


The role of perceived organizational support for nurses' ability to handle and resolve ethical value conflicts: A mixed methods study

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Abstract

Aim: To explore if and how nurses' perceived organizational support affects their ability to handle and resolve ethical value conflicts.

Design: A mixed methods design with a longitudinal questionnaire survey and focus group interviews.

Methods: A questionnaire survey in six hospitals in two Swedish regions provided data from 711 nurses responding twice (November–January 2019/2020 and November–January 2020/2021). A cross-lagged path model tested the mutual prospective influence between the organizational climate of perceived organizational support, frequency of ethical value conflicts, and resulting moral distress. Four focus group interviews were conducted with 21 strategically selected nurses (April–October 2021). Qualitative data collection and analysis were inspired by Grounded Theory.

Results: A climate of perceived organizational support was empowering, contributing to role security. It prospectively decreased the frequency of ethical value conflicts but not the moral distress when conflicts did occur.

Conclusion: It is important to facilitate the development of perceived organizational support among nurses, but also to reduce the occurrence of ethical value conflicts that the nurses cannot resolve.

Implications for the Profession: By ensuring a shared care ideology, good inter-professional relations within the entire care organization, providing clear and supportive organizational structures, and utilizing competence adequately, healthcare managers can facilitate and support the development of perceived organizational support among nurses. Nurses who are empowered by perceived organizational support are stimulated by and take pride in their work and experience the work as meaningful and joyful.

Impact: The study addressed the question of whether healthcare organizations could support nurses to resolving ethical value conflicts, and thus reduce moral distress. Perceived organizational support is related to factors such as ideological caring alignment and supportive organizational preconditions. This study contributes specific

knowledge about how healthcare organizations can empower nurses to effectively resolve ethical value conflicts and thereby reduce their moral distress.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS

focus group interviews, moral distress, nurse turnover, nursing, longitudinal survey, organizational healthcare development, healthcare quality

1 | INTRODUCTION

Registered nurses often perceive high levels of stress and low levels of job satisfaction and show symptoms of burnout, which threatens nurse recruitment and retention (Aamir et al., 2016; Almada et al., 2004; Johnson et al., 2016; Weberg, 2010). High nurse turnover rates have been found in several countries and are often closely related to job dissatisfaction (Lu et al., 2005). A specific threat to nurses' health and retention, and also to the quality of care, is the perception of moral distress as a result of value conflicts comprising ethical dimensions (Lamiani et al., 2017; Oh & Gastmans, 2015; Whitehead et al., 2014). Therefore, it is imperative to reduce nurses' ethical value conflicts and support their ability to resolve them.

2 | BACKGROUND

Ethical value conflicts at work result from insufficient fit between the values of the individual nurse and the organizational context (Gaudine & Thorne, 2000). The organizational context encompasses interactions with patients or other healthcare professionals (Barlow et al., 2018), but also organizational constraints (Rainer et al., 2018), such as organizational structures that force the nurses to compromise their professional values (Haahr et al., 2020). Early studies suggested that ethical value conflicts lowered nurses' morale and increased their burnout and turnover (Rodney & Starzomski, 1993). Since then, empirical studies have established a connection between ethical value conflicts and a variety of adverse outcomes such as stress, decreased organizational commitment, turnover intention, and actual turnover among nurses (Thorne, 2010).

A study of approximately 600 physicians and nurses found that moral distress occurred in both professions, but that the nurses perceived significantly higher levels (Whitehead et al., 2014). A strong relationship between moral distress and an intention to leave the occupation was also identified (ibid.). Källemark et al. (2004, p. 1082) defined moral distress as "Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels she/he is not able to preserve all interests and values at stake." In a literature review, Oh and Gastmans (2015) revealed that nurses who often perceived moral distress were more emotionally exhausted and emotionally distanced from the patients, and that nurses who reported a high level of moral distress often had a more cynical attitude toward their patients. Several studies in the same review found a clear relationship between moral distress

among the nurses and an intention to leave or actual turnover. Thus, research indicates that moral distress due to ethical value conflicts threatens the health and well-being of the nurses, is a risk factor for high turnover, and constitutes a threat to the quality of care.

Nurses experiencing ethical value conflicts often turn to their care unit (CU) manager for guidance (Hariharan et al., 2006). CU managers may utilize diverse activities to help the nurses handle ethical conflicts (Laukkanen et al., 2016). However, the CU managers are often unable to resolve specific ethical value conflicts (Aitamaa et al., 2019). Therefore, Usberg et al. (2021) proposed that it is pivotal to provide nurses with a broader form of organizational support in order for them to resolve ethical value conflicts and hence carry out their work to ensure high-quality care. We propose that perceived organizational support (POS) may provide such support.

2.1 | Theoretical background

For long-term high-level performance, an organization must be able to accommodate the tension between competing paradoxical demands (Smith & Lewis, 2011). Lewis (2000) suggested transcendence as a strategy to cope with organizational paradox. Transcendence implies a second-order thinking, "zooming out" and taking a "bird's eye perspective" on the situation at hand. Smith and Lewis (2011) proposed that transcendence provides a different framing of organizational phenomena that allows a dynamic equilibrium, where actors make short-term choices in specific paradoxical situations, but remain aware of and accept contradictions in the long term. Such transcendence would enable the nurses to make well-adapted decisions to give a certain value short-term precedence in a specific situation presenting a value conflict, and also enable them to preserve an array of important values in the long term. This would be expected to benefit the quality of care as well as nurses' health.

POS (Eisenberger et al., 1986) comprises two aspects: that the employees perceive that the organization appreciates their contributions, and that it cares about their health and well-being. Theoretically, POS is based on fundamental socioemotional needs of meaningfulness, social respect, and self-esteem (Rhoades & Eisenberger, 2002). Working conditions that satisfy such needs may be expected to both empower the employees and promote their mental health and well-being. A large body of research supports this proposition. In a comprehensive and systematic literature review, Kurtessis et al. (2017) found POS to be positively related to work commitment, work satisfaction, and work performance, and

negatively related to stress and burnout. POS would make the employees feel more secure in their conviction that the contributions they make to the organization through their judgements and actions are valued by the organization (Neves & Eisenberger, 2014). We propose that, by promoting such role security, POS will enhance the ability and confidence of healthcare professionals to make well-adapted judgements and decisions in situations where different imperative values conflict. Thus, POS would enable transcendence (Smith & Lewis, 2011) when handling ethical value conflicts.

POS is usually treated as an individual phenomenon. However, since healthcare work is teamwork-based, work team members need a common understanding of the work, what is important to achieve, and how this is best done. Schneider (1975) suggested that the organizational climate constitutes a shared apprehension among the organizational members of policy, procedures, and practice in relation to different organizational value domains, and that this offers a frame of reference for the organizational members' behaviour. A shared organizational climate can contribute to a common understanding of the work and guide behaviour. In accordance with this, an organizational climate of POS, shared among the nurses within the care unit, could guide individual behaviour in complex situations and support the ability of healthcare professionals to handle and resolve ethical value conflicts.

3 | THE STUDY

3.1 | Aim

The overall aim of this study was to explore if and how POS affects nurses' ability to handle and resolve ethical value conflicts.

Two research questions were addressed:

1. What is the impact of an organizational climate of POS on the frequency of experienced ethical value conflicts at work, and on the intensity of the resulting moral distress?
2. How does POS affect nurses' ability to handle and resolve ethical value conflicts, and what are the enabling organizational preconditions?

4 | METHOD

4.1 | Design

The study applied a mixed methods approach. We employed a triangulation design that weighted qualitative and quantitative components equally (Bishop, 2015), but where the qualitative study partly took its stance in the results of the first measurement wave of the quantitative study, as described further below. A mixed methods approach is seen as a useful tool for investigating healthcare management and delivery issues, since matters around health service management are broad, complex, and multi-dimensional (Lee

et al., 2022). The overall purpose was to combine the results of these studies to explore and obtain a rich, more comprehensive understanding of whether and, if so, how POS affects nurses' ability to handle and resolve ethical value conflicts. The quantitative part of the study consisted of a longitudinal questionnaire survey with statistical analysis, while the qualitative part consisted of focus group interviews and a qualitative content analysis of the transcribed text. The study was performed among registered nurses within six hospitals with secondary and tertiary care in two regions in Sweden.

4.2 | Study settings and recruitment

4.2.1 | Questionnaire study

Six hospitals in two Swedish regions agreed to participate in the study. All 3471 registered nurses at all 278 health CUs in these hospitals were invited to participate in a two-wave pen-and-paper questionnaire survey.

4.2.2 | Focus groups

We used a strategic selection for the four focus groups. Two "key informants" (Peek & Fothergill, 2009)—the research leader in one region and the chief physician in the other—who had good knowledge of the respective CU participating in the survey study, recruited the informants based on variation in age, experience, and gender, as well as medical area. At the request of the research group, the key informants informed the invited participants that the participation was voluntary and that they could withdraw their participation at any time during the study. Participants for four focus groups were invited and all nurses who were contacted agreed to participate in the interview. For three of the groups, the CUs were selected based on the nurses' responses in the first measurement wave of the questionnaire survey. For one of these groups, the informants were invited from the CU where the nurses had rated the POS climate as high, and for two groups (one from each region), nurses from units where the POS climate was rated as low were invited to participate. The interviewing researchers were not informed about the POS ratings in the respective groups. The informants for the fourth group were invited from a group of nurses attending specialist training in intensive care. These nurses were selected because they had all experienced demanding work situations related to the COVID-19 pandemic and it was assumed that these situations involved ethical value conflicts.

4.3 | Data collection

4.3.1 | Longitudinal questionnaire survey

The first wave of questionnaire data was collected during the period November 2019–January 2020 (T1), and the second wave of data

was collected 1 year later (T2). A one-year interval was selected in order to be able to investigate longitudinal change while controlling for potential seasonal variation. The questionnaires were sent to each respective CU manager, who distributed them to all the registered nurses at the unit. Each questionnaire had an individual code that was interpretable only by the researchers and allowed for follow-up of the participants' responses at T2. The questionnaires were filled in during working hours. Each respondent then placed the questionnaire in an envelope that had been pre-addressed to the research team and sealed the envelope. The envelopes were then posted.

Ethical value conflicts (EVC) were investigated using 17 items. Seven of these items, which were modified slightly to fit a Swedish context, were from the Moral Distress Scale (MDS-R) (Hamric et al., 2012). Additional items were developed within the present project, based on the results in Källemark et al. (2004). The purpose of the items was to capture, as comprehensively as possible, the different types of ethical value conflicts that may commonly occur in Swedish hospital care.

The respondents were presented with different situations that may induce ethical value conflicts (EVC) and were asked to rate how often they had experienced each situation (EVC frequency), as well as how stressful they perceived the situation to be when it did occur (EVC distress). Sample items are "ignore situations in which patients have not been given adequate information to ensure informed consent" and "be forced to prioritize between patients due to too high patient occupancy in the hospital". All items had five fixed response alternatives: for EVC frequency, ranging from "never" to "very often" and for EVC distress (moral distress), ranging from "not at all stressful" to "highly stressful".

Exploratory factor analysis indicated that the frequency of ethical value conflicts consisted of two separate but related factors. EVC Frequency Factor 1 comprised nine items representing ethical value conflicts induced by insufficient resources ($\alpha = .90$ at T1 and $.88$ at T2), and EVC Frequency Factor 2 comprised eight items representing ethical value conflicts induced by inapt organizational structures or interpersonal staff relations ($\alpha = .82$ at T1 and $.82$ at T2). Therefore, EVC frequency was modelled as two separate factors: EVC frequency resources (the mean of the ratings of its nine items) and EVC frequency structures (the mean of the ratings of its eight items). EVC distress, which was considered a measure of the perceived moral distress, was calculated as the mean of all the 17 items assessing the respondents' perceptions of how stressful the ethical value conflict situations were when they did occur ($\alpha = .94$ at T1 and $.94$ at T2). These index variables were calculated such that high values indicate a high frequency of ethical value conflict situations and high perceived moral distress.

The nurses' *organizational climate of perceived organizational support* (POS climate) was measured using the eight-item short version of the Survey of Perceived Organizational Support (Eisenberger et al., 1986; Neves & Eisenberger, 2014), which was reformulated to measure perceived shared POS climate ($\alpha = .94$ at Wave 1 and $.94$ at Wave 2); sample items included "the organization really cares about the employees' well-being" and "the organization takes pride in its

employees' accomplishments at work". This scale had six fixed response alternatives, ranging from "completely disagree" to "completely agree". The index variable "POS climate" was calculated as the mean of these eight items, with high values indicating a high level of POS.

Prior to the full-scale questionnaire survey, the instrument was tested in a pilot study. The questionnaire was then sent to 385 registered nurses at 34 hospital CUs in four Swedish regions that did not participate in the full-scale study. Statistical analyses showed good psychometric properties, and only minor revisions were needed.

4.3.2 | Focus groups interviews

The focus group interviews were performed between April and October 2021. The interviews sought a common view among the participants on how POS, and factors that benefit/counteract POS, can affect nurses' ability to handle and resolve ethical value conflicts. The interviews, which were conducted and analysed by three of the researchers (MSN, CG and MT), were semi-structured based on the results of the questionnaire survey. The data collection and analysis method was inspired by Grounded Theory (Bryant & Charmaz, 2010). All interviews started with a warm-up question to create an open climate of discussion and a common understanding of what designates ethical value conflicts in healthcare and how these may appear, and to stimulate thoughts and access to memories of such situations. Subsequently, the results from the first measurement wave of the questionnaire survey were presented, indicating that POS was negatively related to the occurrence of ethical value conflicts among nurses. Four core questions were then presented, one at a time, where we asked the informants to openly reflect on (1) how they would explain this effect—that is, how the organization showing care for an individual's well-being and appreciation for that person's contribution (the two aspects of POS) could decrease ethical value conflicts at work; (2) what an organization actually does that provides POS that supports handling and resolving ethical value conflicts; (3) how POS influences an individual's own actions in situations of ethical value conflicts; and (4) how individuals are prone to act in situations with ethical value conflicts when they do not perceive POS. All interviews were recorded and, after each interview, the interview was discussed in the research team and the follow-up questions were refined to capture in-depth answers in the remaining group interviews. Once all the group interviews had been completed, all the material was transcribed verbatim. In total, the group interviews lasted for 6 h and 10 min, comprising 253 A4 pages of transcribed text.

4.4 | Data analysis

4.4.1 | Statistical analysis of the questionnaire data

The statistical analysis was conducted by two authors (PL, AP) who have considerable experience in quantitative methodology and

statistical analysis. A cross-lagged panel path model was tested in which the three facets of ethical value conflicts and moral distress (EVC frequency resources, EVC frequency structures, EVC distress) and the POS climate were specified to mutually influence each other over the two time points. The model was tested using AMOS 28, employing the full information maximum likelihood (FIML) estimator. Input data consisted of raw data stored in SPSS version 28.

4.4.2 | Qualitative analysis

The NVivo 12 software was used to support encoding of the text. The analysis of the text was conducted in several analytic steps (Eaves, 2001). First, the analysis involved identifying text that corresponded to the study's purpose and was considered to provide thick descriptions. Second, the identified text was given a code phrase that captured the main idea of what was discussed. During the analytic process, code phrases were used as an analytical tool to label, separate, compile, and organize data. During this analytic step, it emerged that POS were experienced in the form of several organizational resources, which in turn enabled the nurses to handle and resolve ethical conflicts of values. In the third step of the analysis, the codes were reduced by grouping together similar code phrases, resulting in preliminary categories that were then compared for similarities and relationships. In this step, we were able to identify five different types of organizational resources, improved by POS, facilitating nurses' resolution and handling of ethical value conflicts. Fourth, a definition and a narrative description of each organizational resource were created, including an explanation of how it was important to the broader study question. Finally, during the completion of the categories, linkages among categories were identified that, in combination, constructed an overarching identifiable phenomenon. As a result, a core category describing the characteristics of a nurse capable of handling and resolving ethical values conflicts could be described. The analysis was not a linear process of simple passage from one phase to the next. Instead, a movement back and forth between the phases was needed throughout the analysis. The three authors responsible for this qualitative analysis (MSN, CG and MT) were all well acquainted with the transcribed text. The first author conducted the first two steps of the analysis. Categories were discussed, formulated, and refined after repeated discussions among the responsible researchers.

4.5 | Ethical considerations

Ethics approval of the study was obtained from the Regional Ethics Committee in Gothenburg (no. 264-18). The study was conducted in accordance with the ethical standards laid out in the 1964 Declaration of Helsinki and its later amendments. Informed consent was provided by all participants prior to inclusion in the study.

5 | FINDINGS

5.1 | Participants

The questionnaire response rates were 54 percent at T1 ($n=1817$ nurses working in 228 different CUs) and 48 percent at T2 ($n=1362$ nurses working in 213 different CUs). Across the two waves, a total of 1030 nurses completed the questionnaire. The quantitative analyses were based on data from 711 of the nurses who responded twice and who had remained working in the same CU and under the same CU manager on both measurement occasions. These nurses (84 percent of whom were women) were working within 133 different CUs. Their median age (at wave 1) was 44 years ($m=44.0$, $SD 12.0$), and they had been working as nurses for an average of 16.5 years ($SD 11.3$). More than half (59 percent) had been employed by their present regional healthcare organization for more than 10 years.

Four focus group interviews were conducted: two in each of the participating regions. Each group included five to six nurses who were strategically selected from different CUs. The nurses worked in diverse medical specialties (Table 1).

5.2 | Relationships among perceived organizational support climate, the frequency of ethical value conflicts, and perceived moral distress

At Time 1, all variables were significantly inter-correlated. The two facets of EVC frequency were highly positively correlated ($r=.75$, $p<.001$), that is, respondents who perceived a high frequency of ethical value conflicts induced by inadequate resources (EVC frequency resources) tended to also perceive a high frequency of ethical value conflicts induced by inapt organizational structures or interpersonal staff relations (EVC frequency structures). Furthermore, these two facets of EVC frequency were correlated with EVC distress when such situations did occur ($r=.38$, $p<.001$ for EVC frequency resources and $r=.33$, $p<.001$ for EVC frequency structures). All of these aspects of ethical value conflicts were negatively associated

TABLE 1 Participants focus group interviews with nurses.

Variable	Region A	Region B
Participants (n)	10	11
Age, years, m (SD)	39.2 (12.3)	
Gender (n)	F: 17M: 4	
Experience as a nurse, years, m (SD)	11.8 (12.3)	
Represented medical specialties	Anaesthesia, surgery, psychiatry, internal medicine, emergency room, oncology, orthopaedics, neonatal, ambulance, gastrointestinal	

with the POS climate ($r = -.36, p < .001$ for EVC frequency resources, $r = -.30, p < .001$ for EVC frequency structures, and $r = -.10, p = .006$ for EVC distress), that is, respondents who perceived a higher POS climate tended to perceive fewer ethical value conflicts and that they were somewhat less stressful when they did occur.

All autoregressive regression weights ("stability coefficients") were moderate to high ($\beta = .64, p < .001$ for EVC frequency resources, $\beta = .60, p < .001$ for EVC frequency structures, $\beta = .51, p < .001$ for EVC intensity, and $\beta = .65, p < .001$ for POS climate).

The POS climate at T1 was related rather weakly, but statistically significantly, to the frequency of EVC at T2 ($\beta = -.06, p = .039$ for EVC frequency resources and $\beta = -.08, p = .003$ for EVC frequency structures; that is, respondents who perceived a high POS climate at T1 generally perceived fewer ethical value conflicts at T2. However, the POS climate had no prospective effect on the EVC distress ($\beta = .02, p = .652$), which indicates that when EVCs did occur, they induced the same distress intensity regardless of the previous level of the POS climate.

While we found no strong indications of reversed effects, there was a tendency for EVC frequency resources at T1 to influence the POS climate at T2 ($\beta = -.07, p = .135$).

5.3 | The effect of perceived organizational support on nurses' ability to handle and resolve ethical value conflicts, and the enabling organizational preconditions

First, the analysis of the qualitative data revealed the characteristics of a resourceful nurse, empowered by POS and able to handle and resolve ethical value conflicts in a healthcare organization. Second, it identified the organizational resources that contribute to such professional development. Third, the analysis illuminated the role of POS in the mechanism for how these organizational resources enable the nurses to act effectively to handle and resolve ethical value conflicts. An overview of the results of the analysis is presented in [Table 2](#).

5.3.1 | Core category: The empowered nurse perceiving organizational support

The analysis revealed that POS empowers the nurses and thus contributes to their ability to handle and resolve ethical value conflicts at work. Nurses empowered by POS have confidence in their own competence, feel secure in the professional role, and are confident about taking situationally adapted decisions and acting upon these, considering and maintaining a range of important organizational values. Together, this enables the nurses to satisfy the patients' needs, and support their colleagues. Nurses empowered by POS are stimulated by and take pride in the work, and experience the work as meaningful and joyful.

5.3.2 | Enabling organizational resources, contributing to POS and thus empowering the nurses to resolve ethical value conflicts

The organizational resources that were shown to promote POS, in a manner that empowers the nurses to effectively handle and resolve ethical value conflicts, are outlined thematically below.

Ideological alignment in the organization regarding the caring mission

An ideological alignment between and within professional groups and hierarchical levels in the care organization regarding the caring mission was considered an essential organizational resource. This meant a shared ideology regarding the centrality of patient needs and delivering good, safe care. The nurses emphasized the importance of an organization showing respect for their efforts to take a holistic view of the patient and relatives. A perceived ideological alignment provided stimulation, pride in the work and meaningfulness, and contributed to a greater ability to both avoid and resolve ethical value conflicts at work. A CU manager who understood and shared the nurses' care ideology that "*we are here for the benefit of patients and their relatives*" was considered supportive and helped to induce courage and readiness for action when facing ethical value conflicts. An ideological alignment between the CU manager and the work group was described as an agreement on direction and was supportive, not least when the organization was strained, such as when there was a shortage of staff.

The nurses also described how an inter-professional ideological alignment induced courage to act in ethical value conflicts. This alignment provided knowledge about what was the "*right way to act*" at the unit, which made it easier to take a position and to act in ethical value conflicts.

When insufficient resources hindered the nurses from providing care of a quality that corresponded to their professional value, this was perceived as a lack of organizational ideological alignment. This caused resentment and cynicism toward the organization among the nurses.

Clear organizational structures and shared strategies

The nurses described the importance of a stable work group and good and clear work structures, which facilitated commitment and developed competence, "team spirit", and security. Explicated and agreed work procedures (MEMOs) and role descriptions for the team in managing complicated situations were described as supportive for the nurses in handling, and sometimes preventing, ethical value conflicts. Clear work procedures provided security as they guided nurses in what to do and how to do it. Such procedures offered "something to hold on to" in ethical value conflicts, such as in situations where patients refused treatment or medication and where the nurse could be held liable. Work procedures also enhanced the capacity to resist improper influence, such as resisting requests from patients and their families for services that are not part of a nurse's responsibilities or the healthcare system's assignment.

The informants stated that an organization that helps nurses better understand their roles and responsibilities—such as by clarifying

TABLE 2 A core category, five categories, and illustrative quotes illustrate the organizational resources promoting POS and building an empowered nurse capable of handling and resolving ethical values conflicts.

Core category	Category	Illustrating quote
The empowered nurse perceiving organizational support	Ideological alignment in the organization regarding the caring mission	<i>"At my old workplace, my CU-manager was very good at putting in extra vigils, if patients were very sick and didn't have any relatives, so they didn't have to be alone... That's great. Otherwise, you can go outside the room with some obsessions, like you must go in and check that nothing has happened. But now, you know... Yes, first of all, the patient is not alone, and then there is someone who can signal to me if there is any change and so on, it feels very safe. Yes, it was a great CU manager in general who listened to us. Yes, it gives much security."</i> (Focus Group 1)
	Clear structures and shared strategies	<i>"I think it's very good if there is clarity from my employer, how to work ... in the ambulance service, for example, we have something called Care on Site, and then we write a document for the patient and I take a copy of it when I leave. And then I write what the patient has called for, and that we have taken vital parameters. And then what we've agreed on, the patient and I, and how we're going to proceed. I take my notes with me, and then I write a journal afterwards. And then it says on this note that maybe the patients will seek medical care at a later stage, or they should just stay at home. But it's like support, partly for my employer because then they have a little bit of an eye on the fact that we're not doing the wrong things. But it's a support for me too, I can lean on it. Because it's a risk for me ... So, we leave thousands [patients] at home every year. And this documentation is very safe and good. And I think the employer can arrange for it to be clear about how to handle these situations ... so, you don't feel like you don't dare, or that the license hangs loose."</i> (Focus Group 4).
	Adequate competence development and utilization	<i>"Yes, and that's true in all departments, you can't have a shift with only newly graduated nurses just because there's a shortage of staff. It doesn't work, but it requires a mix of skills, with newly graduated who cannot make decisions, but must constantly ask. It will not be so patient-safe, especially in emergency situations. They are good colleagues, but everyone has been new and you also know that you will never know everything. But when you stand alone, as you often do in the summers or with just newly educated colleagues? I think it's becoming an internal stress for me, because I have all the responsibility, I must be able to answer all these questions that they have. I need to be able to help everyone and you might have to run and double check things and ... Yes, and I've been working for five years, but I can still feel new in certain situations. I absolutely don't know everything, so I would have been grateful if it had been a more mixed working group. Because it's one of those things that could help you feel fewer ethical conflicts really if you have experienced staff with you."</i> (Focus Group 3)
	Actively supportive management	<i>"... if you look at what the structure of the hospital looks like, that we have a unit manager and then the step over that is an operations manager, and then deputy hospital director. If you feel like they're all backing you up, I think, 'okay, they believe in me, that I can,' and that you dare to ask, you dare to admit that 'there is a shortage here', you may also dare to take a bigger step and be brave. ... I think that if you feel that you do not have the organization's behind you and that you can get 'shit' on you, that you can be accused of doing something wrong, then, how can you dare to be brave?"</i> (Focus Group 3)
	Collaborative and resourceful care team	<i>"It was very hard, and I think you brought the job home a lot. Yes, then it becomes that it both affects you professionally work, and your social life, dreamed nightmares, all this stuff. So just be able to talk about it with colleagues and maybe the CU manager; well, just talk about it, normalize it while it's not at all a normal situation. And be able to get support and support from each other and confirm each other's experiences and so... We're human, so that is important."</i> (Focus Group 2)

what is expected of them and what is "good enough", providing support in prioritization of care, or clarifying the nurse's role in relation to the rest of the team—helped decrease the occurrence of ethical value conflicts. Such support was considered particularly important for newly graduated nurses.

Shared understanding regarding responsibilities within the work team was considered supportive, for example, that the doctors' duties were carried out in a timely way. In emergency care situations, declared structure and responsibilities among co-workers were particularly important to prevent moral distress. Without clear decision-making arrangements, there was a risk that nurses felt compelled to take responsibility beyond their competence or authority, which created ethical value conflicts.

Clear responsibilities in relation to patient care throughout the whole care chain—that is, a clear plan to avoid patients "falling

through the cracks"—was considered supportive. The nurses called for long-term, proactive strategic planning of collaboration between units and care organizations, as this also enabled good care planning within the care unit. All healthcare units cooperating to ensure good care at the right level of care, throughout the care chain, created security, pride, meaningfulness and prevented moral distress. By contrast, inter-unit coordination that was insufficient for the work task requirements created professional frustration and moral distress.

Adequate competence development and utilization

Informants stated that having the possibility to acquire appropriate skills, and ensure that their skills and experiences were appropriately utilized, was an important resource for the nurses regarding their ability to handle and resolve ethical value conflicts. The nurses described the role of the CU manager in creating

support and confidence in the development and utilization of skills. Also, a CU manager who showed confidence in the nurse's competence and ability to develop and learn enhanced the nurse's self-confidence. Furthermore, a CU manager who identified individuals' deficient competencies and skills and acted resolutely on such shortcomings and needs induced security and confidence. In addition, a CU manager who systematically and competently prepared the nurses for new practical work tasks and was accessible to provide support in complex care situations provided emotional relief for the nurse, and thus confidence to handle and resolve ethical value conflicts. There was a particular need for this type of support to newly graduated nurses. For this group, several ethical value conflicts were related to a perceived lack of competence and experience. A CU manager who provided continuous feedback and encouragement and ensured that supervision/support was phased out in a timely manner ensured individual resourcefulness among newly graduated nurses. An individually adapted and progressively expanded responsibility created self-confidence and created role security. However, the informants described that newly graduated nurses were sometimes placed in caregiving situations they did not feel competent for. Such situations resulted in moral distress due to fear of making mistakes, providing low-quality care, or failing to keep up with the pace of work. Also, requiring experienced nurses to provide care to patient groups new to them, without additional training, could create moral distress.

The informants also said that the ability to make the most of all the staff's knowledge and experience was supportive in relation to ethical value conflicts. Specifically, a CU manager who requested nurses' suggestions for improvements and was responsive to local improvement ideas supported the development of the quality of care, as well as the nurses' pride in their work. All in all, this created a feeling of a resourceful team that was able to provide high-quality care. This, in turn, prevented ethical value conflicts from arising and increased the team's ability to resolve them as they arose.

A CU manager who could provide opportunities for nurses to take responsibility based on individual competence and experience created a sense of security. However, the nurses described several situations where CU managers were unable to ensure work tasks in accordance with the individual's experience and competence. Such requirements created value conflicts, moral distress, uncertainty, and vulnerability among the nurses.

Actively supportive management

The nurses stressed the importance of an established and trusting relationship with the CU manager and overall management to be able to handle and resolve ethical value conflicts.

Active support from all managerial levels, with respect for the work done by nurses, and good communication and understanding between the different managerial levels, created both courage and security when dealing with ethical value conflicts. Such support created trust that the management would support their staff in case something went wrong or if someone was criticized by the patient and their relatives.

A supportive and trusting CU manager strengthens the nurses' confidence in their own ability, their courage to make their own decisions and act, and to acknowledge their own mistakes. It was particularly important that the CU manager was available, could listen, provide professional feedback, and confirmed the work of the nurses. Nurses described the importance of a long-term relationship for building such trusting and respectful relations. However, the nurses also described how distrust from a CU manager could reduce job satisfaction, creating a "culture of silence", reluctance to make decisions, and fear of taking initiative, which would reduce learning and decrease quality and patient safety. A CU manager who demonstrated a trusting relationship with upper management and was able to raise the nurse's needs was also described as a resource in handling ethical values conflict. An established understanding and interest "from above" for staff needs and difficulties, with managers demonstrating an ability to take adapted, supportive decisions, increased the nurses' individual sense of responsibility, perseverance, and ability to act in ethical values conflicts. In other words, having knowledge and confidence in how the upper management reasoned would support the nurses' trust and courage to act when ethical value conflicts occurred.

In contrast, "invisible" upper managers, who were perceived as lacking insight into the everyday work at the CUs and who individualized problems of overload among the staff, eroded trust and created strong and lasting negative emotions among the nurses. A distanced upper management also created uncertainty among the nurses regarding whether the management would stand by their staff if things went wrong when dealing with ethical value conflicts.

Collaborative and resourceful care team

Access to knowledgeable colleagues and a stable, well-established workgroup were stated as important resources for preventing, buffering, and handling ethical values conflicts in daily work. This requires a functional work group with members that are respectful, can cooperate, provide positive feedback, and promote the ability to openly acknowledge and discuss demanding care situations.

The importance of colleagues who could and would make themselves available in the event of an unclear or otherwise problematic care situation was described as an important resource. Colleagues who could, at short notice, take responsibility for patients or administrative tasks and thereby provide relief and allow time for the initially engaged nurse to focus on a care situation that was perceived to require extra time and presence, could also prevent moral distress.

Broad competence within the work group was also seen as an important resource to be able to identify, interpret, and resolve ethical value conflicts with confidence. The nurses also stressed the importance of being able to share experiences and judgements in the work group and that this contributed to self-confidence and the ability to act in ethical value conflicts. The nurses highlighted the importance of having access to experienced colleagues as "sounding boards" to consult for decision support. Professional feedback and frequent collegial discussions, aimed at establishing a shared stance within the work group related to ethical issues,

were regarded as supportive in solving and handling ethical value conflicts.

A good work group created self-confidence and strengthened the capacity to handle and resolve ethical value conflicts in day-to-day work. This included taking responsibility for being a good co-worker, which was also an important prerequisite for getting help and support from colleagues. Also, a respected role as a nurse within the inter-professional work team made the nurses feel prepared, important, and secure.

Furthermore, nurses described how regular follow-up reflections in the work group related to ethical dilemmas, sometimes led by professional counsellors, could be proactively helpful in processing and preventing moral distress. Structured processing, after particularly difficult events, was seen as crucial to moving forward and preventing destructive emotions from being “stored up”. When reflecting with co-workers, actions, feelings, and new perspectives on ethical value conflicts were made visible, processed, and normalized. Thus, the exchange of experience also contributed to learning, with an increased ability to act in a more situationally adapted manner in the future. In addition, receiving confirmation of feelings of insufficiency in the daily work helped alleviate the experience of individuals. Such shared understanding within the work group reduced stress and enhanced self-confidence and role security.

6 | DISCUSSION

Any organization must encompass several competing values regarding, for example, efficiency, quality and the staff's health and well-being. These requirements will inevitably present paradoxical work situations, inducing tension among the staff. Literature suggests that, depending on the framing of the situation, such a contradiction may be experienced either as paralysing and result in role conflict, which may be detrimental to staff health (Katz & Kahn, 1966), or as a normal, even productive, part of organizational life (Tracy, 2004). Tracy (2004) suggested that for individuals framing the contradictory organizational demands as interrelated and not mutually exclusive, one pole of the tension may be viewed as a means of achieving the other pole, and that this type of framing correlates with higher satisfaction. Healthcare managers may encourage such framing through metacommunication encouraging employees' flexibility and resolution of paradoxical situations by viewing them on a case-by-case basis (Tracy, 2004). The results of the present study indicate that POS may aid such framing of paradoxical ethically impregnated work situations faced by nurses since a high POS climate resulted in nurses experiencing fewer stress-inducing ethical value conflicts. There was also a tendency, albeit not statistically significant, for POS to be further reinforced among nurses who were able to resolve such situations effectively. This suggests a positive spiral, where a high POS climate facilitates the resolution of value conflicts, and where fewer such value conflicts, especially those that are resource-related,

further strengthens the POS climate over time. This result is also strengthened by Abou Hashish (2017) study, which showed a positive correlation between nurses' perceptions of the ethical climate in their hospital setting and POS.

The qualitative results suggested that clear organizational structures and shared strategies, a supportive and trustful leadership, adequate competence development and utilization, and a collaborative and resourceful care team were important organizational preconditions that empower nurses to better cope with ethical value conflicts. These results are in line with previous research indicating that supporting psychosocial working conditions, as well as supporting organizational structures and structuring, facilitates the development of POS among nurses (Gadolin et al., 2021).

Furthermore, the present study showed that the two types of ethical value conflicts are highly positively correlated. This means that at CUs where ethical value conflicts related to insufficient resources were common, conflicts related to inapt organizational structures or interpersonal staff relations were also common. One could speculate that if resources are insufficient, interpersonal relations may be strained and there may be less possibility or ability to optimize organizational structures. The reverse relation is also possible, where the organizational structures are inapt and the relations between staff are strained, resources may not be utilized in an optimal manner.

The perceived frequency of both types of ethical value conflicts – those related to insufficient resources and those related to inapt organizational structures or interpersonal staff relations, was correlated with perceived moral distress when such situations did occur. This means that the more often such ethically problematic situations occurred, the more stressful was each such event. This may indicate an exhaustion effect where each ethical conflict event reinforces the negative experience of the next. The longitudinal results further supported such a conclusion since the occurrence at T1 of ethical value conflicts due to insufficient resources predicted the perceived moral distress intensity at T2. Since the POS climate reduced the number of ethical value conflicts that the nurses experienced, it also reduced the occurrence of morally distressing situations. However, POS did not, to the same extent, influence the intensity of the perceived moral distress when “unsolvable” ethical value conflicts did occur. Although it is negative, the distress that nurses feel when facing ethical value conflicts could indicate that the nurses have remained uncynical and have maintained a humane and ethical mental “compass”. The nurses' position on ideology, which generally has a high idealistic ethical orientation (Hussein & Abou Hashish, 2023) may also be reflected in this result. Nurses become distressed when they face barriers to doing the “right thing”. Rainer et al. (2018) implied that moral distress is generally more closely tied to situations where nurses are impeded from doing what they know is right, and not to traditional ethical dilemmas where the choice is between two equally good or poor choices. However, in the long term, moral distress can create undesirable consequences for the quality of care. In a review focusing on nurses' experiences of ethical dilemmas, Haahr et al. (2020) stated that when nurses are forced to act in a way that

goes against nursing beliefs and values, this not only means poor care, but also undermines the ethical and moral values in nursing. These results show the importance of identifying ethical value conflicts that result in ethical stress, to ensure that it does not lead to emotional exhaustion and detachment. Haahr et al. (2020) describes how nurses' moral compass and clinical wisdom provides a basis for how they experience ethical values conflicts in daily work. To prevent burnout and stress, Haar and colleagues advocate for assisting nurses to express and defend their professional views on the individual situation. Although the quantitative results of our study indicated that POS had a modest influence on the perceived moral distress when facing unsolvable ethical value conflicts, the focus group interviews specified certain preconditions for the development of POS as important for the nurses' ability to buffer ethical distress. The nurses highlighted the importance of a functional work group with members who are respectful and cooperative, provide positive feedback, and openly acknowledge and discuss demanding care situations. Having access to experienced colleagues as "sounding boards" to consult for decision support was also considered important. De Casterlé et al. (2008) stated that nurses who are continuously stimulated to reflect critically and creatively in relation to their working conditions and patients' well-being better develop their ethical competence. These authors also highlight that contextual and environmental (conventional) factors tend to guide nurses in their ethical practice. Subsequently, they stated the importance of targeted educational efforts to develop from performing a conventional practice to a post-conventional practice encompassing a more individual patient-centered practice. The above reasoning, in accordance with our qualitative results, shows the importance of arranging structured discussions, led by ethically competent educators, related to nurses' experience of ethical value conflicts. Hussein and Abou Hashish (2023) also emphasized that a useful strategy for promoting ethical awareness and preventing unethical behaviour is to organize educating seminars and communicate the consequences of a poor ethical approach for both new and experienced nurses. This would not only aid the development of nurses' ethical competence, enhancing their ability to provide quality care, but also support the development of a POS climate at the unit.

Ideological alignment between all groups and levels in the care organization regarding the caring mission, with focus on the patients' needs, is viewed as an essential organizational resource. A perceived ideological alignment provided stimulation, pride in the work and meaningfulness, and contributed to a greater ability to both avoid and resolve ethical value conflicts at work. It empowered the nurses by inducing courage to act in ethical value conflicts. When insufficient resources hindered the nurses from providing care of a quality that corresponded to their professional value, this was perceived as a lack of organizational ideological alignment. It caused resentment and cynicism toward the organization among the nurses. These results highlight the importance of investing in an ideological alignment in the organization related to the caring mission, to avoid ethical distress. Such managerial investments may prevent nurses from becoming resigned and cynical about the organization (Gadolin et al., 2022). Thus,

the qualitative results underscore the need to align the organizational support toward professionalization of nursing, with supporting dimensions such as professional specialization, autonomy, and social recognition of roles and responsibilities (Gunn et al., 2019).

Likewise, De Casterlé et al. (2008) highlighted the need for nurses to be personally and professionally empowered to be able to make difficult personal ethical decisions, pursuing the good of the patients, in day-to-day clinical practice. Ethical value conflicts imply a challenge to the ability of healthcare workers to protect deeply held ethical values, to ensure the best possible care for patients. This is stressful and threatens the meaningfulness of the work, as indicated by reduced commitment, and increased turnover intent and actual turnover among nurses (Thorne, 2010; Whitehead et al., 2014). As a profound human need, meaningfulness is part of the theoretical basis of POS (Rhoades & Eisenberger, 2002); therefore, a mutually reinforcing relation between POS and a shared care ideology within the entire care organization, as found in the present study, is not unexpected.

6.1 | Strengths and limitations of the work

The fact that the study was restricted to two regional Swedish healthcare organizations could limit the transferability of the results. However, in the qualitative study, we strove to maximize the variation with participants from different medical specialties and with a variation of work experiences. We also included participants who were particularly exposed to ethical values conflicts in caring for patients during the COVID-19 pandemic. We believe that this variation of participants creates a solid foundation for describing the influence of POS on nurses' ability to manage and resolve ethical value conflicts. The mixed-methods study design, comprising both a longitudinal, qualitative survey and qualitative focus group interviews, also solidifies the results.

6.2 | Recommendation for further research

We suggest that future research should specify how the organizational preconditions to support the development of POS among nurses, which have been identified in the present study, could be enabled by interventions at all different organizational levels in the healthcare system. We also suggest that future research could investigate the importance of POS and its organizational preconditions for physicians, auxiliary nurses, and other categories of healthcare professionals. Finally, we also underline the importance of investigating how today's healthcare structure affects the possibilities for nurses to provide care consistent with basic nursing values.

7 | CONCLUSION

The ability of nurses to handle and resolve ethical value conflicts is pivotal for their ability and motivation to provide efficient and

high-quality care. The study showed that POS is an important resource in this respect. Nurses who are empowered by POS feel secure in their professional role and are confident about making situationally adapted decisions and acting upon these in complex situations with competing demands, considering and in the long-term maintaining a range of important organizational values. Nurses who are empowered by POS are stimulated by and take pride in their work and experience the work as meaningful and joyful. The result of this study explicates the important organizational resources for the development of POS, and what managers need to do and consider to provide such preconditions. Such knowledge is critical in establishing a healthcare organization that can provide effective, qualitative patient care, ensure staff retention, and safeguard the well-being of care professionals.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet the following criteria (recommended by [ICMJE | Recommendations | Defining the Role of Authors and Contributors](#)). Substantial contribution to conception and design, acquisition of data, or analysing and interpretation of data. Drafting the article or revising it critically for important intellectual content.

CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflicts of interest.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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