Good death disrupted: Nurses' moral emotions navigating clinical and public health ethics during the first wave of COVID-19 pandemic

Abstract

Aim: To explore the moral emotions that front-line nurses navigated in endeavouring to ensure a 'good death' for hospital patients and care home residents during the first wave of the COVID-19 pandemic.

Background: Under normal circumstances, frontline staff are focused on clinical ethics, which foreground what is best for individuals and families. Public health crises such as a pandemic require staff to adapt rapidly to focus on what benefits communities, at times compromising individual wellbeing and autonomy. Visitor restrictions when people were dying provided vivid exemplars of this ethical shift and the moral emotions nurses encountered with the requirement to implement this change.

Methods: Twenty-nine interviews were conducted with nurses in direct clinical care roles. Data were analysed thematically informed by the theoretical concepts of a good death and moral emotions.

Results: The dataset highlighted that moral emotions such as sympathy, empathy, distress, and guilt were integral to the decisions participants described in striving for a good palliative experience. Four themes were identified in the data analysis: nurses as gatekeepers; ethical tensions and rule bending; nurses as proxy family members; separation and sacrifice.

Conclusions: Participants reflected on morally compromising situations and highlighted agency through emotionally satisfying workarounds and collegial deliberations that enabled them to believe that they were party to painful but morally justifiable decisions.

Implications for the profession and patient care: Nurses are required to implement national policy changes that may disrupt notions of best practice and therefore be experienced as a moral wrong. In navigating the moral emotions accompanying this shift, nurses benefit from compassionate leadership and ethics education to support team cohesion enabling nurses to prevail.

Public contribution: Twenty-nine frontline registered nurses participated in the qualitative interviews that inform this study.

Reporting Method: The study adhered to the Consolidated Criteria for Reporting Qualitative Research checklist.

What does this paper contribute to the wider global clinical community?

- Frontline nurses experienced major disruptions to long-established practices associated with a good death, having to bear the moral burden around end-of-life care during the COVID-19 pandemic.
- The shift from practice informed by clinical ethics to public health ethics elicited an array of moral emotions that informed decision-making.
- Pandemic and disaster preparedness requires ethical approaches respectful of practice informed stories, such as narrative ethics, which integrate the role of emotions and reasoning.

Keywords: COVID-19, frontline nurses, ethics, moral emotions, good death

1 Introduction

Typically, prior to the pandemic, nurses globally accommodated the constant presence of numerous loved ones throughout anticipated in-patient end-of-life care in their aspiration to ensure a good death for patients (Rushton & Edvardsson, 2021). However, lockdowns and social distancing policies radically altered these practices internationally (Gallagher, 2021; Spacey et al., 2021; Vellani et al., 2021). Frontline nurses rapidly came to occupy a newly coined identity as essential workers. They gained heightened but ambivalent public recognition, as although they put their lives at risk during all the uncertainties of the first wave of the virus, without vaccinations, rapid antigen screening and adequate personal and protective equipment (PPE) they were also shunned as possible vectors of infection. They were also at times vilified for their gatekeeping role, separating families from patients and residents even though they endeavoured to provide comfort, including acting as proxy family members (Cook et al., 2021; Foli et al., 2021). Studies highlight that for nurses, keeping families apart from dying patients caused significant moral distress (see for example Castaldo et al., 2022; LoGiudice et al., 2021).

The policies to restrict visitors were based on utilitarian ethics which guide public health ethics, where the emphasis is on maximising the greatest benefit for all concerned while minimising harm, in this case further virus spread, to other patients and healthcare workers. However, for frontline staff, having to regularly abandon individually focused clinical ethics led to "unsolvable discomforts" (Robert et al., 2020, p.4). Davidson et al. (2020) affirm that while nurses' pandemic-related moral outrage is understandable, unchanneled visceral emotions do not lead to coherent actions. We concur and our data show that nurses drew on moral emotions as integral to their ethical decision-making.

Moral emotions (Haidt, 2003) are emotional responses about others' wellbeing and suffering that complement and inform rational ethical decision-making shaped by principles such as beneficence, non-maleficence, autonomy, and justice (Beauchamp & Childress, 2013). This focus on the emotional drivers of ethical decision-making contrasts with commonplace healthcare ethics approaches that presume that ethical decision-making is primarily a rational process (Gillam et al., 2014; Molewijk et., 2011). This theoretical framework is explicated in the methods section.

A good death is one of nurses' primary goals for end-of-life care. Features of a what constitutes a good death depend on the perspectives of dying person, their chosen people, and staff. Although a contested term because there are no external criteria, commonly noted attributes include the following: emotional wellbeing, which encompasses spiritual and psychosocial aspects; dignity; being pain-free and comfortable; freedom from avoidable distress for all involved; wishes of the dying person and family upheld; and the ability of staff to provide care deemed by all involved to be appropriate clinically, ethically and culturally (Meier et al., 2016; Vellani et al., 2021). However, the COVID-19 pandemic precautions have had an impact on the disruption to rituals associated with an anticipated death that is unprecedented in the lives of people who have not previously encountered pandemics, natural disasters, and war. In the first wave of the COVID-19 pandemic in 2020, crisis measures in hospitals and residential care homes for older adults dramatically altered the taken-for-granted rituals around dying and death. End of life rituals such as bedside vigils were abruptly stopped, and replaced with restrictions on visitor numbers, visiting time periods, enforced 'social distancing' and often the requirement for permitted visitors to don personal protective equipment (PPE), rendering them unrecognisable and untouchable (Hofmeyer & Taylor, 2021). Internationally, virtual goodbyes became a widespread phenomenon (Chen, 2022; Gallagher, 2021; Strang et al., 2020). People, especially those infected with COVID-19, commonly experienced dying alone, which across cultures is a perceived as a significant moral wrong (Yardley & Ralph, 2020).

The study question asked: what moral emotions did front-line nurses navigate in endeavouring to ensure a good death for hospital patients and care home residents during the first wave of the COVID-19 pandemic? This article aims to explore the moral emotions that shaped front-line nurses' decision-making and responses to patients, colleagues, and families as they endeavoured to ensure a good death for hospital patients and care home residents during the first wave of the COVID-19 pandemic in the New Zealand context. The significance of this article is that when nurses are required to implement national policy changes that shift the focus from clinical ethics to public health ethics, the recalibration disrupts notions of best practice and therefore be experienced as a moral wrong. We argue that it is helpful for nurses to have ethics education about their role in disasters and epidemics that affirms the place of emotions in informing to moral decisions.

2 Methods

This theory-driven qualitative study (Collins et al., 2018) used a social constructionist approach to investigate the experiential dimensions of nurses' lives in relation to direct care of dying patients and residents during early pandemic lockdowns. Social constructionism focuses on how individuals and groups understand their world. Meanings are contextual and impermanent, with ideas about truth seen as a product of social processes (Burr, 2015).

2.1 Conceptual framework – moral emotions

Much attention has been drawn to nurses' emotions in the aftermath of complex ethical decision-making during the pandemic (see for example Wald & Monteverde, 2021), with limited focus on the role emotions have in informing decisions. The concept of moral emotions has utility in considering frontline nurses' ethical decisions about dying patients in the first wave of the pandemic. This concept developed by Haidt (2003) proposes that an emotional response to a situation that involves the welfare of others precedes rational ethical deliberation. Rather than the elicitation of emotion

only being viewed as the sequelae of a compromised ethical decision-making process, such as moral distress and moral resilience, Haidt considers that wide-ranging emotions are forerunners in informing ethical decision-making. Haidt's position is that emotions are neither inferior nor superior to rational ethical deliberation, but rather that they have a complementary but typically unrecognised role in guiding decisions. Subsequent ethicists have highlighted the problem of ignoring the emotional component of ethical decision-making. The result is likely to be that health professionals may only have a tacit sense of the significance of these emotions, without language to analyse responses as an aid to moral deliberation and moral agency (Gillam et al., 2014; Molewijk et., 2011).

Increasingly narrative ethics is being taught in healthcare education to encourage the integration of reasoning and emotions. Narrative ethics involves a tailored rather than rule-bound approach to ethical deliberation with an interest in practitioners' motivations and intentions. Narrative ethics supports health workers' practice-informed stories, which include emotions, where clinicians endeavour to construct an ethical identity while deconstructing problematic situations not resolved by applying abstract ethical concepts (Banks & Rutter, 2022). We agree with Banks and Rutter, that practitioners' ethics work has cognitive and emotional dimensions. Haidt's (2003, p. 855) notion of clusters of moral emotions provides a communicative repertoire to analyse emotions. Haidt considers there is an "other condemning" cluster of emotions of contempt, disgust, and anger, and a "self-conscious" cluster of shame, embarrassment, and guilt. As an example of the latter, through the pandemic, nurses have commonly had to weigh up fears of infecting family members, and guilt about separation from loved ones due to their frontline role (Riedel et al., 2022). Moral emotions are also involved in prosocial behaviours. The "other-suffering" cluster of emotions involves compassion and empathy being evoked. The "other-praising" cluster is about positive moral emotions of gratitude and pride in others' actions. Positive emotions have a fundamental role in promoting wellbeing and adaptation during adversity. Belkin and Kong (2021) note that in the COVID-19 context, compassionate leadership elicited teams' moral emotion of gratitude and had a significant

mitigating effect for staff experiencing pandemic related workplace distress. Wright et al. (2017) usefully draw from Haidt's work and identified what the authors term the professional values maintenance work surgeons undertook when events triggered moral emotions. Wright et al.'s research is significant because the analysis indicates the possible actions that moral emotions elicit that empower practitioners. The authors identified three areas of action. Advocacy work entailed the use of a persuasive story about a patient's plight; sanctioning was where the professionals used their status or appealed to those in the hierarchy to approve their decision; and brokering was the term the authors used to name behaviours where the surgeons acted as intermediaries between specialties to bring about a preferred result on behalf of a patient. We draw from Haidt's concept of moral emotions, the narrative ethics interest in practitioner stories and Wright et al.'s professional values maintenance actions to address our research question and to inform the data analysis.

2.2 Study context

These data relate to the first wave of the COVID-19 pandemic, prior to the availability of rapid antigen testing and vaccinations. At the time data for this study were collected, between October and December 2020, New Zealand was at the lowest alert level with people able to move freely within the country's closed borders and the Omicron and Delta variants not yet on the horizon. By 21 March 2020 the government declared a four-levelled alert system. By 25 March 2020 the government moved the country to the fourth and highest level, with the population mandated to form isolation 'bubbles' – small groups accommodated together. Only essential services remained open. People were legally required to stay close to home, only leaving to shop and exercise outdoors. International borders closed with few exceptions to everyone apart from residents and citizens. Those who arrived from overseas faced a mandatory managed isolation period in re-purposed hotels. At level four, hospitals and residential care facilities were closed to all visitors and at level three visits were at the discretion of the person in charge of the local setting. By 31

December 2020, 2162 cases and 25 deaths had been reported country-wide (World Health Organization, n.d.).

2.3 Recruitment and participants

The 29 study participants were recruited via a national nursing organisation via emails to nurses in clinical roles and through journal advertisements. Inclusion criteria were that participants had to be registered nurses or midwives working in direct patient contact roles during the initial phase of the pandemic in 2020. Direct care roles included in-patient, residential, community, and managed isolation contexts. All potential participants who contacted the research team met the inclusion criteria and all completed the interview. The sample consisted of 28 registered nurses and a midwife. Participant ethnicities were two Māori, 19 Pākehā (New Zealand European), one Korean, one Taiwanese, one Canadian, one Scandinavian, two British, and two Dutch. Participants' ages ranged from those in their twenties to their sixties.

2.4 Data collection

Potential participants were emailed, with an accompanying information sheet, to introduce the interviewer, organise a telephone call to address any queries, and arrange an interview time. Following verbal consent protocols associated with online interviewing (Engward et al., 2022), the interviews, lasting approximately one hour, were conducted via Zoom, and field notes were taken. Semi structured interviews were undertaken. Examples of interview prompts are as follows:

> *Please describe an insight or learning you will take forward in your nursing career and your life that has come from working through the pandemic; please describe a 'critical incident' - an event that stands out in your memory - related to diverse reactions in your workplace team that created challenges while working through the pandemic; please describe an experience that occurred through the Covid-19 pandemic that you experienced as ethically or morally challenging in some way.*

Data collection occurred between October and December 2020 and stopped when data saturation was reached. Interview and participant data are stored within a password protected computer, operated by XXXX University. All data will be securely stored for six years and then destroyed, in accordance with the Ethics Committee requirements.

2.5 Data analysis

Thematic analysis was used drawing on Braun and Clarke's (2021) approach, which aligns with social constructionism. These steps involve identification, analysis, and representation of themes. The process involved inductive and theory-driven deductive analysis. As described above, the theoretical notion of a good death and the concept of moral emotions informed our approach to the data (Collins et al., 2018). The authors familiarised themselves with the data individually to ensure rigour and reflexivity and then collaborated. We first coded initial apparently significant features within the data, noting all references to palliative and end of life care, all data pertaining to the exclusions and restrictions of family members, and all indications of moral and emotional responses to these contexts. This initial process was followed by collation of these codes into possible themes and, using a thematic map, selected themes were arrived at.

2.6 Ethical considerations

The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist and was approved by [anonymised] University Human Ethics Committee. Participation was voluntary. Participants were informed about the study; confidentiality and de-identification were discussed; and verbal consent was obtained prior to interviews. The online interviews adhered to international recommendations (Lobe at al., 2020). The digital interview recordings were transcribed with a confidentiality agreement in place.

3 Findings

The dataset highlighted that emotions were integral to the ethical decisions participants described in their efforts to ensure a good palliative and dying experience. Four themes were identified in the data analysis: *nurses as gatekeepers;* where participants had to carry out government mandates and in so doing grappled with difficult moral emotions of feeling culpable for undermining good death experiences; *ethical tensions and rule bending;* where participants described processes of moral deliberation, where they experienced moral emotions of distress in implementing strict guidelines; *nurses as proxy family members*, where participants highlighted the moral emotions of compassion and empathy with which they attempted to 'stand in' for loved ones; and *separation and sacrifice*, where participants indicated the costs in caring, including guilt at their own families missing out on their care. Participants emphasised the moral significance they attached to being present for dying people and assisting communication between the person and their family. Although participants described morally compromising situations, they also spoke of emotionally satisfying workarounds and collegial deliberations that enabled them to believe that for the most part they were party to painful but morally justifiable decisions.

3.1 Nurses as gatekeepers

Participants spoke of the alien experience of having to transition from what was normally a relatively 'open door' policy when people were dying to a tightly controlled system. It appeared that the required actions elicited the moral emotions of shame and compassion. A participant spoke of their distress in having to initiate the departure of family members:

> *We did let family in for 15 minutes, but they had to wear masks. But, again, that's possibly quite frightening to someone who's dying. But, also then the family don't want to leave. So, you've got the trauma of trying to get them out. They understand*

why they're limited to 15 minutes and why they have to wear masks and things. (#16, RN, residential care)

The rational appreciation of why these measures were in place did not spare the participant from describing the experience as a trauma. The quote points to the moral emotion of guilt that staff experienced in separating families around the time of death. In the early weeks of the lockdowns frontline staff were inundated with documentation and rapidly evolving policies that did not cover all contingencies, leaving staff to have to make ad hoc decisions around dying and death. The following participant described the novel and shocking experience of depriving a family member of touching their recently deceased father:

I had a situation when I had person die and the lady [relative who had flown internationally] got out of quarantine and had to come in PPE, who couldn't touch her dad; you know, that sort of stuff. You're very confronted with that straightaway with no policy to look up, no-one guiding you at the time. (#1 RN, Acute care charge nurse)

Participants spoke of the awareness that they and their colleagues were in the invidious position of experiencing conflicting moral emotions that created irreconcilable tensions. They had empathy for families and wanted to do what was right in terms of the national pandemic response, at times resulting in abuse from the public. The following participant in effect recounted the moral emotion of sympathy for colleagues who were condemned by members of the public even though they were trying to protect people:

People were being refused entry [to the hospital]. I heard stories of staff being abused; yelled at; screamed at because of course people were stressed. I…I think there were a couple of times when there might have been a wife or a husband snuck in to their dying partner; spouse….You know we get into health care because we care on the whole. That was tough. Staff were pretty emotionally cut up by

> *some of that. I don't think the public really understood. I don't think they appreciated what we were trying to do. We were seen as the gatekeepers, and we were seen as the bad people. (#25, RN acute area)*

It is quite possible that family members experienced their exclusion as a moral wrong, resulting in these condemnatory behaviours. Another participant spoke of the moral emotion of compassion she had for the older residents in her care who lived with cognitive impairment and were at a palliative stage of life. She was unconvinced that the lockdown measures that separated residents from each other as well as their families were in their best interests:

> *Having contact with the outside world and with their families really is what helps to make their living environment a home… it probably didn't feel like home to them when they were locked up in their room and you've got somebody walking in with a mask. Probably a lot of them, if we had asked them, they probably would have said, "Actually, we still want to come down to happy hour. We don't want you wearing masks. We just want this to be our home and continue on being happy." Our home environment became very clinical. It just sort of highlighted to me how important a rest home environment is having happy, healthy end of life care…. But, to lock someone in their room, and to isolate them from other residents, I think that's a really big thing to do to somebody without asking them if that's what they want. (#16, RN residential care)*

Staff were aware that residents, who were often cognitively impaired, were required to make sacrifices they were unable to comprehend. The rapid shift from a clinical ethics approach to a utilitarian public health approach brought forward moral emotions of compassion and empathy as well as those of anger and possibly disgust at the felt sense of the social violations associated with the disrupted rituals around dying and death. Nurses experienced moral emotions around the grim reality that people were dying alone during levels four and three of the 2020 pandemic lockdowns.

The moral emotions of empathy and sympathy were apparent as nurses felt emotionally challenged and distressed by those dying alone, which appeared to be felt by all concern as a type of moral violation. Concessions were made inconsistently on compassionate grounds to allow a visitor at level four when someone was about to die, and at level three one visitor was permitted.

3.2 Ethical tensions and rule bending

Participants appeared to weigh up tacitly the individual benefits and wider possible risks of allowing visitors. It appeared that when faced with visceral connections with patients, residents and family members, the staff drew from their emotional sense of what they felt were morally justifiable decisions that occupied a type of 'middle ground' response to Ministry of Health edicts. An example of such a work-around in residential care is as follows:

> *We had two residents and they had both come to us for palliative care…. And so we [staff] had a discussion about what we were going to do. Were we going to allow visits while we were in lockdown? And where did the balance of care and risk management lie? And we all felt that it was really, in our minds, unreasonable to completely cut off a person in that situation from their family and vice versa, cut their family off from that person. So, for those two residents we made an exception and once again discussed it with staff and the other residents that they'd have one of their family members could visit each day, for a period of time. (#17, RN, residential care)*

Frontline workers participants described collaborative dialogue with colleagues to come to a decision they felt they was morally justifiable in their context. In the following quote the moral emotion of empathy is evident in taking the family's needs into account:

> *They were anticipated deaths…. Morally, it was really hard not to have family members in with them. That was a really hard tablet to swallow and I don't know*

how they did it, how other people did it. That was really hard. In the finish, we did let them in in those final hours. We're like, "No, come and gown up." Every protection we can. It supported. It was important for the care staff too that [residents'] families be there. We relocated [dying residents] to rooms with external sliding doors and allowed the families to be in the room, provided them with personal protection, when they were in the room they had to wear their [PPE]… when we left the room, we didn't want to know what was happening behind the door. But I think where we were nursing, there were no cases locally. But we did have a comfort of that. Completely different scenario in a facility that had Covid-19 I do appreciate. (#18, RN, residential care)

The metaphor of the "really hard tablet to swallow" points towards a decision informed in part by an emotional response as well as the rational analysis that there was no known COVID-19 locally and nor did the residents appear to have the infection. What is evident in the participant exemplars is that there was not an out-right dismissal of the Ministry of Health's utilitarian ethics approach, but at times decisions were informed by the immediate need, which evoked moral emotions of empathy and compassion about what constituted the right thing to do that over-ruled population-based considerations:

You always felt like you were going to get yourself in a little bit of trouble for stretching the rules, but you actually had to do what was right for your patients…. I still to this day feel, if I had been caught letting this [dying] man's wife into visit, I would have been deeply in trouble. But I did it because I needed to do it. I did it for him and I did it for her. It wasn't until we went to level three that there was in our visiting policy that came "at the discretion of the charge nurse." Up until that point it was a very "No, you don't let anyone in." I understand that. I absolutely

> *understand that. As a country, level four was level four. By letting people in, we were breaking the rules of the 'bubble,' I guess. But every now and then you just had to do what was right for your patient. (#19,RN, ward charge nurse)*

These examples highlight that in all the early uncertainty of the first wave of the pandemic, frontline nurses were at times undertaking significant emotion work because of their felt sense that separating dying people and loved ones was a moral wrong. These emotionally informed decisions did not mean that participants eschewed new policies, but rather they made distinctions between the abstract ideals of the lockdown rationale and their longstanding felt sense about the moral right of dying people being companioned by family.

3.3 Nurses as proxy family members

The moral emotions of sympathy and compassion were also evidenced as nurses recounted doing all in their power to ensure that patients did not die alone. Across the dataset the notion of companioning dying people was a strongly held value around what constituted a morally defensible dying experience. A participant spoke of working in a care facility where older patients had COVID-19 and in effect described the moral positive emotion of gratitude for having the opportunity to nurse in these extraordinary times:

> *There was only staff on the ward. Families, a lot of the families were present via video but that's not the same. I mean it's the best you could do but it wasn't the same as having a loved one holding your hand…. I believe it was a privilege to be involved in their care…. no matter what their illness was when they got COVID or what their circumstances were when they got COVID every single one of these people have lived a life. They have held jobs. They have raised families. They've got sons and daughters and grandchildren and great grandchildren and if it was my*

mum or dad how would I feel? They are all individuals, and you treat them as such. They're not COVID patients, they are people. (#29, RN, medical/older adult care)

The above participant highlighted the humanising view she had of people dying of COVID-19 that informed this sense of the privilege of standing in for family and providing the requisite care. Participants were aware that during the lockdowns they were providing more than nursing care to dying people. The following participant highlighted that their faith enabled them to sustain moral emotions of compassion and empathy:

My faith kept me going, knowing that I serve [God] and I serve my patients and their families. It's not about getting back; it's about giving….No patient visitors could come into the hospital; so, not only was I doing nursing cares, but also being friend, confidante, family member and advocate, more so than usual. People don't stop being diagnosed with terminal illnesses just because it was lockdown. (#23, RN, acute ward)

The following participant spoke of their moral emotion of sympathy for absent families as well as the dying person:

I helped look after a patient who did pass away with no family there. When I reflected on it later on, it made me realise how important that is [supporting the dying person in the family's absence]. That is the memory that that family will have for the rest of their lives, and it has a flow-on effect because they weren't able to be there. I think we were used as a lot more emotional support for families. They felt quite isolated themselves. (#22, RN, acute ward)

The following participant spoke of the positive moral emotions they felt in providing care they believed was morally right and this positioning appeared to mitigate some of the distress associated with separating patients from families, especially when dying:

I think dying alone is a really awful thing and when we had someone on the ward who was [dying] we did everything possible to ensure they were checked, probably a bit more regularly than normal…. I'm very hands-on….I probably [connected with patients] more during Covid knowing that their loved ones wouldn't be able to come in. Eventually you got to know various people [relatives] because of the phone calls, and you'd hold the Zoom up to granddad, so there's all those warm fuzzies sometimes…. I feel very honoured, I feel quite special that I was able to be a nurse in a pandemic. I'm quite humbled, that's special. If it happened again, I would certainly put my hands up and I'd have no qualms about doing it again. (#1, RN, acute ward)

This theme of nurses' felt sense of standing in for family particularly when someone was dying was evidenced across the dataset. It was clear that nurses undertook this work because the sense of doing what was right made the emotions of these situations morally tolerable despite the compromises.

3.4 Separation and sacrifice

Nurses chose to make sacrifices on behalf of patients and residents at the expense of their own personal contexts. One of the participants spoke of the conflicted moral emotions of guilt about her decision and empathy for others in her situation that she experienced in not being with her dying mother and continuing to work:

I had to make the sacrifice that I wouldn't spend the last week or two with my mother while she passed away. I felt really bad but what choice did I have? It's a few months on now but it's sad 'cause in normal circumstances I would've taken a week off work and stayed with her day and night at the rest home and nursed her till she passed away. But I wasn't allowed. I went to visit her in my PPE once but I just couldn't go back again cause I felt too scared if I had it I would give

it to someone in the rest home…That was the hardest for me, but it wasn't a risk to me, it was me providing a risk to other people…. but everyone else [colleagues] was the same. (#4 Charge nurse, acute area)

Participants who worked on designated COVID-19 wards spoke of having to endure some colleagues' apparent moral emotions of fear and disgust that they were working directly with people who had contracted the virus:

When I returned to work after [being on a COVID ward] in the same building I felt like – I actually said to one of my colleagues, "I'm not a leper. I did my job to the best of my ability. I know I'm COVID free because I've been tested. Have you?" Because the reactions I got from some different people really stunned me. They'd like back away from you or take a really wide berth and it's like I didn't get that. It made me angry. It was like how stupid can you be? We're nurses. That's the only negativity I've sort of felt with it. As I said I don't feel guilty about what I did and the work I did and the reactions of my colleagues. (#29, RN, medical/older adults)

This same participant spoke about the sacrifice she made to provide care for people with COVID-19, which elicited the moral emotion of guilt alongside her compassion for people infected with the virus:

I did feel guilty for a long time about what my husband went through while I was doing the best I could possibly do as a nurse. Basically, I separated myself from my family. We had eight weeks where we slept in separate bedrooms….I did see my children and my grandchildren but they didn't come into the house. They would wait outside and I'd talk to them out the window. (#29, RN, medical/older adults)

A staff member recounted their sorrow and discomfort at depriving residents of their usual grieving rituals when a resident died:

> *It's really sad, I might have cried a couple of times. We had five residents die over the Covid period. There was no real celebration of their life with families. We actually didn't even celebrate their life when they passed in the rest home, which is possibly something we could have done; because that person was there and then they were gone, and other residents are locked in their rooms and they know that all these people are dying around them, and they don't know really what's happening, or why it's happening. (#16, RN, residential care)*

Nurses had to weigh up what would be worse to live with morally; following rules and compromising a good death or potentially being responsible for many vulnerable people getting COVID-19 and dying.

> *We had a news article go through [national media] about a patient that we wouldn't let her husband come into the hospital. She was very, very unwell. It went absolutely national. Everyone was like, "Let him in. He's not going to kill her." But I just had this horrible thought that, what if I'm the one that brings it in and someone does kill her. We made very sure not to…We had the sickest patients in. We tried really hard to get everyone else out. (#23, RN, acute care)*

The above quote highlights that at times nurses' reputations were damaged due to media representations of individual situations. In these situations, nurses sacrificed public opinion of them when they took the mandated public health approach to safeguard people from infection. These data highlight the impact these rules had in disrupting rituals around what nurses and the public consider are the moral practices that constitute a good death.

4 Discussion

This study highlights that frontline nurses' ethical deliberation included incorporating emotions in deciding what they could tolerate when making morally compromised decisions around people's dying experiences during the first wave of the pandemic. Nurses' additional-to-routine moral work was elicited by extreme lockdown restrictions, which posed novel disruptions to the felt sense of what constitutes a good death. Although so many facets of what traditionally has constituted a good death were stripped away with pandemic-related restrictions, participants as much as possible held onto the value that no-one should die alone, and that companionship at the end of life was a fundamental ritual not to be abandoned. The data also highlight that although population-based public health ethics make sense rationally, participants' first-hand experiences of implementing the required gatekeeping were deeply unsettling.

Our study shows that participants' moral commitment to the concept of a good death was informed by what these nurses felt was best in the short-term end-of-life period and based on what they perceived was most beneficial for families in dealing with the longer-term grief. Participants' concerns about the likelihood of people's complex and prolonged grief if separated from dying loved ones is borne out in the emerging research focused on family experiences of pandemic-related end-of-life disruptions (see for example Donnelly et al., 2022). Hernández-Fernández and Meneses-Falcón note that staff willingness to breach protocols and to take a more holistic approach to facilitating farewells impacted on reducing families' grief. Our data reflect what Banks and Rutter (2022) have called ethical creativity, in which practitioners use both cognitive and emotional decision-making to respond to novel situations, rather than reactive defiance of new regulations and policies.

Our study demonstrated that although participants reported experiences that evoked moral distress, they also exercised agency and took pride in the teamwork that enabled them to optimise care in

compromised situations. Health workers' moral emotion of pride about their capacity to adapt swiftly and creatively to work in the pandemic related end-of-life context is noted in other studies (see for example Fox, 2021; Marsaa et al., 2021; Spacey et al., 2021). We concur with Wright et al. (2017) that health professionals are not necessarily helpless in the face of moral emotions, which rather can spur on action-oriented values maintenance work of advocating, sanctioning, and brokering. Our data provide examples of nurses' professional responses in the face of moral emotions. For example, participants described advocating for people's right when dying of COVID-19 to experience an undiminished quality of care. When local COVID-19 cases were low, participants weighed up risks and at times sanctioned family visits with limited scrutiny of these occasions, which meant they chose not to police whether there was physical contact and the removal of PPE once staff left the room. Drawing from Wright et al.'s (2017) notion of professional values maintenance work, we identified that participants in effect indicated the use of brokering, where they deliberated with colleagues, residents, and family members to organise a workaround that enabled dying residents to be visited. In participants' accounts it did not appear that they considered these decisions were recklessly undertaken but rather involved a weighing up of a justifiable degree of stretching the rules with the felt sense of what was right. Similarly, in terms of a sense of moral agency, Jiménez-Herrera et al. (2020) found that nurses' positive moral emotions were elicited in emergency situations when they were able to accommodate holistic interventions for patients and families beyond narrow biomedical considerations.

Across the dataset none of the participants spoke of any ethical preparedness for the profound shift in focus from prioritising individual and family wellbeing to new norms focused on benefit to the wider community. Although it is beyond the scope of this article to explore the ethics of interventions that prioritise containment and limit liberties, it is important we signal that the pandemic has highlighted the value of ethics education as part of disaster readiness for all health professionals (Angeli et al., 2021). In the current study, during the early months of the pandemic, nurses appeared to only have a tacit understanding of the ethical shifts they were required to make.

The pandemic has undoubtably added to the complexities around grieving, including nurses' grief. We concur with Williams et al. (2022) that frontline workers require education and support systems that enable them to voice the extraordinary moral and practical dilemmas they face around dying and death. In terms of considering the role of emotions in ethical decision-making, Gillam et al. (2014, p. 334) offer the following questions for healthcare ethics educators to draw from in facilitated group work focused on moral case deliberations:

> *1. What sort of emotion/s am I feeling?*
>
> *2. What are my emotions about? (Are they directed towards myself, other people or some feature of the situation?)*
>
> *3. Why am I feeling these emotions?*
>
> *4. What emotions are others feeling, and how does this help me understand my own emotions?*
>
> *5. How do these emotions relate to other ethically salient features of the situation?*

We consider these questions have utility in the context of considering what a good death means in a pandemic. The salient features in the COVID-19 context mean the nurses have the opportunity to speak about how they prevail when faced with the impossibility of reconciling conflicting ethical values: non-harming and upholding autonomy; and compassion for patients and families alongside professional obligations to the wider community, including legislated requirements. Recognising the presence of emotions and articulating their often unrecognised role is fundamental to teams collaborating on ethical decisions with respect and empathy (Gillam et al., 2014; Haidt, 2003).

The dataset highlight that for participants, visitation restrictions for dying people posed at times dissonant tensions that are associated with wicked problems in health. Pandemic-related wicked problems have real-world constraints, provoking value-laden, conflicting views about the scope of the issue and contradictory recommendations about solution trajectories (Angeli et al., 2021). Our

study highlights the importance of local leadership and teamwork in fostering positive moral emotions in the pandemic related palliative care context. Participants repeatedly spoke of collaborative decision-making so that they felt their decisions were morally justifiable among their immediate peers who had a sense of weighing up the same tensions, even if they knew the decisions might err outside of policy guidelines. Participants indicated that governmental and hospital level policy oversight were rapidly evolving and did not necessarily fit in helping resolve frontline wicked problems. Hofmeyer and Taylor (2021) concur that leadership that includes empathic conversations is fundamental to nurses prevailing through the pandemic. Hofmeyer and Taylor draw on what is known as the Stockdale Paradox; the capacity to accommodate brutal facts and to continue to hold hope and a belief in an underlying sense of purpose.

The dataset in the current study illustrates that participants did not escape difficult moral emotions in having to deny patients, residents, and family members a preferred dying experience. However, they gave examples of prevailing through connections they were able to facilitate, both in person and remotely that provided a sense of meaning and moral purpose to their actions. Participants' suffering occurred when they had to tolerate anger and blame from the public and families. At times they were even ostracised by other colleagues fearful of their possible contagion. These experiences occurred concurrently with participants taking additional precautions to protect their own loved ones, which meant they chose to forego prioritising their own wellbeing. We concur with Hofmeyer and Taylor (2021), that collegial collaborative efforts and expressions of gratitude are fundamental to ameliorating the dehumanising and demoralising aspects of the pandemic among nurses.

4.1 Limitations

This study had a relatively small sample size. However, the data collected had high information power, with rich data holding highly relevant information. There were challenges in recruitment as the nursing organisation assisting with emailing potential participants about the study had to juggle not overwhelming nurses with an array of communications about COVID-19. Many nurses felt

inundated with multiple sources of communications and chose not to check emails. It is possible that participants were those who were either very satisfied or dissatisfied with their pandemic experiences. These limitations require the study results be treated with caution and limits the generalisability of these results.

5 Conclusion

The aim of this study was to explore the moral emotions that front-line nurses navigated in endeavouring to ensure a good death for hospital patients and care home residents during the first wave of the COVID-19 pandemic. This research presents a novel analysis of frontline nurses' experiences, using the theoretical lens of moral emotions to make sense of the challenges, creative decision-making and individual and team learning for nurses as they attempted to facilitate a good death with the shift from clinical ethics to public health ethics. The study highlights the integral role of emotions in ethical decision-making. In this case, these emotions related to the ethical confusion and distress due to the almost overnight disruption to long-established hallmarks of supporting palliative and dying people and their families. Early in the pandemic, wider organisations and governments were unprepared for the scale of the changes. Therefore, frontline staff had to contend with policies without substantive ethical and practical guidance that radically altered practice requirements, with the unprecedented shift for most practitioners for people to die without family physically close. Across cultures this situation is typically considered a significant moral transgression. The dataset importantly shows that nurses engaged in what has been called professional values maintenance work through advocating for patients and families; sanctioning actions that breached policies if the team considered there was moral justification; and acting as intermediaries between colleagues, patients, and families in the effort to arrive at a consensus decision. Amongst the many difficult emotions associated with being seen as gatekeepers and social pariahs, nurses also emphasised the pride they took in their role and the privilege of being entrusted

as a proxy family member. The study highlights the importance of compassionate local leadership, where gratitude and appreciation of team members' efforts foster collaborative ethical work. This cohesion ameliorates the inevitable suffering nurses experience when unable to provide an optimal good death experience. The rapid transition from clinical ethics to public health ethics highlights the ill-preparedness of participants to navigate a rapid shift in moral terrain. Disaster and pandemic ethics education is recommended. This is education using approaches such as such as narrative ethics that address the shift from clinical to public health ethics and include inquiry about both cognitive and emotional aspects of decision-making.

6 Relevance to clinical practice

Frontline nurses are required to implement national policies and legislative changes that may radically disrupt notions of best practice and therefore be experienced as a moral wrong. This first-hand experience has been the case in the context of pandemic-related public health policies that impact on cherished notions held by healthcare workers and the public about what constitutes a good death. In navigating the inevitable moral emotions accompanying this shift, nurses benefit from compassionate leadership and ethics education to support team cohesion and to enable nurses to prevail when caught between being party to brutal decisions and yet holding a `belief in the underlying purpose of the nursing care they can offer.

References

Angeli, F., Camporesi, S. & Dal Fabbro, G. (2021). The COVID-19 wicked problem in public health ethics: Conflicting evidence, or incommensurable values? *Humanities and Social Sciences Communications, 8*(161) https://doi.org/10.1057/s41599-021-00839-1

Banks, S., & Rutter, N. (2022). Pandemic ethics: Rethinking rights, responsibilities and roles in social work. *The British Journal of Social Work*, *52*(6), 3460-3479. https://doi.org/10.1093/bjsw/bcab253

Beauchamp, T. L., & Childress, J. F. (2013). Principles of biomedical ethics (7th ed.). Oxford University Press.

Belkin, L. Y., & Kong, D. T. (2021). Supervisor companionate love expression and elicited subordinate gratitude as moral-emotional facilitators of voice amid COVID-19. *The Journal of Positive Psychology*, *17*(6), 832-846. https://doi.org/10.1080/17439760.2021.1975157

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide.* SAGE Publications.

Burr, V. (2015). *Social constructionism* (3rd ed.). Routledge.

Castaldo, A., Lusignani, M., Papini, M., Eleuteri, S., & Matarese, M. (2022). Nurses' experiences of accompanying patients dying during the COVID-19 pandemic: A qualitative descriptive study. *Journal of advanced nursing*. 78(8), 2507-2521. https://doi-org.ezproxy.aut.ac.nz/10.1111/jan.15195

Chen, C. Y. C. (2022). Grieving during the COVID-19 pandemic: In-person and virtual "goodbye". *OMEGA-Journal of Death and Dying*, https://doi.org/10.1177/003022282210907

Collins, C. S., & Stockton, C. M. (2018). The central role of theory in qualitative research. *International Journal of Qualitative Methods*, *17*(1). https://doi.org/10.1177/1609406918797475

Cook, C., Brunton, M., Chapman, M. K., & Roskruge, M. (2021). Frontline nurses' sensemaking during the initial phase of the COVID-19 pandemic in 2020 Aotearoa New Zealand. *Nursing Praxis in Aotearoa New Zealand, 37*(3), 41-52. https://doi.org/10.36951/27034542.2021.034

Davidson, P. M., Padula, W. V., Daly, J., & Jackson, D. (2020). Moral outrage in COVID19—Understandable but not a strategy. *Journal of Clinical Nursing*, *29*(19-20), 3600-3602. https://doi.org/10.1111/jocn.15318

Donnelly, S., McDonald, F., & Goodyer, C. (2022). Whānau experiences of patients' deaths in Wellington Hospital during 2020 COVID-19 pandemic Levels 3 & 4. *The New Zealand Medical Journal, 135*(1552), 16-26.

Engward, H., Goldspink, S., Iancu, M., Kersey, T., & Wood, A. (2022). Togetherness in separation: Practical considerations for doing remote qualitative interviews ethically. *International Journal of Qualitative Methods*, *21*, 1-9. https://doi.org/10.1177/16094069211073212

Foli, K. J., Forster, A., Cheng, C., Zhang, L., & Chiu, Y. C. (2021). Voices from the COVID-19 frontline: Nurses' trauma and coping. *Journal of Advanced Nursing*, *77*(9), 3853-3866. https://doi.org/10.1111/jan.14988

Fox, M., McIlveen, J., & Murphy, E. (2021). Death, dying and bereavement care during COVID-19: Creativity in hospital social work practice. *Qualitative Social Work, 20*(1-2), 131-137. https://doi.org/10.1177/1473325020981074

Gallagher, A. (2021). Reflections on a COVID death: Naming a family's pain and reparation. *Nursing Ethics, 28*(5), 587-589. https://doi.org/10.1177/09697330211038795

Gillam, L., Delany, C., Guillemin, M., & Warmington, S. (2014). The role of emotions in health professional ethics teaching. *Journal of Medical Ethics, 40*(5), 331–335. https://doi.org/10.1136/medethics-2012-101278

Haidt, J. (2003). The moral emotions. In R. Davidson, K. Shcherer & H Goldsmith (Eds), *Handbook of affective sciences* (pp.852-870). Oxford University Press.

Hernández-Fernández, C., & Meneses-Falcón, C. (2021). I can't believe they are dead. Death and mourning in the absence of goodbyes during the COVID-19 pandemic. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.13530

Hofmeyer, A., & Taylor, R. (2021). Strategies and resources for nurse leaders to use to lead with empathy and prudence so they understand and address sources of anxiety among nurses practising in the era of COVID-19. *Journal of Clinical Nursing*, *30*(1-2), 298-305. https://doi.org/10.1111/jocn.15520

Jiménez-Herrera, M. F., Llauradó-Serra, M., Acebedo-Urdiales, S., Bazo-Hernández, L., Font-Jiménez, I., & Axelsson, C. (2020). Emotions and feelings in critical and emergency caring situations: A qualitative study. *BMC Nursing*, *19*(1), 1-10. https://doi.org/10.1186/s12912-020-00438-6

Lobe, B., Morgan, D., & Hoffman, K. A. (2020). Qualitative data collection in an era of social distancing. *International Journal of Qualitative Methods*, *19*, https://doi.org/10.1177/1609406920937875

LoGiudice, J. A., & Bartos, S. (2021). Experiences of nurses during the COVID-19 pandemic: A mixed-methods study. *AACN Advanced Critical Care*, *32*(1), 14-26. https://doi.org/10.4037/aacnacc2021816

Marsaa, K., Mendahl, J., Heilman, H., Johansson, H., Husum, M., Lippert, D., Sandholm, N., & Konradsen, H. (2021). Pride and uncertainty: A qualitative study of Danish nursing staff in temporary COVID-19 wards. *Journal of Hospice & Palliative Nursing*, *23*(2), 140-144. 10.1097/NJH.0000000000000722

Meier, E. A., Gallegos, J. V., Thomas, L. P. M., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a good death (successful dying): Literature review and a call for research and public dialogue. *The American Journal of Geriatric Psychiatry, 24*(4), 261-271.

Molewijk, B., Kleinlugtenbelt, D., & Widdershoven, G. (2011). The role of emotions in moral case deliberation: Theory, practice and methodology. *Bioethics, 25*(7), 383–393. doi:10.1111/j.1467-8519.2011.01914.x

Riedel, P. L., Kreh, A., Kulcar, V., Lieber, A., & Juen, B. (2022). A scoping review of moral stressors, moral distress and moral injury in healthcare workers during COVID-19. *International Journal of Environmental Research and Public Health*, *19*(3), 1666. https://doi.org/10.3390/ijerph19031666

Robert, R., Kentish-Barnes, N., Boyer, A., Laurent, A., Azoulay, E., & Reignier, J. (2020). Ethical dilemmas due to the Covid-19 pandemic. *Annals of Intensive Care 10*(84) https://doi.org/10.1186/s13613-020-00702-7

Rushton, C., & Edvardsson, D. (2021). A genealogy of what nurses know about 'the good death': A socio-materialist perspective. *Nursing Philosophy*, *22*(4), e12365.

https://doi.org/10.1111/nup.12365

Spacey, A., Porter, S., Board, M., & Scammell, J. (2021). Impact of the COVID-19 pandemic on end of life care delivery in care homes: A mixed method systematic review. *Palliative Medicine, 35(*8), 1468-1479. https://doi.org/10.1177/02692163211029806

Strang, P., Bergström, J., Martinsson, L., & Lundström, S. (2020). Dying from COVID-19: Loneliness, end-of-life discussions, and support for patients and their families in nursing homes and hospitals. A national register study. *Journal of Pain and Symptom Management, 60*(4), e2- e13. https://doi.org/10.1016/j.jpainsymman.2020.07.020

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349 – 357. https://doi.org/10.1093/intqhc/mzm042

Vellani, S., Boscart, V., Escrig-Pinol, A., Cumal, A., Krassikova, A., Sidani, S., Zheng, N., Yeung, L., & McGilton, K. S. (2021). Complexity of nurse practitioners' role in facilitating a dignified death for long-term care home residents during the COVID-19 pandemic. *Journal of Personalized Medicine*, *11*(5), 433. https://doi.org/10.3390/jpm11050433

Wald, H. S., & Monteverde, S. (2021). COVID-19 era healthcare ethics education: Cultivating educational and moral resilience. *Nursing Ethics*, *28*(1), 58-65. https://doi.org/10.1177/0969733020976188

Williams, L. A., Accardo, D., Dolgoff, J., Farrell, A., McClinton, T., Murray, E., & Jacob, S. R. (2022). A mixed methods study: The grief experience of registered nurses working on the frontlines during the COVID-19 pandemic. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.16579

World Health Organization. (n.d.). *WHO health emergency dashboard: COVID-19 homepage.* https://COVID19.who.int/region/wpro/country/nz

Wright, A. L., Zammuto, R. F., & Liesch, P. W. (2017). Maintaining the values of a profession: Institutional work and moral emotions in the emergency department. *Academy of Management Journal*, *60*(1), 200-237. https://doi.org/10.5465/amj.2013.0870

Yardley, S., & Rolph, M. (2020). Death and dying during the pandemic. *BMJ, 369*, m1472. https://doi.org/10.1136/bmj.m1472

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.