bedside staff nurses caring for patients with COVID-19 with full texts available on the Internet in English.	Nurses had concerns with bene-ficence—nonmaleficence, patients' autonomy, injustice of care and coping with ethical issues.
Beheshtaeen F, Torabizadeh C, Khaki S, abshorshori N, Vizeshfar F., Moral distress among critical care nurses before and during the COVID-19 pandemic: A systematic review, 2023.	To compare the factors affecting moral distress among critical care nurses before and during the COVID-19 pandemic.	Systematic review of the relevant literature encompassed databases such as PubMed, Scopus, ProQuest, Web of Science, medRxiv, bioRxiv, Embase, and Google Scholar. The search was carried out from 2012 to December 2022.	52 quantitative studies (descriptive and analytical designs) and studies with qualitative and mixed-methods approaches in English and Persian language carried out among Critical care nurses working in Intensive Care Unit (ICU) or Coronary Care Unit (CCU) and with full text available.	Moral distress factors were similar before and during the pandemic, with futile care and end-of-life issues being primary causes. At the beginning of the COVID-19 pandemic, factors such as fear of contracting and transmitting the disease, lack of personal protective equipment, and staff shortages were also cause for moral distress.

Author(s), title, year, country (only for empirical studies)	Purpose	Design and tools	Sample size and characteristics	Main results
Falcó-Pegueroles A, Bosch-Alcaraz A, Terzoni S, et al., COVID-19 pandemic experiences, ethical conflict and decision-making process in critical care professionals (Quali-Ethics-COVID-19 research part 1): An international qualitative study, 2023, Spain and Italy.	To explore the sources of ethical conflict and the decision-making processes of ICU nurses and physicians during the first and subsequent waves of the COVID-19 pandemic.	A descriptive phenomenological study. In-depht interviews between December 2020 and May 2021. A thematic content analysis of the interviews.	38 critical care nurses and physicians from five hospitals in Spain and Italy.	Two main themes as sources of ethical conflict: 1) the approach to end-of-life in exceptional circumstances with two subthemes: end-of-life care and withholding and with-drawal of life-sustaining treatment; and 2) the lack of humanisation and care resources with three subthemes: the possibility of guaranteeing the same opportunities to all, fear of contagion as a barrier to taking decisions and the need to humanise care.
Firouzkouhi M, Alimohammadi N, Kako M, Abdollahimohammad A, Bagheri G, Nouraie M., Ethical challenges of nurses related COVID-19 pandemic in inpatient wards: An integrative review, 2021.	To explore the ethical challenges of nurses in COVID-19 pandemic.	Integrative review conducted from 2007 to 2020. Databases of PubMed, Google Scholar, Scopus, Web of Science. English quantitative and qualitative articles, reviews, letter to the editor, and perspectives papers published in national and international indexed scientific publications.	12 studies with conducted with different methodology.	Results showed ethical challenges of nurses in caring for patients with COVID-19 consisted of three areas, including nursing; patient and family; and treatment equipment and facilities.

Author(s), title, year, country (only for empirical studies)	Purpose	Design and tools	Sample size and characteristics	Main results
Gebreheat G, Teame H., Ethical challenges of nurses in covid-19 pandemic: Integrative review, 2021.	To identify the main ethical challenges faced by nurses during COVID-19 pandemic.	Integrative review of all studies published in English that reported ethical challenges of nurses` during the COVID-19-pandemic from November 9, 2019 to November 9, 2020 found from the electronic databases PubMed, Google Scholar, JURN, Cochrane Library E-Journals, MEDLINE, Academic Search Complete, CINAHL and grey literature.	8 papers from which 6 opinion papers, one descriptive correlational and one qualitative study.	Ethical challenges of nurses were categorized into three thematic areas: nurses' safety, role and moral distress, resource allocation, and client–nurse relationship.
Muñoz JM, Msn Q., Ethical conflicts among physicians and nurses during the COVID-19 pandemic: A qualitative study, 2022, Spain.	To understand and explore experiences of new moral challenges emerging among physicians and nurses caring for indivi-duals during the COVID-19 pandemic.	Qualitative study with semi-structured interview in February and March 2021. Convenience and snowball sampling.	13 health care professionals from two basic healthcare districts in Spain, encompassing hospital and primary care.	Four main themes: (1) Betrayal of moral and ethical values as a key source of suffering; (2) Ethical and moral sense of failure accompanying loss of meaning; (3) Lack of confi-dence in performance; (4) Self-demand and self-punishment as personal condemnation among healthcare workers.
Oh Y, Gastmans C., Ethical issues experienced by nurses during COVID-19 pandemic: Systematic review, 2023.	To better understand how frontline nurses who care for patients with COVID-19 experience ethical issues towards others and themselves.	Systematic review of qualitative evidence searched from the electronic databases PubMed, Embase, Cinahl, Web of Science, Philosopher's Index, and Scopus appearing from March 1, 2020, to December 31, 2022. Inclusion criteria: (1) Published qualitative and mixed method studies and (2) ethical issues experienced by nurses caring for patients with COVID-19.	26 qualitative and mixed-method studies from different countries (Iran, Sweden, Turkey, USA, Canada, China, Indonesia, Italy South Korea, Jordan, Greece, Spain) and from different hospital settings.	Ethical issues were characterised by two key themes: (1) the moral character of nurses as a willingness to respond to the vulnerability of human beings and (2) ethical issues nurses acted as barriers sometimes, impeding them from responding to requests of vulnerable human beings for dignified care.

Author(s), title, year, country (only for empirical studies)	Purpose	Design and tools	Sample size and characteristics	Main results
Silverman HJ, Kheirbek RE, Moscou-Jackson G, Day J., Moral distress in nurses caring for patients with Covid-19, 2021, USA.	To explore causes of moral distress in nurses caring for Covid-19 patients and identify strategies to enhance their moral resiliency.	Qualitative study with focus group discussions and in-depth interviews from Arpil to June 2020. Purposive sampling method.	31 nurses caring for Covid-19 patients in the acute care units within large academic medical systems in Maryland and New York City.	Themes of causes of moral distress included (a) lack of knowledge and uncertainty regarding how to treat a new illness; (b) being overwhelmed by the depth and breadth of the Covid-19 illness; (c) fear of exposure to the virus leading to suboptimal care; (d) adopting a team model of nursing care that caused intra-professional tensions and miscommunica-tions; (e) policies to reduce viral transmission (visitation policy and PPE policy) that prevented nurses to assume their caring role; (f) practicing within crisis standards of care; and (g) dealing with medical resource scarcity.
Yasin JCM, Barlem ELD, Silveira RS da, Ruivo ÉDG, Longaray AA, Brehmer LCF, Ethical issues experienced by nurses during COVID-19 in university hospitals, 2023, Brazilia.	To identify the ethical issues experienced by nurses in the care for patients with COVID-19 and the factors that influence their occurrence.	Cross-sectional, quantitative study, between February and May 2022 with E*thical issues Experienced by Nurses in Emergency Questionnaire*, adapted and validated for Brazilians. Descriptive statistical analysis, Pearson's correlation test and linear regression.	101 nurses from two university hospitals.	Ethical issues were related to concern and stress in caring for infected patients, being influenced by perception of social stigmatization and perception of hospital measures. Agreement with infection control measures and perception of hospital measures against COVID-19 were factors with the highest mean between the constructs.

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