Feeling trapped and being torn: Physicians narratives about ethical dilemmas in hemodialysis care - a phenomenological hermeneutic study

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Abstract

Background: By describing ethically difficult situations that infuse a troubled conscience, ethical conflicts may be brought into consciousness and thereby opened up for further considerations. The aim of this study was to illuminate ethically difficult situations that evoked the burden of troubled conscience, as narrated by physicians in dialysis care.

Method: A phenomenological hermeneutic method was used to analyze the transcribed narrative interviews with five physicians with varying lengths of experience in nephrological work.

Results: The analysis shows that physicians in this study expressed feelings of being trapped in irresolution and torn by the conflicting demands of ethical dilemmas when they had to decide whether to withhold or withdraw dialysis from fragile and often cognitively impaired patients. The physicians tried to avoid arousing conflicts with overbearing relatives, felt uncertain about their own authority and felt burdened by having sole responsibility. They also expressed feelings of being squeezed between time restraints and professional and personal demands and of being doubted and unconfirmed. The results point to an alternative way of meeting ethical dilemmas, unburdened and guided by their own conscience.

Conclusion: When crucial decisions had to be made in ethical dilemmas physicians spoke of being alone, burdened by moral responsibility and a troubled conscience. When reflecting on their conscience, physicians wished for the courage to present the crucial problem; to share the agony of deciding how to act; to reach a consensus about how to reduce patients’ suffering; and to be respected for the decisions they made.
Introduction

In the care of hemodialysis patients, parallel with improved treatment methods for severely ill patients’ new ethical problems arise. Uneasy feelings about giving uncomfortable orders and a lack of communication between physicians and other healthcare personnel, reported in ethical “rounds”, became the point of departure for this study, the purpose of which was to illuminate situations of ethical difficulty evoking the burdening feelings of troubled conscience as, narrated by physicians.

Background

The development of hemodialysis as a way of prolonging life causes physicians in hemodialysis care to face new ethical problems [1]. Hemodialysis, herein after referred as dialysis has become easily available even for an ageing population with end stage renal disease [1] and the average age for Swedish patients in dialysis is now over 65 years [2].

For patients with end stage renal disease, with no physical chance of transplantation, dialysis is life saving but regressive and might have an extended course [3]. Cohen et al (2003) believe that dialysis is a both life-prolonging therapy and a death-prolonging treatment [4]. Patients, prescribed dialysis have to deal with several physical disabilities affecting their quality of life [1, 5], such as ischemic heart disease, stroke [4] and peripheral vascular disease requiring amputation [6]. Being dependent on dialysis means several changes in life style and it is not uncommon for patients to become depressed and anxious about their wellbeing. A significant proportion of patients who need dialysis are unlikely to comply with the treatment [7]. To summarize, for patients whom dialysis will have problematic effects on their quality of life, ethical problems generates that their physicians have to deal with[1].

Several studies show that physicians experience ethical dilemmas concerning the withholding or withdrawing of life-sustaining treatments [8-10] especially in the case of patients developing dementia [8, 9]. Withdrawal of treatment may be experienced as contradictory because physicians have a responsibility and a duty to save life [10]. Holley, Carmody, Moss et al (2003) showed that physicians in nephrology in United States feel they are insufficiently trained for end of-life care. They feel inadequate in maintaining psychological and existential aspects when caring for dying patients [11]). Studies have reported physicians’ assertions that
guidelines would be helpful when making decisions about withdrawing or withhold treatment for incapacitated patients [8, 9, 12].

However, guidelines for withholding and withdrawing dialysis have already been published by the Renal Physicians Association and the American Society of Nephrology. The guidelines concern a process of decision making shared between physician and patient. It entails psychological considerations, planning, decisions and palliative care directed to achieving a good death [4, 13]. Guidelines have also been developed in Sweden according to established ethical principles about withdrawing or withholding life-supporting treatment [14]. The purpose of Swedish guidelines is to preserve respect for the patient’s integrity and dignity and to discover whether or not life supportive treatment will benefit the patient. They entail a dialogue between the physicians, patient, relatives and healthcare personnel familiar with the patient. Ultimately the physician responsible for the patient has to decide according to her/his own judgment grounded in medical knowledge and reliable experience [14].

Despite these guidelines, physicians struggle with ethically difficult conflicts due to lack of communication with healthcare personnel and relatives about decisions concerning limitation of life supportive treatment [15]. In a study by Oberle and Hughes (2001) physicians described the difficulties of witnessing suffering and that they felt uncertain about their course of action concerning patients and relatives. They felt burdened by having to make decisions and give uncomfortable orders [16]. Söderberg (1999) showed that when ethically difficult situations are not dealt with or when they are forced to act against their conscience healthcare personnel, experience severe frustration, later interpreted as a troubled conscience [17].

Several studies state that conscience is a cornerstone of ethics in healthcare. According to Glasberg (2007) healthcare personnel often set high ideals for what they believe is good care. Being unable to carry out care according to their own ideals makes healthcare personnel question themselves and their morality [18]. In some situations, to avoid having a troubled conscience, healthcare personnel believe they have to break or bend laws and rules in their practice [19, 20]. Several studies show that conscience is seen as an asset when one is able to express and discuss moral concerns with others, but having to deaden conscience because of an inability to deal with moral problems was significantly related to burnout [21-24].
According to Lindseth and Norberg (2004) people live and act according to their ethical thinking, moral values, norms and attitudes without necessarily being conscious of it. By telling stories involving ethically difficult situations it is possible to access the ethical thinking below the surface and making it visible [25]. To date only a few studies, if any, describe situations of ethical difficulties resulting in a troubled conscience among physicians in nephrology. Describing ethically difficult situations evoking the troubled conscience experienced by physicians in nephrology may raise consciousness and thereby open the way for further considerations and reflections. Conscience points to the meaning of the ethical conflict which, when clarified, may be addressed in order to restore feelings of integrity and peace of mind.

The aim of the study was to illuminate ethically difficult situations that evoked the burden of troubled conscience, as narrated by physicians in dialysis care.

Methods

Participants
The convenience sample comprised five physicians with 5 to 20 years (m=10) of experience in nephrological work employed at a hospital in northern Sweden. Some were specialists in nephrology and others were training to be specialists. The chief physician selected other physicians based on variations in gender, age, length of work experience and experience of ethically difficult situations. The chief physician then met with these physicians as a group, informed them, verbally and in writing about the study and their rights to withdraw at any time without prejudice. The five physicians who agreed to participate were assured their confidentiality would be protected. Approval to carry out the study was granted by the Ethics Committee of the Faculty of Medicine at Umeå University (03-499).

Data collections

Interviews
Tape-recorded narrative interviews with each individual participant were performed in a private room at the nephrology department. Participants were asked to narrate any ethically difficult care situation that had affected their conscience. The open-ended interviews lasted 25-40 minutes without interruption and included follow-up questions, such as ‘How did you
Data analysis  
*Interpretations*

The text was analyzed and interpreted using a phenomenological hermeneutic approach inspired by Paul Ricoeur, developed and described by Lindseth and Norberg [25]. The approach is useful when attempting to illuminate the meaning of lived experience through interpretation of personal narratives. According to Ricoeur (1976), a person’s lived experience remains private but the meaning of it may be grasped through interpretation of a narrative dialogue [26].

This analysis process comprises three phases. *First*, a naïve reading which involved reading the text several times with an open attitude to guess at the meaning of the text as a whole. The naïve reading indicated direction the structural analysis should take. *Second*, in a structural analysis, the text was divided into meaning units which were condensed, coded and abstracted into subthemes and themes. The purpose here was to ascertain whether or not the structural analysis supported the guesses made after the naïve reading. Discussions continued until the group agreed. *Third*, a critical reading leading to a comprehensive understanding was formulated. This was based on the researchers pre-understanding, the naïve understanding, themes and relevant literature. All the authors participated in the analysis processes which continued until agreement on the interpretations and findings was achieved.

**Findings**

**Naïve understanding**

The narratives about ethically difficult situations that caused the physicians to feel burdened by a troubled conscience concerned situations when they felt hesitant and uncertain about their professional responsibility. When making crucial decisions about withholding or withdrawing dialysis, the physicians were trying to cope with ethical dilemmas. They found themselves torn by conflicting demands, indecisive, alone, unconfirmed and accused. The way they handled ethical dilemmas evoked a troubled conscience that made them feel they had failed their patients and the patients’ relatives.
Structural Analysis

From the structural analysis, two themes and five sub-themes emerged describing ethical dilemmas in the nephrologists’ daily work that gave rise to a troubled conscience. The dilemmas concerned crucial decisions about life and death concerning medically fragile and often cognitively impaired persons. The incompatibility of demands from patients, their relatives, co-workers and family caused tension.

Table 2. Themes and sub themes

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<th>Subthemes</th>
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<td>Avoiding arousing conflicts with overbearing relatives</td>
<td>Feeling trapped in irresolution</td>
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<td>Feeling uncertain about one’s authority</td>
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<td>Feeling the burden of sole responsibility</td>
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Feeling trapped in irresolution

Avoiding arousing conflicts with overbearing relatives

It all these situations the physicians had to make crucial decisions about life support treatment when the patient and relatives disagreed about it. The narratives told of situations when a patient decided not to start or not to continue dialysis, but lacked the strength to resist an overbearing relative. The relative claimed to have the right to decide for the patient whether dialysis treatment should start or continue. The physicians risked being caught in conflict between the patient and the relative, and believed a conflict would threaten the patient’s wellbeing. If the relative insisted on treatment the physicians did not want to intervene in a conflict and so had difficulty upholding the patient’s best interest. Physicians knew from experience that, once started, dialysis treatment can continue for a long time with the risk that the patient will become totally confused. Yet, in order to avoid a conflict, physicians hesitated to make the final decision to withdraw treatment. They felt trapped by demands from the
patient, the patient’s relatives and also from frustrated RNs who hear complaints from the patient.

“He started to get sores on the legs that didn’t heal, which became more and more painful. We let the relatives know that he wanted to stop the treatment but they ignored him… a daughter…was overbearing…. He suffered from an infection which he couldn’t cope with and we were obligated to amputate one of his legs. The wound from amputation never did heal and it became necrotic with an open wound area where the bone was visible. Despite that and repeated discussions she [the daughter] could not accept that there was nothing to be gained”

Another physician narrated a very similar story:

“I think one should withdraw all treatment because it became a long history, about a month or more before he died….. In retrospect, from an ethical perspective, I think we should have defended the patient, disregarded the daughter and taken the risk of being reported, but she was strong and overbearing, so we did as she wished. I still wonder if we did the right and who we did it all for, was it for her [daughters] sake or for his [patient]? And I think we failed the old man [patient] ”

When they reflected, physicians questioned the purpose of dialysis treatment and wondered who, after all, benefited from it. They had a troubled conscience which made them realize they had not been sensitive enough to the patient’s wishes. Their intention was to do good by complying with the relatives’ demands and avoiding conflicts. Instead, the patients suffered. The physicians wished they had been brave enough to help the patients and relatives understand what was best for the patient, even if it meant encountering conflict.

Feeling uncertain about one’s authority

In all these situations the physicians found that it was not medically defensible to start or continue dialysis, yet felt uncertain about their authority and the power of their words. They did not want to influence the patient’s and relatives’ choice and hesitated far too long before opening the question about withdrawing treatment for a fragile patient whose opinion was sometimes difficult to interpret due to dementia or ambiguous communication. According to physicians, this was a life or death question; the patient’s answer depended on how physicians raised the question

“We have some kind of power over life and death Dying sometimes takes a while but it obviously creates frustrations and you always get the answers afterwards in some way… sometimes there can be something positive in such extended dying. Sometimes it can be painful”

The narratives told about patients, relatives and physicians from different perspectives and provided a variety of interpretations of the situation. The relative may have perceived some quality of life for the patients in her/his deteriorating condition and, therefore wanted dialysis
to continue. From experience, the physicians could see the condition on the patient deteriorating, but maintained a defensive manner because they sympathised with the relatives and were afraid of influencing them too much. The physicians became uncertain, decided to continue dialysis and hoped that the relatives would gradually gain some insight.

The narratives speak of situations when the patient was very critically ill suffering severely with no chance of improving. The RNs complained because they have to be very attentive to the patients during dialysis and sometimes even have to restrain their arm to prevent them hurting themselves. The physicians believed that patient and relative were living with a kind of hope and did not want to force them to face reality, even though they wanted to suggest withdrawing treatment. They felt trapped in their uncertainty.

"One woman started dialysis and as the year passed she suffered more and more from dementia. She and her husband had been living together for a long time and were quite isolated so the husband had to take a great responsibility. Most of their life revolved around her and her care....we started a discussion about her life.... and I asked if there was really any motivation for keeping her a live on dialysis. In some way it felt like we were giving her dialysis her for his [husbands] sake rather than for her own.... the nurses started to get frustrated because she was lying there without really understanding and sometimes they had to hold her arm straight to give her the treatment...He didn’t want to withdraw treatment because he still felt she had a kind of quality of life when not on dialysis."

On reflection, physicians had a troubled conscience because they realized they were afraid of exercising their authority to guide the patient and their relative to take the most realistic direction. Physicians’ believed they did the right thing in giving the patient and relative enough time to let the best decision mature, but, afterwards, it felt as though they had failed the patient.

*Feeling the burden of sole responsibility*

In all these situations the physicians felt alone when having to make a critical decision. They experienced a lack of consensus. They tried to discuss things with each other but found it difficult because they had different values, professional experiences and opportunities to see alternatives. Thus, consensus was not easy to reach. Ultimately, the principal physician had to make a decision alone and take responsibility for the consequences, unsure if it was for the best. Less experienced physicians believed dialogue with colleagues with similar views would be helpful and wished they had more time for in-depth discussions in ethically difficult situations.
"It is the person who makes the decision who has to be responsible. Therefore one should not be forced to make decisions that one not can stand up for."

The narratives concern the difficulties that can arise when the decision to withhold dialysis has been made but a physician with temporary responsibility begins dialysis without consulting the principal physician. That physician then has to shoulder the responsibility for a decision taken by another physician. Physicians know from experience, that once dialysis is started it is much more difficult to withdraw and a temporary treatment order may become permanent.

"If you are responsible for a long time, perhaps you can see a decision with different eyes from someone who is there temporarily and just walks in and sees the possibilities but may then walk out again."

On reflection, physicians may feel their own vulnerability, having to make decisions about life and death without support from their colleagues or superiors and to accept decisions made by someone else. Having to make crucial decisions alone leaves them with feelings of having failed the patient and a troubled conscience.

Being torn by conflicting demands
Feeling squeezed between time restraints and professional and personal demands
In all these situations the physicians experienced felt inadequate because of lack of time and conflicts between ideals and reality. Physicians described a stressful work situation with high demands, an increasing administrative workload and reduced time with the patient. They wished there was enough time for careful discussions with patient and relatives in situations where crucial decisions had to be made. In the narratives, physicians talked about feeling squeezed in impossible situations and feeling inadequate when facing prioritizing patient care against necessary administrative tasks.

"The difficulty is what the aim is. What tasks do we have and how much time do we have? Sometimes it is not very reasonable. Quality controls are increasing, documentation will increase and paperwork takes more time. There is less time for patients so you really do not manage to do the work you should do. If you do not do everything, then you get a troubled conscience because if you do not manage to do everything then you do not feel quite easy."

When reflecting on their work situation, physicians spoke about a troubled conscience brought on by feelings of inadequacy because of ambiguous treatment goals. They experienced a moral duty to provide patients and their relatives with enough information, yet felt hindered by their administrative workload.
The physicians described demands to realise their own high expectations, tacit professional ideals of adequacy and great competence or skill. The narratives talked about feelings of inadequacy when they were unable to live up to their own high expectations and demands for competence, imposed by themselves or others. In order to achieve the necessary competence and search for medical information, physicians needed to use their personal time which interfered with their private lives.

‘You have high ambitions and cannot live up to them, due to external or personal reasons’

The narratives spoke about ambitions to engage in unfinished research and about being ashamed to ask already overloaded colleagues for help with unfinished work. Physicians felt a tacit demand not to burden colleagues with their unfinished work and struggled to complete tasks in their spare time. In this struggle, physicians tried to find solutions by themselves instead of sharing their burden and asking for help.

‘Feelings of insufficiency are completely influencing me, I am very much working in my spare time.’

The narratives spoke about demands and expectations from their family and from work causing feelings of being split between personal and professional demands. The experience of inadequacy emerged when they were involved in a conversation with a patient while being aware that their family was waiting for them or their children had to be collected at kindergarten. Being unable to give the patient enough time and defaulting on their own family because of lack of time created in these physicians a sense of feeling devalued.

‘If you have children and have to collect them from kindergarten at five pm and you know that you do not have time to register the patients properly …then you feel that you really are not handling your situation in life’

Reflecting on their work, physicians realized that, although they tried to do their best to master all the situations, their conscience might still condemn them, pointing out that they should work harder and do better in order to live according to tacit ideals of their profession.

Feeling doubted and unconfirmed

In all these situations physicians and RNs met the same patient, but in different situations and from varying perspectives. Often physicians had seen they in the consulting room, sometimes
for some years before the patients became dependent on dialysis. From experience physicians know that patients are usually healthier when they first encountering the physician, but that the situation may change. When dialysis is started patients are sometimes in a deteriorating health and often depressed. Physicians also know that during dialysis, the patient will usually entrust the RNs with their troubled life story but, a few days later, may tell the physician that everything is just fine.

‘You see things from different angles. One thing is that patients behave strangely. They are here so many hours per week with the dialysis personnel and they meet almost the same nurse every time. The patients seem to be able to complain a lot to the RNs. Then when I, as a doctor, arrive ten minutes later, everything is going quite well for the patient. We get different information from the patient as well’

RNs’ opinions about whether to start or continue dialysis treatment for a very critically ill patient was one area of dissension between RNs and physicians. When physicians decided to start or continue dialysis for a critically ill patient, they felt questioned and accused of failing the patient. They experienced a lack of respect or understanding from RNs, even if at times they felt uncertain about whether or not their decision was appropriate.

The narratives also revealed a major conflict between the curative and palliative aspects of dialysis. On the one hand, there is a curative view of dialysis which deems it a failure when a uremic person without transplantation options deteriorates and finally dies, often in a critical condition. On the other hand, dialysis may increase the patient’s wellbeing resulting in improved appetite and increased energy, at least for some time. From a palliative perspective, dialysis treatment can be experienced as meaningful; however, there was lack of consensus among physicians or between physicians and RNs.

‘We are after all working with palliative treatment and of course, if one’s approach means that, we start dialysis and the patients die anyway and it may be experienced as a failure but from another perspective it[treatment] may be meaningful. The patient and relatives have time to end their life’

Physicians perceived a distance between themselves and RNs and wished they were could understand the RNs’ intentions. They wanted to find a way to explain the reality of the patients’ and relatives’ situation. When obliged to defend their decisions, or decisions made by the physicians’ group with which they themselves may have disagreed, the physicians sometimes felt uncertain or ambivalent. Reflecting on these situations, their conscience was troubled because they had not stood up for their decisions.
Comprehensive understanding and reflections

The aim of the study was to illuminate ethically difficult situations that induce burdensome feelings of having troubled conscience, as narrated by physicians working in dialysis care. The findings show that the physicians felt *trapped in irresolution* when obliged to decide about withdrawing or withholding dialysis in the face of dissonant opinions. They experienced *being torn by conflicting demands* when ideals and reality clashed. The situations related in their narratives represented true ethical dilemmas in which physicians wanted to do good by avoiding doing wrong. In ethical dilemmas, however, there is no one truly good solution [27]. The physicians’ choice was therefore not between doing good or bad but rather which would be the lesser of two evils [28]. When telling their stories physicians realized that by avoiding one evil they unintentionally opened the door to the worse evil by not being sensitive enough to the patient’s wishes, failing the relatives by not bringing up the crucial problem for discussion and ultimately failing themselves by not being true to their own values. Ricoeur (1992) says that in the concrete situation when conflicts between different demands clash and we not only have to choose between good or bad but rather between evil and a lesser evil to protect life, it is important to validate one’s standpoint [28]. Silfverberg (2005) believes that an ethical dilemma makes us feel confused and uncertain because we do not know what to do, but we still feel bound to act with no rules to follow [29]. To find a clue to what is best for the other in an ethical dilemma, it is essential to be sensitive to one’s own attitude and clarify one’s inner motives [29, 30].

The physicians in this study tried to follow what they believed was a good way of handling the ethical dilemma caused by conflicting opinions. They tried to do good by avoiding conflict between patients and relatives and wanted to open the way for consensus while not influencing the relatives’ opinions. In hesitating to make a final decision about withdrawal of treatment they hoped the patient and relative would arrive at the right decision. Instead of following their own conscience in giving the patient and relative guidance, the physicians said they kept out of the way. They expressed a defensive attitude by avoiding taking action. Lögstrup (1994) claims that by continuously considering instead of acting in difficult situations we may escape uncomfortable moral obligations to take the initiative for change. It
is easier to continue considering but to do it continuously robs us of the power to act [30]. Nykänen (2009) argues that if one’s conscience knows what is right but one still does what one believes others expect, one is directed by a false conscience and ultimately turns against one self.

Disregarding one’s conscience means escaping from the true self and is often followed by feelings of guilt [31]. According to Fromm (1990) when you are not sensitive enough to follow the voice of conscience, conscious feelings of guilt about the person being failed will be induced. Later on a whole complex of unconscious guilt feelings for failing oneself arises. In the midst of unconscious feelings of guilt the experience of being trapped is generated [32]. The presence of such feelings of unconscious guilt was traced in the interview situation when the physicians’ expressed a desire for another way in which to meet an ethical dilemma. The physicians wished they had been more sensitive to their own conscience and had been brave enough to influence the relatives in order to avoid the patients’ suffering. Ricoeur (1992) claims that conscience comes both from outside and inside. Its function is to examine our actions with suspicion, the judgmental function of conscience, but also to give us attestation of being a sufficiently ethical being, in other words our power to be [28].

According to the authors’ interpretation the physicians in this study wanted to be confirmed, by their conscience but also by their colleagues and RNs when making decisions in ethical dilemmas. Lacking support from colleagues and understanding and respect from RNs, the physicians felt devalued. Sörlie (2001) found that in ethical dilemmas in pediatric care physicians felt lonely and burdened by uncertainty and responsibility [33]. As mentioned above facing an ethical dilemma means facing conflicting moral demands where no decision is totally good [27]. It means that we often need to consult not only our conscience but also others to ascertain that the decision is as good as it can be, given the circumstances. We need to feel assured that we have not overlooked better ways to act [34]. Analysing situations involving ethical dilemma together with others open the way for sensitivity to others perspectives and promotes moral development [35]. Interviewing psychiatric care providers about having troubled conscience Dahlqvist et al (2009) found that being sensitive but having a realistic approach towards one’s conscience enhanced reconciliation and an ability to feel “good enough” [36].
In this study, physicians spoke about feelings of being burdened by having sole responsibility in situations involving decisions about life or death. When investigating the ways physicians dealt with challenges in their work Andrae (1996) found that they are educated to master all situations, are generally expected to have answers to all questions [37, 38] and to make medical decisions on their own[37]. Hansson (2008) describes the medical profession as not having developed a collaborative culture with support and shared responsibility for patients [39]. The physicians in this study did not only have difficulties in reaching a consensus with colleagues, they also described feelings of being questioned and blamed by RN: s. Sörlie (2000) showed that support, encouragement and shared feelings of uncertainty helped physicians to develop an insight and acceptance that in an ethical dilemma one has to deal with insoluble problems. A prerequisite for being able to endure sole responsibility was being able to share the agony of being moral responsible when things go wrong [40]. Silverberg (2005) emphasizes that an ethical mind with a feeling for concerns and judgements can be developed not only through being sensitive to the voice of conscience but also by observing and being corrected, in a sense of togetherness by other people. In such an ethical climate personal character and virtues may develop [29]. In a study about ethically difficult situations Lindseth (1993) showed that physicians and RNs had differing ethical perspectives in relation to the patient but when reflecting more deeply, they had similar core values. While different perspectives can be seen as complementing each other, in-depth dialogue between and among various professionals allowed mutual understanding and consensual arrival at acceptable actions [41]. Studying ethically difficult situations in intensive care, Söderberg (1999) showed that a good outcome in an ethical dilemma can only occur in an atmosphere of consensus. Physicians who succeeded in implementing very difficult decisions shared the characteristics that they dared to stay in difficult situations, acted respectfully towards their opponents, were open to criticism, created a feeling of solidarity and succeeded in discussing the situation in such a way that they could achieve consensus [17].

Conclusion
To summarize, physicians in hemodialysis care regularly face ethical dilemmas which may induce a complex feeling of having a troubled conscience because they failed patients, relatives and themselves by unintentionally causing more suffering. In these ethical dilemmas, physicians voiced feelings of being left alone, burdened by moral responsibility, given no understanding or confirmation when a difficult decision had to be made. The result points to a
way of meeting ethical dilemmas, not being burdened but guided by their conscience. When reflecting on their troubled conscience, physicians wished they were brave enough to bring up the crucial problem among those involved. This means sharing the agony of how to act in ethical dilemmas; reaching consensus about how to reduce patients suffering; and being respected and confirmed regarding the decisions made.

Competing interests
The authors declare that they have no competing interests

Authors’ contributions
CFG participated in the design of the study, carried out the interviews, participated in the analysis and completed the manuscript

VD read the interviews, participated in the analysis, helped to draft and complete the manuscript.

AS designed the study, read the interviews, participated in the analysis, helped to draft and complete the manuscript.

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