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DISCURSIVE PAPER

When nurses' vulnerability challenges their moral integrity: A discursive paper

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Abstract

Background: Both vulnerability and integrity represent action-guiding concepts in nursing practice. However, they are primarily discussed regarding patients—not nurses—and considered independently from rather than in relation to each other.

Aim: The aim of this paper is to characterize the moral dimension of nurses' vulnerability and integrity, specify the concepts' relationship in nurses' clinical practice and, ultimately, allow a more fine-grained understanding.

Design: This discursive paper demonstrates how vulnerability and integrity relate to each other in nursing practice and carves out which types of vulnerability pose a threat to nurses' moral integrity. The concept of vulnerability developed by Mackenzie et al. (2014) is applied to the situation of nurses and expanded to include the concept of moral integrity according to Hardingham (2004). Four scenarios are used to demonstrate where and how nurses' vulnerabilities become particularly apparent in clinical practice. This leads to a cross-case discussion, in which the vulnerabilities identified are examined against the background of moral integrity and the relationship between the two concepts is determined in more detail.

Results and Conclusion: Vulnerability and integrity do not only form a conceptual pair but also represent complementary moral concepts. Their joint consideration has both a theoretical and practical added value. It is shown that only specific forms of vulnerability pose a threat to moral integrity and the vulnerability–integrity relationship is mediated via moral distress.

Implications for the Profession and/or Patient Care: The manuscript provides guidance on how the concrete threat(s) to integrity can be buffered and moral resilience can be promoted. Different types of threats also weigh differently and require specific approaches to assess and handle them at the micro-, meso- and macro-level of the healthcare system.

KEYWORDS
decision-making, ethics, narrative, nurse–patient interaction, nurse–patient relationship, philosophy, self-care

Anna-Henrikje Seidlein and Eva Kuhn made equal contributions to this manuscript (joint first authorship).

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1 | INTRODUCTION

Nurses' *integrity* has traditionally been strongly emphasized as an essential component of professional self-image. The International Council of Nurses' (ICN) "Code of Ethics for Nurses" determines integrity as a core professional ethical value (ICN, 2021, p. 3). It states that nurses must uphold the integrity of the nursing profession personally and in all media (ibid., p. 7).

Not only the term itself (Latin *integer* for unharmed/uninjured) but also the requirement to maintain integrity implies that this state of integrity is not absolute. The (potential) threat to integrity is revealed in vulnerability (Latin *vulnus* for injury) (Rushton, 2018, p. 83). Taking into account mere semantics and propositional logics, the concept of vulnerability, understood as the risk of being injured or damaged, in turn, presupposes that there is a state where one is uninjured or unscathed—correspondingly, therefore, in the original sense of the word, integrity. Consequently, integrity and vulnerability do not only form a conceptual pair, but are, prima facie, closely related to each other. Different approaches to integrity and vulnerability in (moral) philosophy consider their counterparts but, so far, do not see them as complementary concepts with theoretical and practical value for professional ethics.

The protection of vulnerable groups and individuals has always been of particular importance in the context of nursing. Vulnerability is mainly discussed in research and practice with a focus on the *patient* (Sanchini et al., 2022; Sarvimäki & Stenbock-Hult, 2016; Sellman, 2005; Wardrop et al., 2021) and extensive knowledge exists about its sources, including uncertainty and existential threats posed by illness (Schrems, 2020). Nurses, by contrast, are primarily considered through the lens of integrity in research and practice (Lach, 2019; LaSala, 2009). However, vulnerability and integrity in the nurse–patient relationship are located on the side of both nurse and patient (Angel & Vatne, 2017; Morberg Jämterud, 2022). Even if, as the following remarks show, these two spheres cannot be sharply separated from each other (cf. Carel, 2009), the focus of this article is on the nurse's own integrity and vulnerability. It is particularly the *moral* relevance of the *relationship* between the two concepts that has been insufficiently explored in scholarly literature to date. The aim of this paper is, thus, to characterize the moral dimension of nurses' vulnerability and integrity, specify the concepts' relationship in nurses' clinical practice and, ultimately, allow a more fine-grained understanding of their characterization and relationship.

2 | METHODOLOGICAL CONSIDERATIONS

After a presentation of the concepts of vulnerability and integrity, the analysis focuses on their moral dimension(s) and relates the two to each other. Accordingly, the concept of vulnerability, following Mackenzie et al. (2014), is applied to the situation of nurses and expanded to include the concept of moral integrity according to Hardingham (2004). The argumentative-analytical steps are carried out against the background of a keyword-based literature search on the article's key concepts in relevant international nursing and medical ethics databases (MEDLINE via Pubmed, CINAHL). This was followed by a snowball search. The theoretical considerations are related to four scenarios that are paradigmatic for clinical nursing practice in Central European countries to increase the relevance of the discussion for daily nursing practice and pave the ground for a practice-informed and experience-saturated understanding of nurses' vulnerability.

The scenarios are built on the basis of one of the authors' long-standing experiences as a nurse and both authors experiences in clinical ethics consultation and on case reports in grey and scholarly literature. In line with the biomedical and nursing ethics applied, the scenarios are discussed through the lens of integrity and vulnerability. A classification of the respective scenario based on the four principles of biomedical ethics (the coherentist principlism), namely, patient autonomy, beneficence, non-maleficence and justice, is only carried out insofar as it is relevant for the main interest—the possible threat to moral integrity. Each case is followed by a reflection on the relationship between vulnerability and integrity. In these sections ("relationship determination"), we combine the case presentation with our theoretical considerations and describe the respective relationship between vulnerability and integrity as a synopsis. This leads to a cross-case discussion in which the vulnerabilities identified are examined in more detail from the perspective of moral integrity and the relationship between the two concepts is determined more precisely.

Focusing on a certain framework of vulnerability and a specific setting (here, clinical care) also implies that some (sub-)types of vulnerability might not be covered in the following. Among these are vulnerabilities that arise on a superordinate level, for example, with nurses being a target of health politics and/or activists for better healthcare (e.g. Dickman & Chicas, 2021).

3 | BACKGROUND

3.1 | Vulnerability

As shown above, vulnerability applies not only to individuals in need of care. Nurses are also exposed to the risk of specific vulnerability when practicing their profession (Schrems, 2020, p. 35). It includes physical and psychological aspects, which can be based on a variety of causes, such as the increased risk of infection or confrontation with suffering and death. Not least, the COVID-19 pandemic has now made the vulnerability of nurses—already eminent—visible to the wider population (Polinard et al., 2022; Smith, 2020). However, only a few papers start from and emphasize the meaning and relevance of the *everyday* vulnerability of *nurses* in clinical practice: Carel (2009) carved out the so-called "responsive vulnerability", a certain vulnerability that arises out of the experience of others' (the patients') vulnerability. Accordingly, nurses can be regarded as more vulnerable than people who do not regularly witness someone else's

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extraordinary vulnerability and suffering. Additionally, Gjengedal et al. (2013) discussed how vulnerability manifests itself in the interaction with patients and relatives, and critically address the different strategies nurses use. Delgado (2021) even conceptualized vulnerability from a threefold perspective as shared between patient and relatives, caregivers and the institution. However, its relationship to integrity is not specifically covered.

Despite the ubiquity and seeming self-evidence in dealing with the concept of vulnerability, it exhibits numerous ambiguities. There is no consensus on whether the normative force of vulnerability actually emanates from the concept itself or if the normative content and obligations to be derived from it do not instead arise from the underlying concepts, such as harm; vulnerability, thus, only acts as a mediator (Panitch & Horne, 2017). Therefore, the lack of specificity in the former can lead to an unwarranted attribution of vulnerability, and in the latter, to stigmatization and/or paternalistic acts of protection out of an over-motivated need to care (Mackenzie, 2017).

At the normative level, such stigmatization is countered by approaches that view vulnerability as a universal experience for all people (e.g. Fineman, 2008). In addition to discussing individual predispositions, these allow for the inclusion of structural conditions that reveal human vulnerability. This, in turn, can help identify or develop interventions to reduce the (negative) impact of different forms of vulnerability and map the responsibility for their implementation (Mackenzie et al., 2014). One such approach, which, at the same time, incorporates the relational perspective that is particularly significant in nursing, is that of Mackenzie et al. (2014). According to this, three forms of vulnerability can be differentiated: inherent, situational and pathogenic (Mackenzie et al., 2014).

'Inherent vulnerability' is the general vulnerability inherent in human existence (also 'ordinary' or 'ontological'). As such, it is part of the *conditio humana* that unites us all. Consequently, it is also the vulnerability shared between nurses and patients. Situational vulnerability, on the other hand, is context specific. It is caused situationally by temporary or permanent conditions or circumstances (e.g. social or economic). Inherent and situational vulnerability are not categorically different but influence each other: environmental conditions are reflected in the inherent origins of vulnerability in different ways and to different degrees, and the impact of situational causes of vulnerability depends on the resilience of the individual (Mackenzie et al., 2014). Finally, 'pathogenic vulnerability' arises from or through other unaddressed forms of vulnerability. It can occur when existing vulnerabilities are exacerbated, or new vulnerabilities are generated. Pathogenic vulnerability undermines agency or exacerbates powerlessness. It results from "morally dysfunctional interpersonal and social relationships characterized by disrespect, prejudice, or abuse, or by sociopolitical situations characterized by oppression, domination, repression, injustice, persecution, or political violence" (Rogers et al., 2012, p. 25).

In contrast to other attempts at systematization, such as the distinction between physical, emotional and cognitive vulnerability (Boldt, 2019), the differentiation of Mackenzie et al. (2014) is characterized by the fact that it not only focuses on the individual but also includes the environment in which the respective individual operates. Its openness to different normative considerations also makes it particularly amenable to dialogue with other approaches, such as that of integrity.

3.2 | Integrity

"Professionals seem to feel that if they act with integrity that all will be well with their life and practice. Without it, they stand naked amidst a hostile and complex world" (Edgar & Pattison, 2011, p. 95). Practicing and maintaining integrity is a central goal of professional nursing, also embedded in the ICN Code of Ethics (2021).

In addition to extensive debates on the benefits and content of integrity as well as various systematization attempts (Sastrawan et al., 2019), it is the distinction between professional or occupational integrity and personal integrity that has to be kept in mind when contemplating the integrity of a profession such as nursing that has its own professional ethics (Edgar & Pattison, 2011). This distinction emphasizes the difference between one's own value system (personal integrity) and adherence to professional ethical standards in the performance of one's professional role (professional integrity). From an analytical perspective, personal and professional moral integrity do not necessarily coincide. Notwithstanding, it is assumed for both kinds of integrity that moral integrity remains undamaged *only* when moral beliefs and actions are congruent (Wicclair, 2019).

However, there are also other conceptions of moral integrity and, accordingly, different demands on moral actors that can be derived from it. Other authors, for instance, emphasized that such a traditional, narrow conception of integrity in terms of a rigid consistency between action and one's own deep moral convictions is obstructive in everyday life and should be replaced by a conception oriented towards dialogue and reflection, which does not prohibit compromise but allows or even demands it (Edgar & Pattison, 2011; Schwartz, 2016). Rushton proposed that healthcare professionals should hold "relational integrity" (Rushton, 2018, p. 90 ff.); one that is "intertwined with the integrity of those one serves and those one collaborates with" (Rushton, 2018, p. 91). This kind of integrity comprises one's own personal and professional integrity—both of them already including moral integrity and considering them as a precondition for relational integrity. Such relational integrity "enables a clinician to best preserve personal and professional integrity while being interdependently connected with others whose integrity is also at stake" (ibid.). In her approach to moral resilience, Rushton also touches on the relationship between the two entities of integrity and vulnerability insofar as she notes that "[c]linicians of integrity [...] are intimately aware of their own personal bias, assumptions and vulnerabilities" (Rushton, 2018, p. 79). With a slightly different focus, Hardingham (2004), drawing from May (1996), also conceptualized moral integrity as relational and manifesting in or through social processes and relationships. Nurses act as moral agents in the context of the interprofessional team and institution, which can be understood as a moral community ("a community in which there is coherence

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between what a healthcare organization publicly professes to be, and what employees, patients and others both witness and participate in" [Webster & Baylis, 2000, p. 228]). Even though Rushton and Hardingham propose a relational conception of integrity—away from an isolated consideration of the individual, Hardingham puts more emphasis on the structures in which professional nursing is carried out. Borrowing from the principle of ought implies can, a person can only be expected to maintain moral integrity if this is possible in the environment and structures in which he or she operates (Hardingham, 2004). This approach takes into account the social embeddedness of nurses in an organization and the practice of interprofessional team decision-making, thus, allowing for a more practical reflection of moral integrity.

The distinction and relationship between moral and professional integrity and between moral and personal integrity (e.g. van Willigenburg, 2000) has not been conclusively clarified; neither has the question of how the other forms of integrity relate to moral integrity. In the present essay, the authors—following Wicclair's (2019) understanding—assume that while professional and moral integrity can be artificially separated, maintaining or (re)establishing personal integrity is an essential contribution to the perception of professional integrity and vice versa. Professional integrity is, thus, a part of personal integrity that relates concretely to the practice of the profession so that personal and professional integrity are ultimately inseparable (Calhoun, 2016). In summary and following Hardingham's (2004) account of moral integrity, we assume for the scenario deliberation that nurses possess full moral integrity if they do not perceive their integrity as compromised and are also actually not limited in their adherence to moral values and norms.

4 | THE RELATIONSHIP BETWEEN VULNERABILITY AND INTEGRITY IN NURSING PRACTICE: CASE-RELATED CONSIDERATION

It has been shown that integrity and vulnerability are, in themselves, multidimensional and, in part, presuppositional concepts. In addition, it is obvious that a differentiation between an objective assessment (related to objective risks) of vulnerability and subjective assessment (related to internal feelings) of vulnerability, as well as between self-perception and attribution by others, is important (cf. Carel, 2009; Sellman, 2005). The same also applies to moral integrity. The form of representation and the resulting evaluation focuses here inevitably on the *external* perspective. Consequently, situations in which the nurse's feeling or perception and a bystander's or other actors' observation diverge cannot be elaborated in the following. It is rather that empirical studies including participatory observation and in-depth narrative interviews would be needed. Such an investigation could also shed light on the question how the self-attribution of vulnerability and/or integrity and the attribution by others relate to each other and to vulnerability and integrity as perceived from a meta-view. Against the evidence available, the scenario presentations are based on the premise that nurses are more vulnerable in certain situations due to the framework conditions, but that moral integrity can only be violated in interaction with concrete actors who behave according to these constraints.

4.1 | Scenario I

Mrs. Mayer is a nurse in a neurosurgical intensive care unit. There, she accompanies 25-year-old Mrs. Wolff, who suffered a thalamic haemorrhage with ventricular collapse. The patient was in her 34th week of pregnancy at the time of the event; the baby was delivered by caesarean section. Mrs. Wolff is intubated and without sedation but contact with her is not possible. The husband brings the infant several times a day for bonding, and the patient does not respond. Mrs. Mayer, who is a mother herself and is currently in early pregnancy, finds the situation very distressing and increasingly unbearable for her in her bodily experience. She is confronted with the fragility of her own existence and family, and, at the same time, asks herself questions concerning the future of the family, until, finally, she starts to cry.

4.1.1 | Relationship determination

The case describes the occurrence of a culminated inherent vulnerability as a concrete experience of vulnerability. Mrs. Mayer perceives a special closeness to the patient's situation due to similar biographical key data (age) and role (mother; "this could be me") and feels an extraordinary vulnerability as a result ("this could also affect me"). Accordingly, vulnerability, in this case, is not intensified by a specific behaviour but rather by the coincidence of the characteristics and life histories of two people. The case offers no evidence that Mrs. Mayer feels or is limited in her adherence to moral values and norms, so that her moral integrity is not compromised.

Instead, the inherent vulnerability she experiences epitomizes what it means to be a nurse who is also a human being, who is in relationship with others, and whose perceptions and actions are influenced by them.

4.2 | Scenario II

Mr. Müller is a nurse in an emergency room. He is caring for 72-year-old Mr. Scholz, who has been admitted from an inpatient nursing facility due to sepsis. The patient has a history of severe vascular dementia. On admission, the patient is already agitated, lashes out and kicks, and loudly insults Mr. Müller. Neither the taking of blood samples for further diagnostics nor the monitoring of vital parameters and initial nursing care are possible. After Mr. Müller suffers a painful kick in the lower abdomen, he decides to temporarily 4-point restrain Mr.

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Scholz, whereupon the latter shows even stronger resistance. Mr. Müller doubts his decision and wonders whether he has done "the right thing". He is accompanied by an uneasy feeling. He discusses the experience with a colleague afterwards. Together, they decide to request a retrospective case reflection from the facility's ethics advisors in order to enter into a structured exchange, possibly develop further ideas for dealing with similar situations and, thus, benefit from the experience in the future.

4.2.1 | Relationship determination

The case presented thematizes an event in which situational vulnerability becomes apparent. Mr. Müller finds himself in the conflict of having to weigh up the two prima facie valid professional ethical obligations of care for Mr. Scholz (best possible treatment of the illness) as well as the non-harm requirement (restriction of personal rights of freedom against the patient's natural will; potential psychological and physical effects of restraint and negative effects on the relationship of trust between nurse and patient) and the patient's right to self-determination—at least temporarily. The threat to one's own physical integrity against the background of the duty of self-care and, thus, also the right to self-protection of nursing professionals also plays a role in the overall assessment of the situation. As expected, no satisfactory solution can be found to this ethical dilemma. Mr. Müller has failed to comply with the professional ethical norm of respect for autonomy and (potentially) also of non-harm. Of course, in view of the patient's medical history, the question arises as to what extent the expressed will is to be understood as freely given. In the present case, it is assumed that the patient was not capable of giving consent at the time of the event. Nevertheless, the natural will expressed by the patient (refusal of the measures) must also be taken seriously into account in the decision-making process.

As a vulnerability-reinforcing factor on the part of Mr. Müller, there is also the fact that the alternatives available are severely limited by the general conditions in the emergency room (high patient volume with short length of stay, acute nature of the disease states and hardly any possibility of creating an environment that is calming for people with dementia).

The case describes a concrete experience of vulnerability, which is made tangible by Mr. Müller's moral discomfort. However, based on the course of the case, it can be assumed that no damage to moral integrity occurred. Instead, the situational vulnerability experienced was overcome with the help of the resources available so that it can be assumed that moral integrity is intact.

4.3 | Scenario III

Ms. Schulz is a nurse on an internal medicine ward. She cares for and accompanies Mr. Williams, an 87-year-old patient who was initially admitted with sepsis as a result of acute pancreatitis and has now been under treatment for 70 days. Ms. Schulz assesses the curative therapy goal intended as hardly achievable and only questionable in the patient's best interest. She perceives the current situation as overtreatment and tries to address this several times in the team without success. This is not the first time that her concerns have not been taken seriously. A clinical ethics consultation she requests is cancelled by the senior physician, arguing that this was a medical decision that both nurses and ethicists are not permitted to doubt, as they have neither the knowledge nor the competence to do so. It is not the first time that this has happened; the working atmosphere in the ward is characterized by a lack of appreciation and poor interprofessional cooperation.

4.3.1 | Relationship determination

The scenario depicts a manifestation of pathogenic vulnerability. Ms. Schulz perceives an overtreatment, which, as such, at least violates the principles of non-harm, beneficence and distributive justice (solidary financed health care; scarce resources). The search for moral orientation and ethical reflection is deliberately prevented by third parties, which puts Ms. Schulz in a situation of pathogenic vulnerability. The behaviour of her team and the senior physician testifies—at least on an interprofessional level—to a climate that stands in the way of dealing appropriately with ethically challenging situations. Her assessment of not being able to act in accordance with the values to be protected makes it impossible for Ms. Schulz to maintain her moral integrity and, at the same time, points to the relational dimension of moral integrity as being tied back to the behaviour of the team and the senior physician.

Consequently, for Ms. Schulz, the pathogenic vulnerability evoked and the violation of her moral integrity enforced by others coincide.

4.4 | Scenario IV

Mr. Schmidt has been working as a specialist nurse in an interdisciplinary intensive care unit for 10 years. He has also been caring for patients with life-threatening SARS-CoV-2 since the beginning of the pandemic. Particularly in the first two waves of the pandemic, he—similar to many of his colleagues—was forced to put his physical health at risk beyond the inherent risk of the nursing profession due to the lack of personal protective equipment and the absence of vaccination. In addition, the extra work to compensate for staff shortages and the associated shortened recovery times led to sleep disturbances for Mr. Schmidt; as did the concern for patients due to the suspension of the nursing staff minimum limits. The psychological stress, including the fear of infecting his family, has also increased steadily for him since the beginning of the pandemic. Finally, as a specialist nurse, he often bears the responsibility of instructing and supervising semi-skilled support staff.

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4.4.1 | Relationship determination

The scenario shows very clearly how the various forms of vulnerability are interrelated. It depicts a hodge-podge of inherent, situational and pathogenic vulnerability. Inherent vulnerability is manifested in the need for rest and sleep resulting from corporeality. The increased situational vulnerability results from the pandemic situation and is potentiated by the pre-existing problems of the German health care system (e.g. concerning the general conditions of employment and shortage of skilled personnel).

Mr. Schmidt's vulnerability is amplified by the pandemic at all levels. However, the situational, knowingly imposed vulnerability, through which a violation of integrity is marked in this constellation, is of primary importance for the classification of the relationship between vulnerability and integrity in this case: third-party decisions make caregivers (even) more vulnerable. Thus, the suspension of the nursing staff lower limit regulation, the use of unqualified support staff and the lifting of the quarantine for SARS-CoV-2 positive tested nursing professionals tangentially affect their professional ethical obligation to self-care. The specific examples imply that, in the context of third-party decisions, the self-care of nurses (tangible as a concrete health hazard) is subordinated to the care of patients.

5 | ETHICAL CONSIDERATIONS IN CROSS-CASE ANALYSIS: THE VULNERABILITY-INTEGRITY RELATIONSHIP

It has become clear that—contrary to the simplistic presentation in the discourse so far—vulnerability per se is not a threat to moral integrity but only specific forms of the same in their concrete (inter) relationship to moral integrity. The case-related presentation and determination of the relationship of various forms of vulnerability to moral integrity makes the latter comprehensible in an exemplary manner and produces an important contribution to penetrating moral integrity, which has not been defined with sufficient precision in nursing practice to date and makes it fruitful for practice. With the help of these concrete clues, it is subsequently possible to deduce how the moral integrity of nursing professionals can be (better) protected and preserved. In addition, by referring to vulnerability, it is also possible to identify more clearly where the cause(s) of the violation of moral integrity lies in each individual case. Ultimately, it becomes clear that both vulnerability and moral integrity must be understood as relational—embedded in the context of the moral community.

Inherent vulnerability is, thus, always present as a basic constant of human existence and is merely more or less pronounced. In addition to physical vulnerability, for example, which is manifested in an individual's need for rest and sleep (cf. Scenario IV), inherent vulnerability also has a moral dimension: situations in which nurses are confronted with existential questions are not experienced and interpreted by them independently of personal ideas of a good life or the question of the meaning of illness, suffering and dying. Nevertheless, inherent vulnerability cannot per se violate moral integrity because we ourselves cannot escape our bodily constitution—which is the basic condition of our existence.

Pathogenic vulnerability, on the other hand, if understood morally, always leads to damage to the moral integrity of the nurses affected. The rationale for this finding is as follows: pathogenic vulnerability, which is caused by social framework conditions, for example, the institutional setting, can be (re)activated and intensified in every contact with the causative structure and/or the problematic behaviour occurring therein and the underlying deficient framework conditions. Because this type of vulnerability results from social structures that have usually been established over a long period of time and are also inevitably reflected in the behaviour of the actors acting within them, it can be assumed that the moral room for manoeuvre of the nursing professionals is restricted over a longer period of time. They consequently face persistent internal or/and external barriers that lead to their not being able to perform the action that is morally required. As a result, moral distress may build up, resulting in longer-term mental health issues (Lake et al., 2022). Moral distress in such a case (cf. Scenario III) can be evaluated “as the correct ethical response to a morally troubling situation” (Fourie, 2016, p. 24).

The ethically relevant core of moral distress is compromised moral integrity (Thomas & Bruce, 2016; Thomas & McCullough, 2015). Pathogenic vulnerability should, therefore, be evaluated as a paradigmatic case of the violation of nurses' moral integrity. Under the current conditions in the health care system—from permanent overload due to, among other things, a shortage of nursing staff to a lack of recognition (Lücker et al., 2022)—it can be assumed that such a violation will be experienced sooner or later and also repeatedly. Finally, nursing professionals as moral actors cannot exert any immediate and short-term influence on the actual factors or structures from which pathogenic vulnerability arises—which do not lie at the micro level in the characteristics of and relationships with individual patients or colleagues but rather affect the meso and macro levels of health care.

Unlike pathogenic vulnerability, situational vulnerability usually occurs acutely and typically results from a constellation of circumstances and characteristics at the micro level between patient and nurse. If values, principles or norms are affected in this situation, situational vulnerability represents a threat to moral integrity. Such a threat can either be averted or manifests itself in a violation of or damage to moral integrity. Accordingly, the consequences of determining the relationship of this form of vulnerability to moral integrity—also in view of its entanglement with inherent vulnerability and the distinction from pathogenic vulnerability—are particularly instructive. Damage to the nurse's moral integrity in this context is to be expected when coping with the help of moral resilience (the “competence in dealing with vulnerability and the experience of moral distress [...] [in order to, author's note] stabilize moral integrity and overcome degrees of moral vulnerability” [Riedel and Lehmeyer 2021, p. 18, own translation]) is unsuccessful or an attempt at coping is not even made. In such a case, moral distress could also arise due to a, possibly unique, moral conflict or dilemma.

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Of course, circumstances of situational vulnerability can accumulate (without being pathogenic vulnerability) so that moral distress (Morley et al., 2021) can also develop as a result of the experience of situational vulnerability—and, thus, damage to moral integrity—from this accumulation due to increased stress or the overlapping of different circumstances. If this distress is experienced not only initially during the challenging situation but also after the nurse is no longer in that situation, moral residue ("Lingering feelings after a morally problematic situation has passed; in the face of moral distress the individual has seriously compromised himself or herself, or allowed others to be compromised, resulting in loss of moral integrity" [Epstein & Hamric, 2009, p. 330]) may occur. The relationship between moral residue as reactive and recurrent distress, as well as broader issues involving conditions and originating factors of moral distress, has been extensively studied in other works and will, therefore, not be discussed here. See Epstein and Hamric (2009) and ten Have and Patrão Neves (2021), inter alia, for an overview. As a consequence of manifested vulnerability experience(s), i.e. compromised moral integrity and associated moral distress or residue, the vulnerability experience (concerning situational vulnerability) may subsequently be increased, which, in turn, increases the risk of the sustained violation of moral integrity.

The explanations illustrate that vulnerability and integrity not only form a conceptual pair but are also closely related in a moral sense. It becomes clear, particularly regarding situational and pathogenic vulnerability, that this is a relationship in which moral distress has a mediating function. Moreover, this relationship is characterized by reciprocity: the experience of vulnerability can threaten or damage moral integrity, which, in turn, can increase vulnerability. This observation suggests overlaps with the "crescendo effect", which Epstein and Hamric (2009) use to describe the relationship between moral distress and moral residue and which is characterized by a steady increase (Latin *crescere* for increase) in moral distress. An extension of the two-dimensional representation with the time course on the x-axis and the degree of moral distress on the y-axis to include the dimension of vulnerability would take into account the complexity of determining the relationship at the conceptual level. At the same time, such a model could be used to illustrate the effects of moderating factors.

6 | CONCLUSION AND OUTLOOK

In addition to integrity, it is also vulnerability that must be considered as a basic constant for nurses because it is never absent but always more or less pronounced. It has become clear that—contrary to the simplistic presentation in the discourse so far—vulnerability does not represent a threat to moral integrity per se but only specific forms of the same in their concrete (inter)relationship to moral integrity.

An isolated consideration of one or the other concept is not expedient since only their concrete relationship enables one to understand in which situations, for which reasons and in which respect nursing professionals (can) suffer a violation of their moral integrity in the exercise of their professional role due to their specific, context-sensitive vulnerability. The concept of vulnerability, with its close link to the moral principles of non-harm and care, thereby, also provides a framework for reflecting on inevitable tensions between these professional ethical norms: vulnerability experiences that threaten moral integrity are unavoidable for nurses. As such, they also serve an important warning function and raise the awareness of the ethical dimension of everyday actions. Damage to moral integrity, however, perverts this added value. Such a reversal must be counteracted.

Finally, this article also makes an important contribution beyond professional ethics by encouraging a *differentiated* view of vulnerability. Although there is important preliminary work on breaking down the frequently prevailing negative connotation of vulnerability, such as that of Carel (2009), who emphasized that the vulnerability of nurses when faced with their vulnerable patients provides an opportunity for flourishing in so far as it can foster openness, and Daniel (1998), who sees vulnerability as a call to become active, to be aware of one's own vulnerability and to perceive it as "a vehicle for practicing authentic nursing" (ibid., p. 191), our work adds the important aspect in determining the moral relevance of the vulnerability–integrity relationship.

In a health care system where the resilience of the individual is often emphasized and the view of vulnerability(ies) has so far been an exception, this is a shift in perspective that not only has a signal effect but whose moral relevance has become clear with the present contribution. "Being aware of the circumstances and vulnerabilities that create the conditions for lapses of integrity is vital in taking steps to regain moral wholeness" (Rushton, 2018, p. 83). Explicit clues for nursing practice emerge from the aforementioned determination of the relationship regarding at least three factors relevant to action.

This concerns (i) the question of how the concrete threat can be buffered and how moral resilience can be promoted. To this end, nursing practice requires, on the one hand, continuing education concepts that expand and deepen specific ethical competencies based on the those acquired in undergraduate education and the experiences lived through in everyday clinical practice (e.g. the comments by Riedel and Lehmeyer [2021] on "moral courage"). On the other hand, interventions are needed that address moral distress—in the broadest sense and as both a primary and secondary prevention approach—in its hinge function. These include clinical ethics consultation (both prospective case discussions and retrospective case analyses as requested in Scenario II), concepts of collegial support (e.g. mentoring) and help for self-help. Along with this, appropriate intervention studies are also needed to examine the effects of such complex interventions and demonstrate their added value for the people concerned on the basis of outcome parameters relevant to themselves.

Furthermore, (ii) aspects concerning the assessment and processing of patient-evoked threats to moral integrity in comparison to one evoked by the moral community are to be emphasized. At best, the moral community represents a resource that can buffer situational vulnerability and strengthen resilience (Delgado et al., 2021).

If a threat and/or violation of moral integrity is caused by the actions of actors from within their own moral community—which actually follows the same code (professional ethical values and norms as well as implicit communal morality of the team)—such misconduct will carry more weight in the moral judgement.

The last factor concerns (iii) the incidence of situational vulnerability (and possibly related cumulative effects). Successful intra- and interprofessional collaboration is a necessary condition for the realization of the goal of good patient care—this is particularly evident in situational and pathogenic vulnerability. The addition of vulnerability to moral integrity illustrates the intertwining of intra-individual and meso- and macro-level factors. This reveals that it is also incumbent on nurses themselves to bear (co-)responsibility for shaping the framework. Assuming this responsibility means exerting influence on the framework conditions of professional practice and, thus, by remedying specific situational vulnerability to which they are knowingly and sometimes even willingly exposed by third parties, also remedying factors of pathogenic vulnerability, as it were.

AUTHOR CONTRIBUTION

Both authors (Anna-Henrikje Seidlein, Eva Kuhn) equally contributed to conception, design and writing of the manuscript. They drafted the article and revised it critically together for important intellectual content. Both authors gave final approval of the version submitted.

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