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Dietary counseling in primary care: Exploring unspoken ethics

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Research Article

Keywords: Dietary Counseling, Ethical challenges, Ethical Competence, Ethics of Care, Interpretative Phenomenological Analysis, Moral Distress, Primary Care

Posted Date: November 18th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11304389/v1

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Additional Declarations: No competing interests reported.

Abstract

Background: Dietary counseling is a central part of nutritional care in primary care. Despite this, the ethical dimensions of this practice remain underexplored. Previous research has mainly focused on acute and specialist care settings involving medical nutrition therapy, while everyday ethical challenges in dietary counseling in primary care have received limited attention. Therefore, this study explores how professionals in primary care experience and make sense of ethical challenges in dietary counseling.

Methods: A qualitative inductive interpretative design. Eleven professionals were purposively recruited through profession coordinators, managers or a dietary advisor network. Semi-structured interviews were conducted between August 2023 and November 2024, each lasting approximately 45 minutes. Interviews were audio-recorded, transcribed verbatim, and analyzed through interpretative phenomenological analysis.

Clinical trial number: Not applicable.

Results: Through the analysis, three themes with a total of nine sub-themes were developed. *Setting boundaries or going the extra mile* captures how professionals navigate responsibilities, often stretching their role to meet patients' broader needs, which can lead to emotional strain and a sense of not being enough. *Meeting people where they are* reflects how professionals adapted dietary counseling to patients' everyday circumstances, social and cultural contexts, and readiness for change. This required tactfulness, patience, and sensitivity to avoid causing harm while supporting sustainable change. Finally, *A need for community and peer support* highlights how professionals often navigated ethical challenges independently, with limited opportunities for collegial reflection and a lack of shared language for discussing ethics, contributing to feelings of isolation and uncertainty.

Conclusions: Professionals experienced ethical challenges in dietary counseling when balancing professional responsibilities with patients' broader needs, circumstances, and capacity for change. Ethical considerations were closely intertwined with everyday practice but often remained implicit and were largely managed individually. Opportunities for ethical reflection, collegial dialogue, and shared responsibility may help support professionals in navigating ethical challenges in dietary counseling.

Background

Dietary counseling is a central component of nutritional care in primary care, aimed at both treating and preventing nutrition-related conditions. Despite its central role, the ethical dimensions of dietary counseling remain underexplored.

Dietary counseling is commonly understood as a collaborative process in which healthcare professionals and patients work together to identify priorities, set goals, and develop individualized plans to support self-care and health improvement [1]. However, food is rarely only a matter of nutrition. Food choices and eating practices are closely intertwined with people's values, relationships, culture,

resources, and everyday lives [2–7]. Conversations about food may therefore involve ethical considerations concerning autonomy, responsibility, well-being, and respect for individual circumstances.

In healthcare, the principles of autonomy, beneficence, nonmaleficence, and justice provide a framework for identifying and balancing ethical considerations [8–10]. However, dietary counseling takes place within ongoing relationships and is shaped by patients' everyday circumstances. An ethics of care perspective may therefore be particularly relevant, as it emphasizes relationality, interdependence, and attentiveness to patients' lived realities [11, 12].

Previous research on ethical challenges in nutritional care has primarily focused on specialized and inpatient settings, particularly issues related to medical nutrition therapy, life-sustaining treatment, and palliative care [13–18]. Comparatively little attention has been paid to ethical aspects of dietary counseling in primary care. While studies have identified organizational and contextual challenges related to nutritional care in primary care settings [19–22], ethical challenges have rarely been explored as an explicit focus.

In this study, ethical challenges are understood as dilemmas and situations involving the balancing of competing values [8]. Ethical challenges may also arise when healthcare professionals are unable to act in accordance with their values because of internal or external constraints [21, 23]. Such situations may give rise to moral distress, which can be understood as psychological distress resulting from being unable to act in accordance with what one believes to be ethically appropriate [24–30].

To our knowledge, ethical challenges in dietary counseling in primary care have received limited empirical attention, particularly from the perspectives of registered dietitians [RDs] and registered nurses [RN] with specialist qualifications. Increased knowledge about such challenges may contribute to a better understanding of the ethical dimensions of everyday nutritional care and help identify areas where healthcare professionals may need support in navigating ethical challenges in practice.

Methods

Aim, design and setting

The aim of this study was to explore how professionals in primary care experience and make sense of ethical challenges in dietary counseling. A qualitative inductive interpretative design was employed.

The study was conducted in Swedish primary care, which provides first-line healthcare including treatment, health promotion, and disease prevention [31–34]. Nutritional care in this setting is often long-term and integrated into patients’ everyday lives. It includes both preventive and therapeutic interventions aimed at supporting healthy eating habits, managing chronic conditions, and preventing or treating malnutrition [34–37]. In Swedish primary care, dietary counseling may be provided by RDs and RNs with relevant training and responsibilities in nutritional care [34, 37].

Ethical challenges were explored within the context of preventive and therapeutic nutritional care in Swedish primary care.

Recruitment and participants

Participants were purposively recruited through multiple channels across three regions in Sweden. The recruitment and inclusion processes for RDs and RNs are presented in Figs. 1A and 1B, respectively. The final sample comprised ten RDs and one RN with specialist qualifications as a district nurse [DN].

The number of participants was guided by the concept of information power, which suggests that fewer participants may be required when the study aim is narrow, the sample is specific, and the data are rich and relevant [38].

Participants represented both public and private healthcare providers, with a predominance from the public sector, and worked in urban settings across a range of socioeconomic contexts. Professional experience ranged from early career to more than three decades in practice. Most participants held a bachelor's degree, while some had additional postgraduate education.

Although the inclusion criteria specified at least one year of professional experience in primary care dietary counseling, one participant with slightly less experience was included due to extensive specialist care experience and the ability to provide rich experiential accounts. In addition, only one DN was included. These decisions were considered methodologically appropriate given the idiographic focus of IPA, which prioritizes experiential depth and relevance over sample uniformity [39, 40].

No prior relationship had been established with participants before recruitment. Participants were informed about the researcher's role as a doctoral student with a professional background as a district nurse in primary care.

Data collection

Data were collected through individual semi-structured interviews conducted by the first author, a PhD student at the time of data collection [39, 40]. Figure 2 provides an overview of the data collection process.

The interview guide (Additional file 1) consisted of open-ended questions and prompts and was used flexibly to follow participants' narratives. Following a pilot interview, minor revisions were made to make ethical aspects less explicit. This approach was intended to encourage participants' own descriptions and interpretations of their experiences [39, 40].

Data analysis

Data were analyzed using interpretative phenomenological analysis (IPA) [39, 40]. An overview of the analytic process is presented in Fig. 3. Open Code software [41] was used to organize meaning units, analytic notes, themes, and subthemes.

The analysis was informed by IPA's double hermeneutic, recognizing that participants' accounts are already interpretations of their lived experiences, while the researcher seeks to interpret participants' meaning-making [39, 40]. The analysis involved both an empathic engagement with participants' perspectives and a more critical interpretation attentive to underlying meanings, tensions, and assumptions [40].

Consistent with IPA's idiographic commitment, each interview was treated as a distinct case before patterns across cases were considered. Patterns of convergence and divergence were subsequently explored to identify both shared and uniquely situated aspects of ethical challenges [39, 40]. Themes and subthemes were developed inductively from the data.

Interpretation was guided by the hermeneutic circle, involving movement between parts and whole, whereby individual passages were considered in relation to the context of the entire transcript and the dataset. Particular attention was paid to expressive and analytically powerful excerpts, referred to as gems, which contributed to the development and illustration of the analytic narrative [40].

Reflexivity was central throughout the analytic process. The first author, who conducted the analysis, had a background as a healthcare professional and educator. Consistent with IPA, pre-understandings were treated as a resource for interpretation rather than something to be bracketed [40]. To enhance credibility, interpretations were continuously discussed with co-authors. Illustrative quotations are provided to show how the findings were derived from participants' accounts.

Use of Generative AI Tools

During manuscript preparation, generative artificial intelligence (AI) [42] was used to support translation and language editing. All AI-generated outputs were reviewed and edited by the authors, who take full responsibility for the final manuscript.

Ethical considerations

Ethical approval

was obtained from the Swedish Ethical Review Authority (Reference No. 2023–03151–01). Participants received written and verbal information about the study and provided informed consent prior to participation.

The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [43] (Additional file 2). To protect confidentiality in this small and potentially identifiable sample, participant characteristics are presented at group level [44]. Participants were assigned fictitious names, and ethical principles regarding confidentiality, anonymity, and responsible data handling were followed throughout the study [45].

Results

Three themes and nine subthemes were developed through the IPA analysis (Fig. 4). Together, they illustrate how professionals experience and make sense of ethical challenges in dietary counseling. Professionals described navigating boundaries of responsibility, balancing professional recommendations with patients' circumstances and values, and responding to needs extending beyond nutrition. These experiences were often accompanied by feelings of uncertainty, emotional strain, and a sense of not always being able to provide the support patients needed. Professionals also described ethical reflection as largely intuitive and solitary, with limited opportunities for structured collegial discussion and support.

Setting boundaries or going the extra mile

This theme captures how professionals negotiated the boundaries of professional responsibility in dietary counseling. They navigated needs extending beyond nutrition, sought ways to remain engaged without becoming overwhelmed, and were sometimes left with a lingering sense of not having done enough despite considerable efforts to support their patients.

It is never just about food

The boundaries of professional responsibility in dietary counseling were often experienced as unclear. Professionals negotiated expectations regarding what dietary counseling should entail and how far their responsibility extended. Nora reflected on this ambiguity, asking “what are we supposed to offer, where do we draw the line?” and wondered whether professionals were expected simply “to give the information and then feel like ‘well, I did my job’” or whether their role also involved ongoing coaching and support. Her account highlighted the uncertainty surrounding where professional responsibility begins and ends.

When patients’ needs were not captured by the healthcare system, professionals often felt compelled to respond. In dietary counseling focused on lifestyle change, conversations moved between nutritional, psychosocial, and medical concerns. Without clear guidance regarding where their responsibility ended, professionals themselves had to determine how much support to provide and when enough had been done.

Maya recalled a patient who “came in with a completely different problem that had nothing to do with food” and was so distressed that “it was hard to carry on our conversation about food.” The encounter shifted from dietary counseling toward addressing an immediate emotional need, illustrating how dietary counseling often came to involve concerns extending beyond food itself. Spending time addressing patients’ loneliness, psychological distress, mistrust, and previous negative experiences of healthcare before nutritional care could begin, were often experienced as necessary for establishing a foundation for further care.

Ella reflected on how some patients brought their entire life stories into dietary counseling. Although she saw herself as a good listener, she tried to clarify her professional limits by saying “I’m not trained in this, it’s not my profession,” “I’m not a counselor,” and “I don't have the tools” to support complex emotional needs. She explained: “I can listen to you, but I might not be able to give you much guidance when it comes to the psychological side of things.” Her account illustrates how dietary counseling often became a space where problems extending beyond nutrition were brought forward and expected to be addressed.

A similar experience emerged in Max’s account. Some patients were retained in primary care because “it’s convenient for the patient,” despite believing that “they don’t get as good treatment” and would benefit from specialist services. He referred to this as “playing hobby-psychologist” and acknowledged that “we’re not trained for that kind of conversation.” His account reflected a perceived gap between what patients seemed to need and what he felt able to provide within the limits of his role and competence. As he reflected, “you feel like you’re not doing as good a job as you should” because “this patient needs more.”

Unexpected situations could also redirect the focus of care. Emma recalled an elderly patient who “didn’t want ONS, but his wife wanted him to have them,” creating tension between patient autonomy and family expectations. Although “she got really, really angry at me because he didn’t get them,” Emma maintained that “I think it feels a bit unethical to prescribe something to someone who doesn’t want it.”

Similarly, Sofia recalled how a child’s father collapsed in the waiting room and failed to wake up. When she realized that “the child didn’t react at all, maybe it was normal for him that his dad was like this,” her concern shifted to the child's wellbeing. After informing the father that she would file a child protection report, “he got furious and said he would blow up the whole place.” What was planned as an ordinary dietary counseling consultation became a situation requiring immediate attention to safeguarding concerns.

The boundary between professional responsibility and patients’ broader needs was not always clear. Responding to needs that emerged during encounters was often less a deliberate choice than a response grounded in empathy, attentiveness, and the relationship with the patient. Yet within a healthcare system shaped by organizational constraints, such responsiveness could become both necessary and demanding. While professionals often felt compelled to respond, doing so raised questions about sustainability. Repeatedly meeting needs within a constrained system could carry personal consequences. With increasing experience, some professionals described learning that professional responsibility involved not only responding to patients’ needs, but also attending to their own well-being and limits. The next subtheme explores this shift and how professionals sought to remain engaged without becoming consumed.

Remaining engaged without being consumed

Luna recalled reaching her limit, simply telling a patient: “I can’t do any more, unfortunately.” She also avoided guessing and instead said, “I don’t know, but I can look it up and get back to you.” For Luna, acknowledging limits did not mean withdrawing from care but finding ways of remaining helpful without taking on responsibility she could not carry. Max expressed a similar stance when patients, despite repeated efforts, did not follow advice: “We focus on what we are able to change.” His account reflected an acceptance that appeared to be shaped by experience and a capacity to remain engaged without overextending himself.

Over time, experience appeared to reshape how professionals related to their work. Rather than trying harder, they described learning to work in ways they considered sustainable. Stella reflected that she had stopped “rushing around like I used to and maybe trying to squeeze in one more patient,” having realized that “we’ll never be able to meet all the care needs.” She added that “that’s something the manager has to decide,” and that without additional resources, “I’ll just keep working the way I do.” Max expressed a similar view, noting that “if there are long waiting times, there’s nothing we can do” and that “it doesn’t get better by overbooking ourselves.” Their accounts suggest a shift from taking personal responsibility for systemic shortcomings toward recognizing the limits of what can reasonably be achieved.

Professionals also emphasized the risk of becoming consumed by responsibility. Freja noted that many colleagues experienced exhaustion because “they take on a bit too much.” Max similarly observed that less experienced coworkers often continued taking on responsibility until “it becomes a burden on their own psyche.” As he put it, “it doesn’t help anyone if I hit a wall,” adding that “we have to be able to let things go.” Over time, looking after one's own well-being became part of what professionals understood as professional responsibility. This also involved accepting that some patients may not be ready or able to change, and that doing one’s best within existing constraints sometimes had to be enough.

Yet acceptance was not always accompanied by peace of mind. Although professionals learned to set limits and work in more sustainable ways, this did not necessarily remove feelings of frustration. The sense that more should have been done sometimes remained. The next section explores how professionals made sense of situations where dietary counseling did not lead to the hoped-for outcomes.

Giving everything, yet still not enough

What begins as a commitment to help can turn into a feeling of not being enough when dietary counseling fails to take hold. Professionals often found themselves revisiting encounters, questioning whether they could have done something different. For Max, it felt like a failure, prompting questions such as “Could we have been clearer?” and “should we have had more follow-ups?” Looking back, he reflected, “if we had retained this patient earlier, maybe they wouldn’t be in this situation now that it’s gotten worse.” His account illustrates how lack of progress could lead professionals to revisit and question their own actions.

Nora expressed a similar struggle, describing how professionals could end up in “this martyr role ‘I just give and give of myself, and nothing happens.’” For her, the burden was not simply the absence of visible outcomes, but the experience of carrying responsibility without feeling that the patient shared in the work of change. The sense of giving without reciprocity created frustration and contributed to a feeling of being left alone with the responsibility.

Nora also highlighted how patients’ cognitive limitations and psychiatric conditions could make even small changes difficult. “They come back the next time and say, ‘No, it didn’t really work’ or ‘It just didn’t happen.’” In these situations, it was not necessarily a lack of motivation but a limited ability to act on information. She expressed frustration, noting that “they neither have the ability nor the resources to make the change or absorb the information. But they end up with me anyway,” and continued, “it almost becomes unethical for them to see a dietitian, I think, because they get their hopes up when you already know from the start that this won’t work.”

Stella described similar experiences when efforts to establish common ground failed. “The person puts up a lot of barriers,” she explained, adding that “finding that meeting point is hard,” especially when the patient had “no willingness at all.” Even seemingly simple changes could feel overwhelming when a patient viewed “buying and peeling a carrot as a huge process, and just want fast food.” These accounts illustrate how professionals could become caught between their desire to help and patients’ varying abilities, readiness, or opportunities to engage in change.

Feelings of not being enough were also linked to structural conditions. Emma described supporting patients in nursing home facilities managed by the municipality while working as a dietitian in primary care. “There’s no municipal dietitian,” she noted, adding that “according to the relatives, nothing is followed, and when I talk to the nurse, everything is followed. So, who should I believe?” The lack of continuity and conflicting accounts left her trying to influence situations she could not fully oversee, creating a sense that her efforts might never be enough.

Several professionals reflected on how patients often had more extensive needs than primary care could realistically meet. Stella described how “patients on medication should be followed up every twelve weeks” and that “people with diabetes or prediabetes should at least see someone once a year,” while acknowledging that “it’s just not possible.” These accounts reveal the moral weight of working in a system where resources fall short of the demands, and the awareness that some patients will not receive help elsewhere reinforces the feeling of not being enough.

Across professionals’ accounts, feelings of not being enough emerged when considerable effort failed to translate into meaningful change. These experiences involved not only unmet goals but also uncertainty about what more, if anything, could have been done. For some professionals, certain patients and encounters remained with them long after the consultation had ended, leaving lingering concerns and unanswered questions. Barriers to change were not always related to resources or coordination, but could also be connected to patients’ readiness, capacity, and ability to sustain new habits. The next

theme explores how professionals made sense of these complexities by adapting dietary counseling to patients' everyday lives and navigating the social, cultural, and emotional dimensions of food practices.

Meeting people where they are

This theme illustrates how eating habits were understood as embedded in patients' everyday lives and shaped by social and cultural norms. Professionals emphasized the importance of adapting support to each individual's circumstances and approaching sensitive issues with tactfulness to avoid guilt or shame and foster trust. Sustainable change was understood as a gradual process, supported through small and realistic steps that fit within the patient's everyday life.

It is just how we eat: managing social and cultural norms

Cultural and social norms shape how patients relate to food practices and how professionals support change, requiring sensitivity to individual traditions, expectations, and beliefs. Ella shared that she often "encounter all kinds of strange diets and gurus," and stressed the need to "try to talk about it in a way" when addressing misconceptions. She laughed and expressed a degree of frustration, noting that "we Swedes are so gullible," pointing to a perceived vulnerability to diet trends. Her account suggests that addressing beliefs about food and health requires tactfulness. Rather than dismissing patients' perspectives outright, professionals sought ways of raising alternative perspectives while keeping the conversation open.

Nora recalled when a patient "just laughed and shook her head, 'We always have a big, big bowl of dates out. You can say whatever you want, I won't be able to change that,'" and reflected that "you learn how the food culture works and try to find individual solutions." Her account suggests that supporting change sometimes requires professionals to work with, rather than against, established food practices and traditions.

Stella recalled that"many who come from other countries are used to being told what to do."While supporting a person-centered approach, she noticed that"they try to adjust and 'Swedify' their answers,"and reflected that"then we don't really meet and talk together."Even visual aids like the plate model may fail when patients"just try to fill in what they think I want to hear."This shows how ideals such as shared decision-making can fall short when cultural expectations differ, creating an illusion of participation rather than genuine dialogue.

Professional interpreters also shaped these encounters. Sofia noted that"there are interpreters who create a bad atmosphere in the room, and there are interpreters who create a very good one."Professionals described situations where interpreters introduced their own advice rather than translating information as intended. Her account illustrates how interpreters became active participants in the encounter, influencing how dietary advice was communicated and understood. This highlighted the importance of accurate communication as a prerequisite for patients' opportunities to make informed decisions.

These accounts suggest that patients' food practices were embedded in social and cultural contexts that professionals needed to understand and navigate. Professionals described encounters shaped by diet trends, cultural food traditions, different expectations regarding professional authority and participation, and the role of interpreters in communication. The next section turns to another layer of complexity: how professionals sought to avoid causing harm when sensitive issues associated with guilt and shame entered the conversation.

Being careful not to make things worse

In dietary counseling, professionals often encountered situations that required particular sensitivity. Supporting change involved not only identifying what might be helpful, but also considering how conversations and advice could affect patients and their families. Professionals therefore described the need to balance support with a desire to avoid causing harm.

Respect for the child's wishes was considered an important value in dietary counseling, particularly in situations where the child withdrew, indicating discomfort. Lucas recalled how parents often preferred children not to be present because "they feel that food is a sensitive issue and they do not want the children to be overly affected." His account suggests that professionals sometimes had to balance involving the child in discussions about food with parents' wishes to protect the child from being negatively affected by such conversations.

Some patients entered dietary counseling without having sought it out themselves and without feeling ready to receive support. In such situations, professionals emphasized the importance of remaining responsive rather than confrontational, as pushing too hard could provoke resistance. Nora described how "they would just walk out the door" if she brought up topics such as sustainable food choices. For many, "it's just about getting food on the table." She stressed, "it's also important not to end up in something moralizing. Not to add another burden." Even suggesting vegetables could be "a far too big a step," and in this context, she argued, "it would be unethical for me to start talking about climate issues too in the middle of all this. They don't have that perspective in any way; many are just in survival mode." Her account highlights how professionals sought to adapt their advice to patients' circumstances and avoid introducing expectations or concerns that could become an additional burden.

Lucas reflected on the importance of keeping his personal beliefs separate from the advice he gave. He shared, "I'm a vegetarian myself" and added, "it's better from an environmental perspective," showing how personal values can be present in the background. However, he continued, "it's not something I can say like 'now you should become a vegetarian,'" and clarified, "it's good for your health and the environment," but still, "I would never say that to a patient." His account suggests a reluctance to impose personal convictions on patients. Instead, he emphasized providing support that was responsive to the patient's own circumstances and priorities.

Weight-related issues were often experienced as sensitive. Luna reflected on the difficulty of "not being able to reach them" and wondered "whether the patient dares or is able to tell the truth about their food

intake.” Her account suggests an awareness that conversations about food and body weight could evoke discomfort, shame, or guilt. In such situations, professionals sometimes chose not to address certain topics directly, viewing this as a way of avoiding unnecessary harm. Rather than focusing on restrictions or what needed to be removed from the diet, they often emphasized what could be added instead. This approach was perceived as more supportive and less likely to reinforce negative feelings.

These accounts suggest that supporting change required careful attention to how issues were addressed within dietary counseling, particularly when there was a risk of causing harm or adding further burdens. Yet avoiding harm was only part of the challenge. Professionals also needed to find ways of supporting change that patients could realistically engage with and sustain over time. This is further explored in the next section.

One step at a time: supporting change that lasts

Supporting sustainable changes required patience and persistence, as well as presence and timing to avoid overwhelming patients. Holding back became intentional, as Luna illustrated: “sometimes you have to bite your tongue, because you can’t give as much advice as you’d like. The person isn’t there.” Rather than overwhelming patients, professionals often limited the information they provided, guided by a sense of what was manageable.

Prioritization developed with experience. As Noah explained: “you want to give all the advice, a long list,” but instead he chose “the most important,” noting that “If you give ten pieces of advice, the patient might choose two of the least relevant.” Noah gave an example of a patient with diabetes who drank large amounts of soda: “that’s the most important thing,” not “does the bread contain five or six grams of sugar?” The goal was not perfection but identifying a starting point for change. Maya echoed this stance, emphasizing that “it might not always be optimal, but at least you’re making some improvements,” highlighting how small, realistic adjustments can still be meaningful. Instead of focusing on restrictions and prohibitions, professionals emphasized inclusion and small, realistic adjustments in everyday life as a more sustainable approach to change.

Noah recalled a patient saying: “you won’t get me to stop. I’m here because the doctor said so, but you won’t change what dietary fat I use on my sandwich.Instead of insisting, he replied: “no, I won’t if you don’t want to. We’ll base the advice on what you like to eat.”When the patient mentioned mayonnaise, he suggested: “could you use mayonnaise instead of Bregott [butter]?”and the patient agreed. Noah noted: “just because patients say one thing at first doesn’t mean they’ll stick with it. If I had said from the start, ‘yes, but you have to,’ it would have led to conflict.”Rather than rejecting patients’ ideas, professionals tried to meet them where they were. Maya said: “if you choose to eat an LCHF [Low-Carbohydrate High-Fat] diet, it’s not something I recommend or am allowed to recommend,”but added, “if it works for you and you want to continue, is it okay if I give you some advice on how to improve it nutritionally?”Her approach illustrates a willingness to work with patients’ existing choices rather than insisting on an ideal dietary approach from the outset.

When results were not immediately visible, professionals worked to sustain motivation. Noah noted this was common in diabetes or high cholesterol, where “patients don’t notice much difference, it’s something they benefit from in the future,” unlike IBS [Irritable Bowel Syndrome] where “do this and you’ll feel better tomorrow.” In such situations, sustaining motivation required patience and continuity despite the absence of immediate rewards. Max reflected that “not everyone wants the support we offer,” yet saw value in being there because “you can plant a seed and then they come back a year later, actually ready.”

Supporting eating behavior change was described as a gradual process that required patience, persistence, and sensitivity to each patient’s readiness for change. This work often unfolded within the individual consultation, with limited opportunities to share strategies or reflections with colleagues on a daily basis. How professionals experienced the need for collegial support and a sense of community is explored in the next theme.

A need for support and community among professionals

Professionals’ accounts pointed to a tension between freedom in clinical practice and feelings of isolation. While some considered existing structures sufficient, others expressed a need for more opportunities for collegial exchange. Ethical considerations were deeply embedded in daily practice but often remained intuitive rather than explicitly discussed. The need for support was therefore not only about organizational resources but also about creating spaces for shared reflection and a sense of belonging.

Being independent or feeling lonely

Working independently could be both empowering and isolating. Professionals valued the freedom to shape their own practice, yet this autonomy could also limit opportunities for collegial exchange and support. Emma, who moves between several units, reflected on the lack of connection to the teams she supports: “We’re not very closely connected to the primary care centers” and added, “We also cover all the primary care centers in the region.” She described one healthcare center she visits occasionally as a place where “I kind of just pop up like a jack-in-the-box,” which meant that “those kinds of deeper conversations don’t really happen in the same way.” Professionals in this study often belonged to multiple teams, such as obesity and diabetes teams, without feeling like a natural part of any. Unlike other professionals who share tasks and reflections with colleagues in the same field, RDs especially, were expected to manage several teams in parallel. Ella captured this sense of fragmentation: “we can’t clone ourselves into ten different teams. we’re so alone.”

The lack of informal contact could make seeking support more difficult. Maya noted, “it’s a bigger step to contact someone at another healthcare center than just bumping into someone in the corridor.” Without these spontaneous exchanges, opportunities for reflection and support were limited. Some professionals also noted the absence of formal forums for discussing difficult situations. As Maya put it,

“I don’t really have a forum for those tough situations. It’s really up to me to take the initiative to turn to a manager or colleague.”

Ella recalled, “all kinds of professions got supervision, but we didn’t,” adding, “there was no room or money for it. I think doctors had it, psychologists had it, they need it, but we didn’t, even though we meet the same kind of patients.” This comparison suggests a perceived hierarchy of support, where professionals experienced their need for supervision as receiving less recognition than that of some other professional groups, despite working with similar patient populations. Together, Emma’s and Ella’s accounts suggest that professionals sometimes experienced themselves as being on the periphery of the organization, making their need for support less visible.

Independence in clinical practice also meant managing one’s own schedule and responsibilities without backup. Sofia noted how this became visible: “when I’m away, it’s a disaster, I think. No one does my job.” This sense of irreplaceability illustrates how independence, while valued, can also lead to vulnerability. For some professionals, loneliness was reinforced when managers came from other professions. Ella shared, “we kind of did as we pleased,” adding with a slight laugh, “no one said anything, that’s the thing with dietitians, we’re so few, and we work in our own little corners.” Her account suggests that professional freedom sometimes came with a sense of being overlooked, as few others had insight into their work.

Even when managers were supportive, internalized pressure to be sufficient remained. Lucas reflected, “I know best myself, and I know how I want things to be,” acknowledging that “a lot of it comes from me, because I want to do the best job.” His account suggests that professional autonomy was accompanied by a strong sense of personal responsibility.

When no one else had an overview of the workload, some professionals tended to continue raising the bar without anyone to signal that it was enough. Over time, this can create a quiet but persistent obligation to carry full responsibility alone, regardless of whether the conditions were reasonable or not. How professionals sought ways to counterbalance the isolation that could accompany independent practice is explored in the next section.

Someone who gets it: The value of peer support

To manage challenges in dietary counseling, many professionals developed their own structures for support and exchange. Professional meetings and collegial connection were central for creating a sense of security and coherence in decision-making, particularly for RDs who often work without direct interaction with colleagues from the same profession. Max explained that they have built a strong network because “we don’t have what doctors have, like meetings at the primary care center” and emphasized the value of monthly gatherings that correspond to the weekly physician meetings. This illustrates how peer networks compensate for structural gaps, offering a sense of belonging.

Professionals valued having colleagues with varying levels of experience, forming a dynamic group where knowledge and perspectives could be shared. Shared routines and guidelines were seen as essential for consistency in practice. Freja highlighted the importance of clear criteria by explaining that when different referrals came in, “it’s helpful that we have clear criteria for what we accept and what we don’t,”which helped avoid decisions based solely on individual judgment, such as“Well, this person really needs help, of course we’ll take them.”Instead, as she put it, “it’s about doing what we’re supposed to do.”Her account illustrates how collective norms provided clarity and reduced the risk of individual over-responsibility.

Luna recalled how more experienced colleagues helped normalize difficult situations by saying, “this kind of thing happens. It’s okay, you did what you could.” Such exchanges offered validation and perspective, mitigating feelings of isolation or not being enough. Stella also highlighted the importance of access to others when facing complex decisions, noting that “we have good support from colleagues, doctors, other nurses and so on, to ask how we should prioritize and how we should think. That makes it easier to go home with the feeling that we’ve done the best job we could.” Together, these accounts illustrate how informal reassurance helped professionals navigate uncertainty and feel supported in difficult situations.

While some professionals felt collegial support was sufficient, others expressed a need for more immediate access to peers. Lucas reflected on the limitations of delayed discussions, noting that “to discuss specific patient cases in the moment, not three weeks later at a meeting with other dietitians, that would actually be valuable.” This suggests a desire for more responsive and situationally relevant collaboration. Emma, who had developed confidence through years of practice, shared that she “developed routines and experience for how to handle different situations,” while acknowledging that “at my first job, I probably needed it more [support].” This points to how professional growth reduces but does not eliminate the value of collegial exchange.

Professionals appreciated the networks they had built and valued interprofessional support at the primary care centers. Still, they stressed the importance of having access to colleagues from the same profession for deeper reflection. Lucas pointed out that having a fellow RD to consult with was especially valuable because “they actually know what I’m talking about” unlike physicians who “understand their own questions.” This underscores the need for profession-specific spaces to foster shared understanding.

Interprofessional collaboration was also seen as essential for continuity and for handing over responsibility when one’s own capacity or competence was insufficient. Sofia shared, “here it’s great, I could just run down and talk to the doctor who was on call yesterday and ask her to prescribe something. She fixed it right away.” Such moments show that collaboration does not always require complex structures. Simply being close can make support immediate and meaningful.

These accounts suggest that collegial support offered opportunities to share responsibility, gain perspective, and feel understood by others facing similar challenges. Such spaces may also help address the often-unspoken dimensions of care. One such dimension is ethics. It is constantly present in

encounters with patients, yet rarely named directly. The next section explores how professionals experience ethics in their work, even when it remains largely invisible in everyday conversations.

Integrated but invisible: ethics in professionals' daily Practice

Ethics was a central yet often implicit part of professionals' work in primary care. It rarely appeared as an explicit topic, even though it permeated decision-making and patient encounters. Rather than being named directly, ethics tended to emerge through everyday reasoning and clinical judgment. As Emma explained, "we don't say 'Now we're going to talk about ethics for 45 minutes,'" but it still came up in questions like"What do we do with this patient?"She added, "it's basically impossible not to touch on it."Her account illustrates how ethical considerations are woven into routine practice rather than treated as separate discussions.

Several professionals expressed a need for more structured opportunities to engage in ethical issues. Ethical concerns were often handled intuitively, guided by an internal compass rather than through formal discussion. This suggests that ethical reflection is embedded in practice but not always made visible or systematically explored. As Max noted, "we do talk about them, but we don't name them as ethical." He emphasized, "sometimes you need to use the word and clarify what it's really about." This highlights the risk that ethical reasoning remains fragmented when there is no shared language.

For many professionals, ethics was not something they consciously referred to but rather something internalized and taken for granted. Lucas said, "we do have a code of ethics, but exactly what it means, I'm not really sure." For him, ethical awareness was not tied to formal principles but to a sense of personal integrity: "I feel like I have it built into me," he said, adding that it was "just part of being normal." Such statements suggest that ethics was deeply integrated into professional identity and everyday practice rather than consciously reflected on as a distinct aspect of professional work.

These accounts indicate that while ethical awareness was present in professionals' daily work, it often remained unspoken and individually held. Ethics was described as something woven into everyday decision-making rather than openly discussed. When ethical reasoning remains largely implicit, opportunities for shared reflection on ethical challenges may become limited. This may be especially relevant for professionals who work largely independently and lack regular opportunities for collegial discussion, making ethical concerns more likely to remain individually managed rather than collectively explored.

Discussion

Dietary counseling in primary care can be understood as a relational practice, where ethical challenges are part of everyday interactions. Ethics of care provides a framework for interpreting the results, which are further discussed in relation to moral distress, moral resilience, moral sensitivity, moral agency, ethical competence and the importance of a moral community.

Dietary counseling as a relational practice

Professionals rarely described ethical challenges as isolated conflicts between competing values. In the subtheme It's just how we eat, professionals adapted advice to cultural practices, family circumstances, and social expectations. In Being careful not to make things worse, they sought to avoid reinforcing guilt, shame, or conflict, while One step at a time illustrates how change was negotiated through realistic and individually tailored goals.

These findings suggest that dietary counseling can be understood as a collaborative and relational process in which professionals and patients negotiate goals, priorities, and possibilities for change. Adaptation to individual circumstances, patient involvement, empathy, and readiness for change have been identified as important strategies for effective dietary counselling [1]. The present findings resonate with these strategies. However, our findings extend beyond consideration of effectiveness by illustrating how such practices also involve ethical work, including ongoing negotiations of responsibilities and competing values.

While principles such as autonomy, beneficence, non-maleficence, and justice [8] help illuminate value conflicts present in these encounters, ethics of care offers a complementary perspective by drawing attention to how ethical challenges emerge within relationships and are shaped by the contexts in which care is provided [11]. Similar relational and adaptive practices have been described among general practitioners and nurses in primary care [46] [47].

Ethics of care may also help illuminate the tension between caring for others and sustaining oneself as a professional. From this perspective, ethical practice involves not only responding to patients' needs but also recognizing the limits and conditions necessary for sustaining care over time [11].

Moral Distress and Moral Resilience

In the subtheme Giving everything, yet still not enough, professionals' accounts could be interpreted as expressions of moral distress [24–30]. Such experiences arose not only when professionals were unable to act in accordance with their judgment, but also when they felt that their efforts were insufficient despite doing what they could within existing constraints [27]. Feelings of not being enough emerged when considerable effort failed to translate into meaningful change or when patients' needs exceeded the support that could realistically be provided. Professionals also questioned the value of interventions when patients lacked the resources or capacity to act on the advice offered, creating a tension between providing support and recognizing its limited potential to improve the patient's situation. These accounts suggest that moral distress may arise when professionals remain committed to helping but are unable to achieve the outcomes they believe are needed.

Professionals also described experiences that could be understood as moral distress related to uncertainty. Even when acting within existing constraints, some professionals questioned whether more could have been done or whether they had responded in the most appropriate way. Professionals

continued to revisit encounters after consultations had ended, particularly when situations remained unresolved or lacked a clear sense of closure. These accounts suggest that moral distress may arise when professionals are left with unanswered questions about whether they could have done something differently [26, 28].

In Being independent or feeling lonely, professionals valued the autonomy of managing their own work but at times felt they carried responsibility and workload alone. These accounts suggest that moral distress may be intensified when ethically challenging situations are managed without opportunities for collegial reflection or shared responsibility. Previous research similarly suggests that a lack of continuity and belonging within the workgroup may hinder access to support and increase feelings of uncertainty and stress [48]. Such conditions may make it more difficult for professionals to process ethically challenging situations and share responsibility for difficult decisions [30].

At the same time, the accounts suggest that professionals developed ways of navigating these challenges over time. In Remaining engaged without being consumed, professionals described learning to recalibrate responsibility, set realistic boundaries, and accept the limitations of their role and the realities of primary care. Rather than withdrawing from care, they appeared to develop more sustainable ways of engaging with patients. These accounts may be understood as expressions of moral resilience, defined as the capacity to preserve professional integrity and act sustainably in ethically challenging situations [49, 50].

Collegial support can also be understood as a protective aspect of moral resilience. In Someone who gets it, peer networks and professional meetings provided affirmation, perspective, and opportunities to share responsibility with others. Such support appeared to validate difficult experiences, reduce feelings of isolation, and provide reassurance in situations marked by uncertainty. Professionals also described how access to colleagues for consultation helped strengthen confidence in their professional judgments. Moral resilience is not solely an individual capacity but is also shaped by relational and organizational conditions [49] [50].

Moral Sensitivity and Moral Agency

Moral sensitivity refers to the ability to recognize moral dimensions in a situation, understand patients' vulnerabilities, and reflect on the ethical implications of decisions [51, 52], while moral agency involves acting in accordance with one's values, even under adversity [53]. Agency presupposes sensitivity, as ethically motivated action depends on first discerning what is at stake [54].

In Being careful not to make things worse, professionals recognized that discussions about food and lifestyle could evoke guilt and shame among patients, particularly among those with previous experiences of being blamed for their health conditions. In It's never just about food, they navigated tensions between patient wishes, family expectations, and patient well-being. Similarly, in One step at a time, recommendations were adapted to patients' circumstances, readiness for change, and everyday lives rather than idealized goals.

Professionals demonstrated moral sensitivity through their attentiveness to patients' circumstances, relationships, vulnerabilities, and capacity for change [51, 52]. They demonstrated moral agency by acting on these understandings through adapting communication, supporting patients' expressed wishes, and tailoring recommendations to what was realistic and achievable [53, 54].

Professionals also faced structural barriers to sustaining moral agency. In Being independent or feeling lonely and Someone who gets it, professionals described limited opportunities for supervision, reflection, and collegial discussion despite regularly encountering ethically challenging situations. Such conditions may leave professionals to rely primarily on their own judgment when navigating ethical challenges. Previous research similarly suggests that a lack of organizational support may contribute to feelings of isolation and uncertainty, potentially limiting professionals' capacity to enact moral agency in practice [53].

Ethical Competence and a call for Moral Community

Ethical competence can be understood as an ability to manage ethical challenges in a professional context and includes qualities such as ethical awareness, moral judgment, and the ability to act on ethical concerns [55]. Moral resilience [49, 50], moral sensitivity [51, 52], and moral agency [53, 54] may be understood as expressions of ethical competence in practice. While these qualities were evident in professionals' accounts, the conditions necessary to sustain and further develop ethical competence appeared limited.

InIntegrated but invisible, ethics were often described as implicit rather than explicitly discussed. Professionals expressed limited familiarity with ethical guidelines and described a lack of shared language for talking about ethics. Similarly, in Being independent or feeling lonely, opportunities for structured collegial reflection were limited, leaving ethical challenges largely managed on an individual basis. Such conditions may leave ethical concerns unarticulated and reduce opportunities for shared ethical deliberation. Ethical competence is influenced not only by individual qualities and experience but also by access to ethical knowledge, communication, and supportive organizational environments [55].

According to ethical codes, decisions should be grounded in awareness, reflection, and systematic analysis [9, 10]. However, professionals sometimes described ethical conduct as something self-evident or taken for granted in everyday practice. While moral intuitions are important in professional work, such understandings risk assuming that good intentions alone guarantee ethically sound actions. These findings highlight the importance of creating opportunities where ethical reasoning can be articulated, examined, and discussed collectively rather than remaining implicit and individually held.

Previous research suggests that ethical competence develops through interaction, where ethical reasoning is articulated, challenged, and refined [56, 57]. This is particularly relevant in relation to the present findings, where ethics was often described as implicit and opportunities for structured reflection were limited. Structured forms of ethics support, such as ethics rounds, ethics clubs, or group supervision, have been proposed as ways to facilitate ethical reflection, develop a shared language for

discussing ethical challenges, and strengthen aspects of both individual and collective ethical competence [55, 57, 58]. Such support may also help make previously unrecognized ethical issues visible and enhance professionals' ability to navigate complex situations [59].

These findings point to the importance of a moral community in which ethical challenges can be shared, discussed, and reflected upon rather than managed solely on an individual basis. Interventions aimed at strengthening ethical competence and mitigating moral distress appear most effective when supported at the organizational level, highlighting the importance of systemic approaches rather than relying solely on individual professionals' efforts [49, 55, 56, 58].

Strengths and limitations

A strength of this study is that it explores an under-researched aspect of nutritional care. To our knowledge, few studies have specifically examined how professionals experience and make sense of ethical challenges in dietary counseling within primary care. The use of IPA enabled an in-depth exploration of experiences that participants themselves often described as implicit, intuitive, and difficult to articulate, making it particularly suited to the study aim [39, 40]. The relatively small sample should be considered in relation to the idiographic focus of IPA and the concept of information power, which emphasize depth and richness of data rather than sample size alone [38–40].

A further strength was the reflexive approach adopted throughout the study. As ethical aspects were often implicit in participants' accounts, ongoing discussions among the authors supported the interpretation of participants' meaning-making while helping to keep interpretations grounded in the data [39, 40].

Another strength is that participants represented different levels of professional experience and worked in different primary care contexts, allowing both shared and differing experiences of ethical challenges to be explored. The limited participation of registered nurses and district nurses means that the findings primarily reflect dietitians' experiences of ethical challenges in dietary counseling. While this may reflect the more central role of nutritional care in dietetic practice, it limits the transferability of the findings to other professional groups.

The study relied solely on interview data. As a result, the findings reflect participants' accounts and interpretations of their experiences rather than observations of clinical practice. Ethical challenges that were difficult to articulate or remained outside participants' awareness may therefore not have been captured [40].

Finally, participants volunteered to participate in the study. Professionals with a particular interest in ethical issues may therefore have been more likely to participate, potentially influencing the types of experiences that were shared.

Conclusion

Professionals in primary care experienced and made sense of ethical challenges in dietary counseling when balancing the boundaries of professional responsibility with patients' broader needs and circumstances. Ethical considerations were closely intertwined with everyday practice but often remained implicit and were largely managed individually. Professionals described a need for opportunities to discuss, reflect on, and share responsibility for ethical challenges. Stakeholders should therefore consider implementing structures for ethical reflection and collegial dialogue to support professionals in navigating ethical challenges in dietary counseling and to foster the development of a moral community.

Abbreviations

RD Registered Dietitian

RN Registered Nurse

DN District Nurse

ONS Oral Nutritional Supplements

IPA Interpretative Phenomenological Analysis

COREQ Consolidated Criteria for Reporting Qualitative Research

COPE Committee on Publication Ethics

AI Artificial Intelligence

LCHF Low-Carbohydrate High-Fat

IBS Irritable Bowel Syndrome

Declarations

Ethics approval and consent to participate

Ethical approval for the study was obtained from the Swedish Ethical Review Authority (Reference No. 2023-03151-01). All participants received written and verbal information about the study and gave informed consent prior to participation.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available because they contain sensitive information that could compromise participant privacy and confidentiality. However, the data that support the findings of this study are available from the corresponding au-thor upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

Funding

This study is part of SP's doctoral project funded by the Swedish Research Council [grant number 2023-05992]. The funding sources had no role in the design of the study, data collection, analysis, or interpretation of results.

Authors' contributions

All authors (SP, ÅG, ATH, EL) took part in initiating and planning this study. SP collected the data. SP primarily conducted the data analysis and was responsible for distributing drafts of the manuscript. Co-authors (ÅG, ATH, EL) regularly reviewed and provided feedback throughout the writing process. All authors (SP, ÅG, ATH, EL) took part in regular analysis meetings, reviewed and commented on the drafts and contributed to the overall feedback.

Acknowledgements

The authors thank the healthcare professionals who participated in the study and shared their experiences. The authors also thank Nära vård och hälsa, Region Uppsala, for their collaboration in facilitating the study.

Authors' information (optional)

Not applicable

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Figures

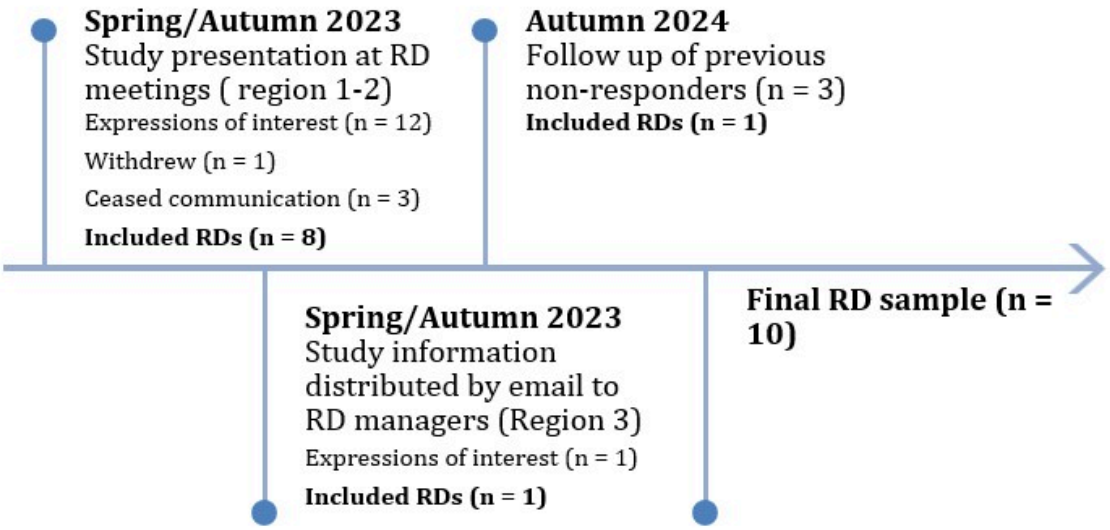


Figure 1A. Recruitment of RDs.

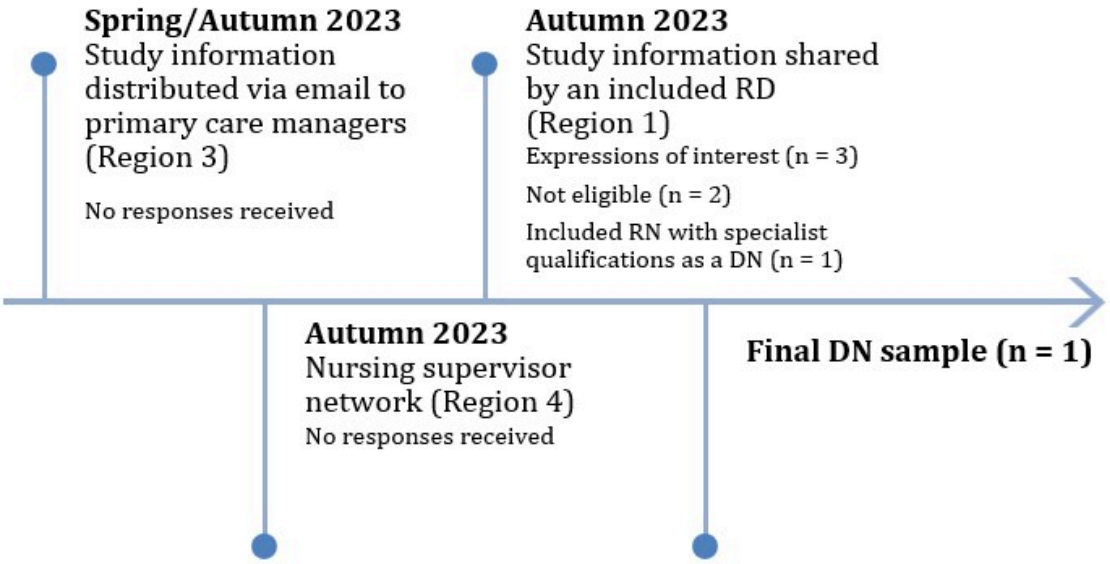


Figure 1B. Recruitment of registered nurses with specialist qualifications.

Figure 1

See image above for figure legend

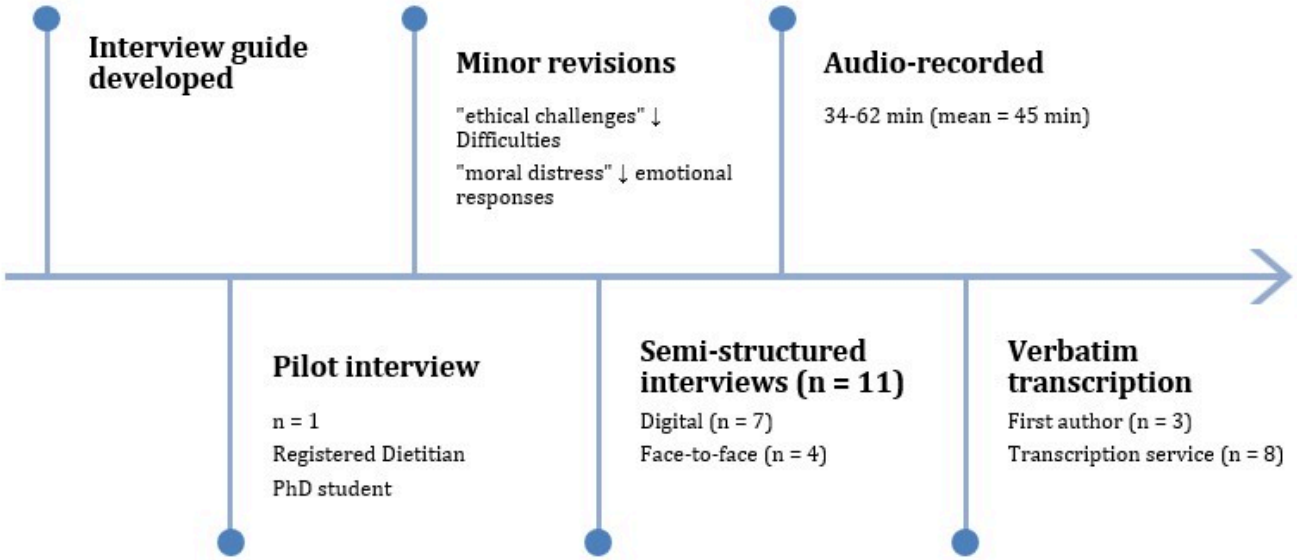


Figure 2

Overview of the data collection process

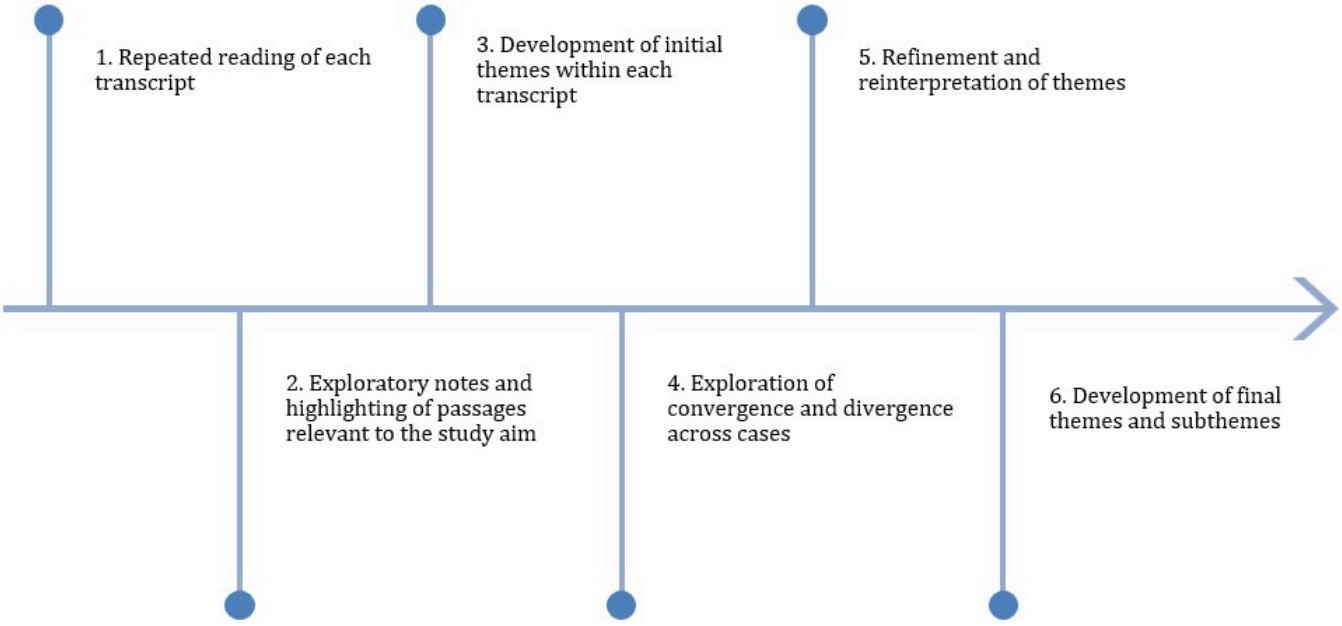


Figure 3

Overview of the analytic process. The process is presented schematically; however, analysis was iterative.

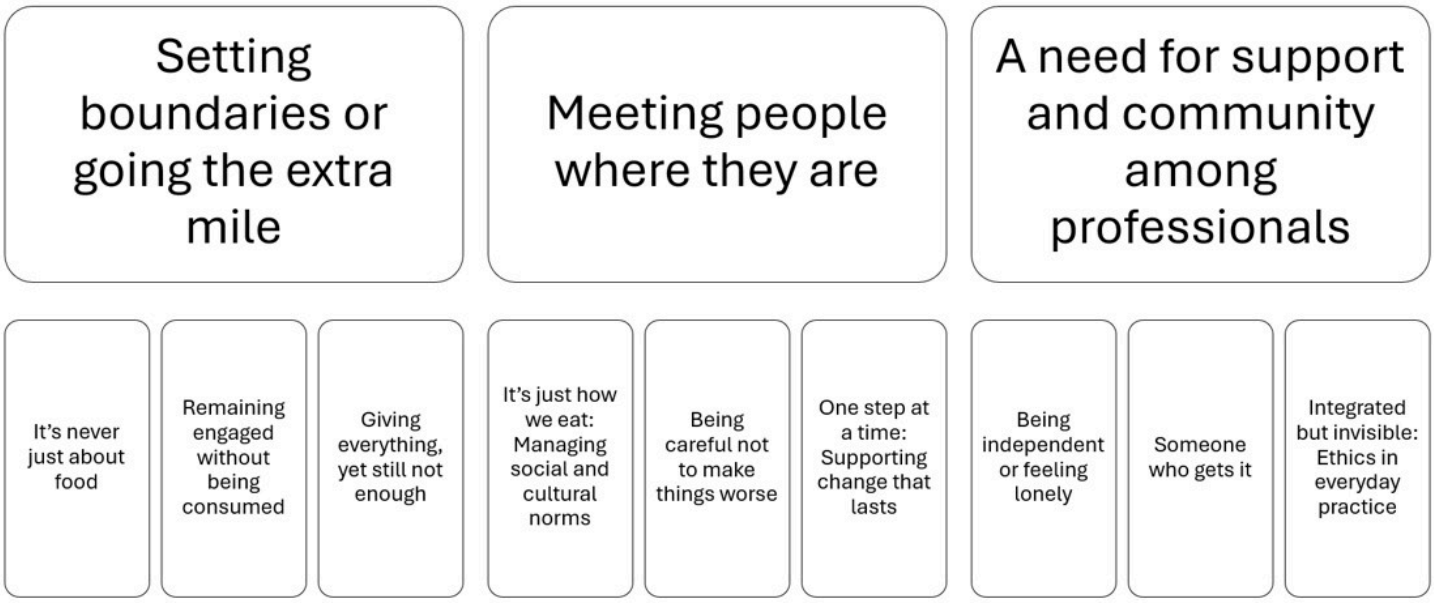


Figure 4

Results presented in themes and sub-themes

Supplementary Files

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- Additionalfile1.docx
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